NHS
Telford and Wrekin
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS 2017/18

Healthier, happier, longer

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Chair's foreword

The last year has been a relatively stable one for Telford and Wrekin Clinical Commissioning Group (TWCCG), although with some notable staff changes.

In April we welcomed Jon Cooke, our new Chief Finance Officer, and elected a new Clinical Board member Dr Adam Pringle to replace Dr Shailendra Allen. I would like to thank Dr Allen for his hard work, energy and enthusiasm while he was a member of our board, and to wish him well in his new role at Shropshire CCG (SCCG). I would also like to thank Dr Pringle for the considerable positive contribution he has made, and continues to make, to the CCG since joining.

Neighbourhood working continues to focus on developing health and social care within the community. In areas such as Newport we have seen some excellent examples in dementia support services and through the Frailty Project we have seen a real positive difference in our older frail population.

Having decided to go out to consultation on the model for Future Fit, preparations have begun. We have also now received NHS England approval to formally launch the consultation.

While we have managed to balance the books again this year, the year ahead promises to be much more challenging and as an organisation we are thinking differently about how we commission healthcare for our population. As part of this we are committed to engaging with our population and the patients who use our services to make sure we are providing quality services based on patient experience.

Jon Cooke is doing a fine job in keeping us all on task and making sure that we remain in financial balance, and the whole board is making a positive contribution to this. I should like to thank all board members for their hard work and dedication to addressing the health needs of our population.

We continue to work on the development of our Sustainability and Transformation Partnership with our partner organisations and I feel confident that we will face the challenges ahead together to achieve the best possible outcome for the people of Telford and Wrekin.

Finally, I would like to say how proud I am to be the Chair of an organisation with a clear sense of purpose and a positive, can-do culture and I look forward to working with everyone for the remainder of my term as Chair.

SIGNATURE

Dr Jo Leahy

CCG Chair

DATE 24th May 2018

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Please note the following report contains a number of links to signpost the reader to more information. These links and the associated information contain within them are not subject to audit.

Performance report

Performance overview by Mr David Evans, Chief Officer

This is the fifth Annual report of Telford and Wrekin CCG, a year of considerable challenge for the CCG in terms of both finance and performance. Whilst it is pleasing to report that the CCG has met all of its statutory financial targets for 2017/18 it is clear that with the current financial settlement for the NHS, the year ahead looks extremely challenging and the CCG Board will need to consider carefully how to prioritise the allocation of funding and will be faced with making some difficult decisions going forwards.

The Future Fit programme has made progress this year with the Joint Committee of the Shropshire CCG and Telford and Wrekin CCG meeting in public in August and agreeing to a preferred option for the programme. The Pre Consultation Business Case (PCBC) has since been approved by the Telford and Wrekin Governing Body. The West Midlands Clinical Senate received the PCBC and agreed that the clinical case for the proposed changes was appropriate. The PCBC was then submitted to NHS England as part of their assurance process and all of the remaining points have been clarified. The health economy has now received a decision to approve £312,000,000 capital funding that was required to move forward with the project.

The CCG continues to work hard with partner organisations to improve services for patients, unfortunately with regard to Accident and Emergency waiting times I am disappointed to write that we have not made the progress that I would like to have seen and our population deserves. This is despite an enormous amount of hard work by all of the partners involved. I particularly would like to thank colleagues in primary care for managing increasing demands on an already strained service and to colleagues in Telford and Wrekin Council, who despite a very challenging time for local authority finances, have continued to fund care for patients outside of the acute hospital.

The development of services to prevent admission to hospital continues within the work to develop neighbourhoods in the CCG. Whilst at the early stages, this is seeing practices working collaboratively and with other partners organisations to enable patients to be seen and cared for closer to home.

I would like to say a personal thank you to all of the staff in the CCG, including the executive team, the Board and the membership for their continued hard work and support. Our continued ability to deliver improvements for our population is entirely down to them and as Accountable Officer I never failed to be impressed by the dedication and commitment of the team.

SIGNATURE

David Evans

Accountable Officer

DATE 24th May 2018

Statement of purpose and activities of the CCG

This section of the annual report provides summary information on NHS Telford and Wrekin CCG; its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed over 2017/18.

About us

NHS Telford and Wrekin CCG is a statutory body established under the Health and Social Care Act 2012.

It was fully authorised as a CCG on 1 April 2013, with no conditions on its operations. The principal location of our business is at Halesfield 6, Telford TF7 4BF.

The CCG is a membership organisation – during 2017/18 there were 14 GP practices in Telford and Wrekin, all of which are member practices of the CCG. As local GPs we have regular contact with patients and know what health services are needed to support our local population.

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

Telford and Wrekin CCG is responsible for designing and purchasing (commissioning) healthcare in the Telford and Wrekin area.

We:

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

This means we commission services from a range of providers:

- the majority of our local acute services come from Shrewsbury and Telford Hospital NHS Trust (SaTH)
- our community services from Shropshire Community Health NHS Trust
- mental health services from South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT)
- out of hours primary care services from Shropshire Doctors Co-operative (Shropdoc)
- ambulance services from West Midlands Ambulance Service (WMAS).

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

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

Our other key local partner is Telford and Wrekin Council, with whom we work closely, commissioning services that cross social and health boundaries. The CCG does this with the Council via the Better Care Fund and services where we have developed a joint strategy, for example starting to align services across four neighbourhood areas making up Telford and Wrekin,

so that social care, self-help support services and health services are located closer to people's homes.

Our vision and objectives

NHS Telford and Wrekin CCG's vision reflects the changed driver from a focus on ill-health to a local one, driven by the need to help maintain an individual's wellbeing:

"Working with our patients, Telford and Wrekin CCG aspires to have the healthiest population in England. Healthier, Happier, Longer."

Working with our partners, NHS services, GP members and patients we have identified five key objectives to help us deliver our vision of health service provision. These objectives will guide our decision making to deliver high quality, equitable, safe and locally driven care:

- to improve commissioning of effective, safe and sustainable services that deliver the best possible outcomes based upon the best available evidence
- to increase life expectancy and reduce health inequalities
- to encourage healthier lifestyles
- to support vulnerable people
- and, in meeting the objectives above, to exercise CCG functions effectively, efficiently, economically, and in accordance with generally accepted principles of good governance and as an employer of choice.

Population challenges

We serve a total GP patient list population of 172,000 people across Telford and Wrekin. Telford and Wrekin has a large, younger urban population with some rural areas. Many of the people we serve live in deprived areas, with more than a quarter (27 per cent) of the borough's population living in the 20 per cent most deprived areas nationally, an increase of 24 per cent in 2010. As a result, tackling health inequalities is a priority for the CCG:

- During the 2011 Census, some 80.2 per cent of the population of Telford and Wrekin reported that they had good or very good health. This is slightly lower than the 81.4 per cent in England generally. A further 6.2 per cent reported having bad or very bad health. This varied by age, with adults aged 16-64 at 3.2 per cent whereas adults 65 and over were at 18.1 per cent.
- The life expectancy at birth in Telford and Wrekin is 78.1 years for males. The equivalent figure for females is higher at 81.8. Both ages are significantly worse than their equivalent England averages of 79.3 and 83.0 respectively.
- The standardised mortality ratio (SMR) due to all causes for those under 75 in Telford and Wrekin is worse than the national ratio. This remains true when the separate and specific causes of either cancer, circulatory disease or coronary heart disease are separately considered.
- The SMR due to all causes (for all ages) in Telford and Wrekin is worse than the national ratio. This remains true when the separate causes of cancer, circulatory disease, coronary heart disease, stroke, and respiratory disease are measured.
- The standardised incidence ratio (SIR) for all cancers in Telford and Wrekin is similar to the national ratio. This remains true when the separate cancer types of breast, colorectal and

lung cancer are measured. The SIR for prostate cancer, however, is significantly better than that nationally.

- The 2011 Census found 1,562 children (aged 0-15) in Telford and Wrekin with a long-term limiting health problem or disability that limited their daily activity. This amounts to a rate of 4.6 per cent of the 0-15 population. In a more detailed age breakdown, the rate increases with age, with those aged 0-4 having a rate of 2.5 per cent. The 2011 Census found 15,938 adults aged 16-64 in Telford and Wrekin with a long-term limiting health problem or disability that limited their daily activity. This amounts to a rate of 14.7 per cent of the 16-64 population. In a more detailed age breakdown the rate increases with age, with those aged 55-64 having the highest rate of 29.6 per cent.
- The 2011 Census found 13,495 older people aged 65 and over in Telford and Wrekin with a long-term limiting health problem or disability that limited their daily activity. This amounts to a rate of 56.0 per cent of the 65 and over population. Telford and Wrekin has 2,400 residents aged 16-64 with serious physical disability. A further 8,300 have a moderate physical disability. Telford and Wrekin is estimated to have 1,000 children aged 5-10 and 1,400 aged 11-16 with a mental health disorder.
- Telford and Wrekin estimates it has 17,400 adults aged 16-64 with a common mental health disorder. The majority of these (10,600) are female, a prevalence of nearly 20 per cent of all females aged 16-64. In men this prevalence is 12.5 per cent.
- In Telford and Wrekin there are estimated to be 700 older people aged 65 and over with severe depression. The prevalence of severe depression in those 65 and over varies with age. It is most prevalent in the 85 and over age group at 3.9 per cent.
- Telford and Wrekin is estimated to have 1,800 residents over 64 suffering from dementia. The number of sufferers increases with age band, with 800 sufferers aged 85 and over.
- It is estimated that 4,000 Telford and Wrekin residents have a learning disability. The majority, 3,300, have a baseline learning disability, the remaining 700 having a moderate or severe learning disability.
- The standardised admissions ratio (SAR) of emergency hospital admissions for a range of common serious conditions are all higher than the national ratio – in Telford and Wrekin the SAR for coronary heart disease (CHD) is 112.8, for stroke it is 136.3, for myocardial infarction (heart attack) it is 116.7, for chronic obstructive pulmonary disease (COPD) it is 112.1.
  (Figures drawn from www.telford.gov.uk/factsandfigures)

As a CCG we are committed to working with patients and clinicians to help people manage their long-term conditions and ensure services can support the ageing population we have.

Our key programmes of work

The CCG is striving to ensure that our strongly held view that 'quality drives efficiency' is reflected in the priorities we set. In other words, our ambition has been to identify priorities and work programmes that will improve outcomes, quality, performance, and efficiency.

It is important that decisions are transparent, and that there is an open and continuing dialogue with the public to inform these decisions.

Initiatives, such as the Better Care Fund, give us the opportunity to drive new approaches to commissioning and new ways of working which provide alternatives to hospital admission, and welcome continued commitment to work with the Telford and Wrekin Council and our partner CCGs to realise these benefits.

We have been determined to ensure the 'what' question has been informed not only by outcome and performance data, but both patient and clinical engagement.

As a result, the CCG planned its focus for 2017/18 on four key programmes to support a local, system-wide healthcare transformation in Telford and Wrekin.

The detailed work in each programme was planned to be delivered through interconnected projects. Some of these were already well established and close to completion, others are in progress or have been amended to respond to changing local circumstances. The four key programmes of work, each with a series of projects, discussed and agreed with our practice members and Health Round Table Representatives were as follows:

i. **change the dynamic -** to strengthen communities and individual's ability to 'self-care'

ii. **patients at the centre -** to sustain and improve primary care, including strengthening integrated multi-disciplinary working in line with current Better Care Fund (BCF) pilots

iii. **streamlined care - robust pathways -** to ensure we commission sufficient capacity for planned care and improve the patient experience of appointments and treatment

iv. **support people in a crisis with the right care at the right place' -** to make sure people can 'navigate,' a simplified 'Urgent Care System,' to meet both physical and mental health needs.

These priority programmes are shown in the diagram below which emphasises putting the patient at the heart of the CCG's priority programmes, and the need for these programmes to inter-link and be delivered simultaneously.


111
Support People in a Crisis
'Right Care, Right Place'
Patients at the Centre
Community Resilience 'Change the Dynamic'
Telford Neighbourhood Care Teams
'Teams working around the Patient'
Streamlined Care
'Robust Pathways'

The following table outlines in more detail what projects make up the four programmes of work for 2017/18:

Programme	**'Change the dynamic'**	**'Patients at the centre of care'**	**Streamlined care – 'Robust pathways'**	**'Support people in a crisis with the right care, right place'**
Goal	To change the traditional reliance on the NHS and social care by promoting 'self-care' and creating supportive, confident and connected communities.	To put patients at the centre of a supportive infrastructure of services organised at locality level with a multi-disciplinary 'Team around the Practice'. (TAP)	To get rid of inefficiencies for both patients and clinicians, and improve access to tests and reduce waits for treatment.	To make sure people can 'navigate' a simplified 'Urgent Care System' to meet both physical and mental health needs.
Current Projects	C1 Develop a joint strategy for 'Building Resilient Communities'. C2 Redesign model of care for people with learning disabilities. C3 Produce and deliver a joint Care/ Nursing Home Strategy. C4 Develop and implement an End of Life strategy – 'A Good Death'.	T1 Design a new sustainable model with and for primary care. T2 Design and implement effective multidisciplinary 'Case Management' for our most complex patients. T3 Design and implement a model for 'Locality Working/ structures' (TAP).	P1 Implement the Musculoskeletal (MSK) model. P2 Ensure sufficient capacity for 'Planned & Cancer Care' & redesign booking systems to improve access and reduce waiting times. P3 Deliver a Cancer project - 'One Stop Shop'/Fit for 2020 by 2017'. P4 Redesign the IAPT model. P5 Redesign the Mental Health model (including Children Adolescent Mental Health Service (CAMHS) & Dementia).	R1 Improve MH crisis management (as part of the MH redesign). R2 Procure new model for NHS111 and Out-of-Hours (OOH) to 'fit' our emerging model of 'Urgent Care'. R3 Design and implement Ambulatory Care model. R4 Redesign Intermediate Care.

However, during 2017/18, NHS England issued planning guidance on the introduction of Sustainability and Transformation Plans (STP). STPs were initially set out in the NHS Shared Planning Guidance to support implementation of the 'Five Year Forward View'. The purpose of the STP is to create and implement local plans that aim to improve health and care. Produced collaboratively by local NHS organisations and local councils, they set out practical ways for the local NHS to improve NHS services and health outcomes for people in every part of England. The STP for our area covers Telford and Wrekin and the rest of the geographical county of Shropshire. Clearly, our operational plan, described above, was then amended in year to allow it to be aligned and integrated into the new STP for our area. Whilst the STP plan considers more radical solutions to the wider system problems, by continuing to also focus on Telford and Wrekin's existing and evolving priorities, the CCG will be playing its part in taking the system in the right direction.

Telford and Wrekin CCG is very clear about planning for three key and overarching priorities which it has reframed in light of the introduction of STPs for delivery in 2017/18 and 2018/19;

	Priority	**Enabling**
Transformational	1. Neighbourhood working and primary care at-scale	Reconfiguration of acute services
	2. Improve crisis response	
Transformational	3. To raise our game in all aspects of commissioning and contract management, so that performance against NHS constitutional targets, patient outcomes, and productivity is amongst the best in the country.	

Delivering neighbourhood working and improving crisis response will in turn enable the reconfiguration of acute services.

Our plan proposes several specific projects to ensure delivery of these priorities; for example, commissioning community-based ambulatory and urgent care services.

The national guidance also required us to include proposals for how the CCG will address the nine 'must do's', including for example, ensuring we commission services that deliver NHS constitutional targets.

These can be summarised:

The nine 'must do's'

1. Deliver the STP
2. Return the system to aggregate financial balance
3. Ensure sustainability and quality of general practice
4. Deliver 95% performance for the A&E Access target

5. Deliver the Referral to Treatment Target (RTT)
6. Deliver the 62-day cancer waiting standard
7. Achieve and maintain mental health access standards and develop plans for 'Five Year Forward View'
8. Transform care for people with learning disabilities
9. Deliver quality improvements.

From 2016/17 we have been participating in the wave two NHS RightCare Programme. The programme is committed to improving people's health and outcomes by making sure each person has the right care, in the right place, at the right time, making the best use of available resources.

RightCare is about identifying priority programmes which offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

By providing the commissioning system with data, evidence, tools, and practical support around spend, outcomes, and quality, the RightCare programme can help clinicians and commissioners transform the way care is delivered for their patients and populations. The CCG has chosen three priority areas after reviewing 11 programme areas:

Priority programmes of care	**Priority areas**	**Potential saving opportunity**
Circulatory	• Hypertension • Coronary Heart Disease • Stroke • Atrial Fibrillation • Diabetes	£607,000 (elective and day-case admissions) £894,000 (non-elective admissions)
Respiratory	• Asthma • Chronic obstructive pulmonary disease (COPD) • 'Other' respiratory conditions	£702,000 (non-elective admissions) £584,000 (primary care prescribing)
Mental Health	• Improving Access to Psychological Therapies (IAPT) • Self-harm • Depression • Dementia • Severe Mental Illness (SMI)	£508,000 (primary care prescribing)

During 2017/18 we added additional programmes, specifically Neurology and Gastrology to the Rightcare priorities.

Working with partners

The CCG continues to build on the strong history of partnership working in Telford and Wrekin with a number of its partners, and this has been furthered cemented with the introduction of Strategic Transformation Plans (STP). The CCG is leading on a number of partnership initiatives that are key to delivery of STP objectives and this will continue to be a key focus for us in 2018/19.

Providers

2017/18 has continued to be a very challenging year for providers. Performance has generally improved for planned care, although there has been an impact from the challenges in Accident and Emergency (A&E) – by making sure the NHS Constitution requirement for patients to have treatment within 18 weeks from referral to treatment (RTT), and cancer targets (also measured by a series of waiting measures), are met. The local health economy has struggled to meet the target of ensuring 95 per cent of people attending emergency departments are seen within four hours and this reflects the national position during the year. This performance has continued to deteriorate and all partners, including social care, are heavily engaged in delivering a recovery plan to bring improvements, which is being overseen by the A&E Delivery Board and an urgent care director.

The CCG has used contractual levers to improve quality of services and waiting times for patients, but has also provided collaborative support to help providers design new ways of working to meet these demands. There have been difficult points in the year where our partnerships have been tested, but the CCG will continue to strive to commission in a way that balances collaboration with contractual requirements, to ensure our population receives high quality healthcare services.

Telford and Wrekin Health and Wellbeing Board (HWBB)

The CCG's Chair Dr Jo Leahy and Chief Officer David Evans both sit on the HWBB. The HWBB has matured over the last three years. The HWBB reviewed its strategy and associated priorities for 2016-19. The following three priorities were identified following discussion with board members at two development sessions and reflected feedback received from members of the public who responded to the 'Are you healthy, safe and independent?' survey undertaken in September 2015:

- encourage healthier lifestyles
- improve mental wellbeing and mental health
- strengthen our communities and community based support.

The strategy can be found at:
http://www.telford.gov.uk/downloads/file/4005/health_and_wellbeing_strategy_2016

The impact of the strategy has been monitored by the HWBB during 2017/18 based on update reports and outcome frameworks produced and presented regularly. The HWBB now forms part of the STP governance structure to ensure that partnership working is truly at the centre of the delivery of the STP.

Telford and Wrekin Council

The Better Care Fund (BCF) continues to be an important focus for our partnership working with the council, and it will continue to be so for a number of years to come. 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 have embarked on joint working though our neighbourhood working model which forms an important element of the STP. This work is allowing us to explore in a more meaningful way how health and social care services can be delivered in more community settings closer to people's homes, and how they can ultimately be more integrated, so we support the whole person and not a disease.

Health Overview and Scrutiny Committee, Telford and Wrekin Council

Our interaction with the Joint Health Overview and Scrutiny Committee has continued to be significant during 2017/18, with a number of service redesign projects discussed at the committee as well as regular updates on the progress of other initiatives. In addition, progress with Future Fit has been presented to the Joint Health Overview and Scrutiny Committee and to Shropshire Council. This has helped to strengthen further our working relationship, as well as ensuring that projects are being undertaken in the best interests of our population.

NHS Shropshire CCG

We work collaboratively with our neighbour Shropshire CCG on a number of key issues including safeguarding, Future Fit, local maternity services, midwifery led units (MLU) service review and lead commissioning arrangements with shared providers.

We continue to explore opportunities to work together, with our greatest focus being on Future Fit and primary care working programmes which are looking at redesigning acute services and creating more sustainable primary care services provision for the future. We generally work in partnership on procurement programmes, and are closely aligned when negotiating contracts with our provider trusts.

Midlands and Lancashire Commissioning Support Unit (MLCSU)

MLCSU currently provides the majority of CCG functions through a contract ranging from financial management to human resources and information governance. The relationship with MLCSU has continued to grow during 2017/18. The CCG continues to work with MLCSU in terms of consistency of services provided.

Key issues and risks

The CCG manages risks through the Board Assurance Framework, which provides the mitigating actions for how the organisation manages its key risks. This is updated regularly and scrutinised through the Audit Committee and Governance Board. Current details are available on the CCG website.

The risks for 2017/18 have been predominantly about performance against meeting NHS Constitution targets, particularly the 95 per cent four-hour access target to the emergency departments.

Other key issues include Future Fit and risks about other priorities impacting on our ability/capacity to reduce health inequalities – one of our key objectives.

In addition, the CCG monitors the continued risk to the quality and sustainability of care delivered to its population by commissioned services. Maternity services delivered by Shrewsbury and Telford Hospital (SaTH) have been the subject of reviews and we await their findings. In the meantime, we are working with all partners to develop a local maternity system that moves this agenda forward in a safe and sustainable way.

The key issues related to commissioned services are the workforce challenges inherent across a wide range of services, for example children and young people's mental health services, ophthalmology, neurology and emergency care at SaTH. All partners are working together to look at alternative models of care and skill mix, to ensure that services can be safely delivered locally for the population in order to manage this risk.

As we move into 2018/19 there is a growing set of risks about the need to deliver a high efficiency target, with the risk of not achieving financial balance and this will consequently take a higher profile over coming months.

The CCG is currently on track to achieve the planned 'business rules' cumulative surplus of at least one per cent and the in year 2017/18 control total of break even. However, within the position the CCG is currently managing a number of significant cost pressures:

- hospital contracts are showing a significant over-trade particularly in relation to emergency costs. In line with other CCGs there appears to be a significant upward shift in urgent care activity costs that are not represented by activity changes. These are being investigated with the trust and a number of contract challenges have been raised. In addition, there is a significant potential pressure associated with sepsis which is still awaiting national resolution between NHS England and NHS Improvement. Outpatient and A&E activity has also significantly risen compared to the same period last financial year. In line with national guidance the hospital trust has established a GP streaming service in the A&E department at Princess Royal Hospital. While this is meant to be self-financing, there is non-recurrent pressure as discussions continue to address financial pressures across the whole of urgent care, including agreement of a local tariff for ambulatory care. In addition to the cost pressures and activity rises above, there has been a significant increase in the volume of trauma and orthopaedics elective activity that has been seen in year across all providers, including those in the private sector
- ambulance costs and activity have significantly risen during 2017/18
- in prescribing, cost pressures exist in relation to 'no cheaper stock obtainable' (NCSO). NCSO status is granted for products listed in Part VIIIA and Part VIIIB of the drug tariff where pharmacy contractors have been unable to purchase product at the set drug tariff reimbursement price. NCSO can create a significant and unpredictable cost pressure for the CCG and the NHS as a whole.
- the CCG is under- delivering significantly against the 2017/18 quality, innovation, productivity and prevention (QIPP) target. This is currently being mitigated using contingencies and reserves. The CCG programme management committee continues to work on contingency schemes and acceleration of 2018/19 schemes. The pressures identified in 2017/18 will result in a significantly higher QIPP requirement for 2018/19 than previously identified. The CCG is focusing senior management and clinical resource to identify areas to consider in development of the 2018/19 QIPP programme and is fully considering opportunities identified through RightCare and the Menu of Opportunities. In addition, we are working across the STP patch to identify and accelerate transformational QIPP programmes.

Adoption of going concern basis

The accounts have been prepared under the directions issued in the 2017/18 Department of Health and Social Care (DHSC) group accounting manual (GAM) and the government financial reporting manual. Following discussion at the CCG board meeting held on 13 March 2018 the board agreed that the CCG is a 'going concern', and the accounts have been prepared on that basis.

Performance summary

Integrated performance and quality dashboard 2017/18

The CCG tracks the progress of its service providers (including local hospitals, community services) against a number of national outcomes indicators, and ensures that patients' rights within the NHS Constitution are maintained. Additionally, the CCG has set local priorities against which providers' progress is monitored. Performance reports are presented to the board on a monthly basis and can be found on the CCG's website: https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers.

The performance dashboard below shows monthly and quarterly achievements from 1 April 2017 to 28 February 2018 against patient rights defined in the NHS Constitution and other Key Performance Indicators. The figures are provided via MLCSU using the Aristotle tool.

Performance Dashboard 2017-18

			Q1			Q2			Q3			Q4		
		Target	2017/18 Apr	2017/18 May	2017/18 Jun	2017/18 Jul	2017/18 Aug	2017/18 Sep	2017/18 Oct	2017/18 Nov	2017/18 Dec	2017/18 Jan	2017/18 Feb	2017/18 Mar
NHS Constitution and supporting indicators														
Incomplete pathways under 18 wks		92%	87.1%	88.5%	88.5%	89.4%	88.0%	90.8%	92.1%	93.0%	92.1%	90.7%	90.4%	89.3%
52-week RTT		0	1	3	3	0	3	1	1	2	0	1	1	1
Referral to diagnostics within 6 wks		99%	99.3%	99.9%	99.9%	99.9%	99.8%	99.4%	99.2%	99.2%	99.4%	99.3%	99.6%	99.4%
2WW suspected cancer referral		93%	93.9%	94.0%	94.6%	95.1%	91.6%	95.0%	90.7%	95.7%	91.6%	92.2%	94.8%	94.8%
2WW urgent breast referral		93%	96.0%	92.1%	97.0%	93.8%	93.9%	96.1%	94.8%	98.0%	93.8%	100.0%	97.0%	97.2%
Diagnosis of cancer to treatment in 31 days		96%	100.0%	100.0%	98.8%	100.0%	100.0%	97.8%	98.6%	97.9%	100.0%	98.6%	100.0%	98.7%
Subsequent surgical treatment in 31 days		94%	95.7%	92.9%	90.9%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	100.0%
Subsequent anti-cancer drugs in 31 days		98%	100.0%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.8%
Subsequent radiotherapy in 31 days		94%	95.0%	96.0%	100.0%	96.8%	96.7%	96.3%	100.0%	96.8%	100.0%	96.9%	100.0%	100.0%
GP referral to cancer treatment in 62 days		85%	81.8%	81.4%	75.0%	89.7%	86.2%	93.8%	76.0%	83.3%	86.4%	79.4%	81.4%	87.9%
Screening service to cancer treatment in 62 days		90%	91.7%	85.7%	75.0%	93.8%	89.5%	100.0%	87.5%	91.7%	100.0%	100.0%	100.0%	80.0%
Upgraded priority to cancer treatment in 62 days		n/a	83.3%	93.3%	100.0%	95.5%	94.7%	92.9%	90.0%	88.9%	90.9%	93.3%	95.2%	94.4%
% CPA followed up within 7 days of discharge	All providers	95%		95.7%			94.4%			94.4%			100.0%	
Trolley waits over 12 hours	SaTH	0	0	0	0	0	0	0	1	5	9	30	12	5
A&E within 4 hours	SaTH	95%	84.5%	77.5%	79.6%	78.6%	76.6%	77.6%	73.3%	73.7%	69.3%	66.0%	67.6%	67.2%
Cancelled Op's not rebooked in 28 days	SaTH	0		1			0			0			3	
Children given wheelchair within 18 weeks	quarterly	92%		100.0%			84.0%			82.7%			not yet published	
Access to Psychological Therapies (SSSHFT)	cumulative	17%	1.1%	3.0%	4.7%	6.1%	7.8%	9.2%	10.7%	12.7%	13.9%	15.8%	17.4%	19.1%
Patient Safety and Patient Experience														
MSA breaches		0	0	0	0	0	0	0	0	3	1	0	0	0
Delayed Transfer of Care Days (DToC)			270	294	328	304	293	259	254	232	161	152	185	247
FFT AE: Patients who would recommend SaTH A&E		improve	97.2%	95.9%	96.6%	93.6%	96.8%	96.8%	96.6%	97.1%	97.5%	96.4%	94.2%	93.8%
FFT IP: Patients who would recommend SaTH stay		improve	98.0%	98.2%	97.9%	97.9%	97.9%	98.1%	97.8%	97.9%	98.0%	97.4%	97.7%	97.8%
FFT AE: A&E Response Rate (SaTH)		n/a	44.0%	24.1%	21.9%	16.9%	20.4%	18.2%	12.0%	10.8%	9.3%	7.0%	7.4%	12.8%
FFT IP: Inpatient Response Rate (SaTH)		n/a	21.1%	21.0%	24.5%	22.0%	19.9%	18.4%	17.9%	17.3%	15.2%	14.8%	19.3%	19.0%
FFT Maternity: Patients recommend Birth service (SaTH)		n/a	100%	100%	100%	90%	100%	100%	100%	n/a	100%	n/a	100%	100%
FFT: Staff Recommend Care at SaTH	quarterly	n/a		64.1%			62%			no staff FFT in Q3			not yet published	
FFT IP: Inpatient Response Rate (RJAH)		n/a	37.1%	27.0%	35.3%	36.4%	36.0%	28.7%	39.8%	41.1%	30.4%	39.5%	45.2%	40.8%
FFT: Staff Recommend Care at RJAH	quarterly	n/a		99.6%			n/a			no staff FFT in Q3			not yet published	
FFT Maternity: Patients recommend Birth service (RWT)		n/a	100%	100%	100%	90%	100%	86%	92%	n/a	95%	92%	99%	95%
HCAI MRSA bactaraemia		0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI C-Diff	2015/16 target	23	5	3	4	7	2	4	6	2	3	2	1	1
SHMI (SaTH)	rolling 12 mths	1		1.02			1.03			not yet published			not yet published	
Safety Thermometer: Harm-free Care	SaTH	n/a	94.3%	94.8%	93.4%	91.1%	92.1%	89.9%	90.9%	90.5%	89.1%	90.2%	92.5%	89.7%
Safety Thermometer: Harm-free Care	RJAH	n/a	93.9%	94.3%	94.3%	93.0%	92.4%	94.6%	94.0%	96.1%	95.1%	95.0%	95.0%	98.0%
FFT: Staff Recommend Care at ShropComm	quarterly	n/a		84.8%			82.1%			no staff FFT in Q3			not yet published	
FFT: Community Services (ShropComm)	(from 2015)	n/a	96.5%	91.3%	96.6%	97.3%	97.1%	96.3%	96.0%	99.0%	97.0%	98.0%	97.6%	94.1%
FFT: Staff Recommend Care at SSSHFT	quarterly	n/a		79.2%			77.5%			no staff FFT in Q3			not yet published	
FFT: Mental Health Services (SSSHFT)	(from 2015)	n/a	93.9%	85.2%	77.4%	80.9%	88.5%	89.7%	85.0%	83.0%	97.0%	n/a	92.0%	n/a
Safety Thermometer: Harm-free Care	ShropComm	n/a	95.0%	95.0%	92.0%	92.0%	92.0%	95.0%	95.1%	96.8%	95.5%	95.0%	96.0%	
Mental Health Safety Thermometer: Harm-free	SSSHFT	n/a												
Never Events	All providers	0	0	0	0	0	0	0	1	0	0	1	1	0
Cancelled Operations: non clinical	SaTH	n/a		142			138			142			not yet published	
Cancelled Operations: non clinical	RJAH	n/a		16			17			43			not yet published	
Improvement and Assessment Framework: Better Health														
Child Obesity: % children in year 6 classified as overweight			not yet published											
Diabetes: % patients achieved all NICE-recommended targets			not yet published											
Diabetes: % new patients attending structured education			not yet published											
Falls: injuries from falls in over-65s per 100,000			734			not yet published			not yet published			not yet published		
Choice: Personal health budgets per 100,000						44			not yet published			not yet published		
Choice: % dying patients having 3 or more emergency admissions			not yet published											
Choice: LTC patients feel supported by practice			not yet published											
Inequality: Emergency admissions for specific conditions			1111			not yet published			not yet published			not yet published		
Prescribing: appropriate prescribing of broad spectrum antibiotics			6.08%											
Carers: Proportion feeling supported to manage LTC			not yet published											
Improvement and Assessment Framework: Better Care														
Learning disability: reliance on specialist IP care			not yet published											
Learning disability: % LD patients having annual health check			not yet published											
Learning disability: % of registered population on LD registers			not yet published											
Dementia: diagnosis rates in practices		67%	62.3%	62.2%	60.2%	62.0%	63.0%	62.9%	72.4%	63.0%	62.8%	62.0%	62.1%	62.7%
Dementia: care planning and post-diagnostic support			not yet published											
Mental Health: IAPT recovery rate		50%		61%						59%			not yet published	
Mental Health: IAPT access													not yet published	
Mental Health: EIP treatment in 2 weeks	rolling 3 mths	50%	66.7%	60.0%	40.0%	26.3%	14.3%	21.1%	30.0%	75.0%	50.0%	25.0%	0.0%	0.0%
Mental Health: CYP service transformation			not yet published											
Mental Health: crisis and liaison service transformation			not yet published											
Mental Health: Out of Area placement bed days			not yet published											
Care ratings: high quality hospital provision						60			not yet published			not yet published		
Care ratings: high quality primary care provision						64			not yet published			not yet published		
Care ratings: high quality adult social care provision						62			not yet published			not yet published		
Cancer: one-year survival for all cancers			not yet published											
Cancer: patient experience			not yet published											
Maternity: neonatal mortality			not yet published											
Maternity: women's experience of services			not yet published											
Maternity: choice in maternity services			not yet published											
Maternity: Mothers Smoking at time of Delivery (SaToD)		reduce		20%			18%			16%			not yet published	
Urgent Care: Emer Adm for Urgent Care sensitive conds				1631			not yet published			not yet published			not yet published	
Urgent Care: DToC attributable to NHS per 100,000			not yet published											
Urgent Care: pop'n use of hospital beds after Emer Adm				450			not yet published			not yet published			not yet published	
Primary Care: Management of LTC - emergency admissions			not yet published											
Primary Care Access										54%			not yet published	
Primary Care Workforce			not yet published											
Seven Day Services: achievement of clinical standards			not yet published											
Sepsis Awareness prioritisation			not yet published											
Improvement and Assessment Framework: Sustainability														
Financial stability: in-year performance										not yet published			not yet published	
Choice: Use of ERS at first referral		80%	44.7%	36.9%	46.1%	54.0%	58.0%	70.0%	66.0%	71.3%	61.9%	68.0%	67.3%	
Quality Premium														
Cancer diagnosed at early stages			not yet published											
Patient experience of making GP appointment (annual)		>=80%	not yet published											
Antibiotics per STAR-PU		<1.161	1.023	1.019	1.014	1.003	0.996	0.988	0.979	0.967	0.951	0.952	0.948	
Antibiotic prescribing for UTIs: ratio		1.356	1.207	1.158	1.108	1.080	1.048	1.025	0.983	0.944	0.915	0.875	0.848	
Antibiotic prescribing for UTIs: over-70s trimethoprim		3656	3774	3715	3672	3631	3635	3606	3564	3511	3448	3400	3343	
E-coli based bloodstream infections (cumulative)			6	11	16	26	28	38	49	58	64	78		
Mothers Smoking at time of Delivery (SaToD)		<=15%		20%			18%			16%			not yet published	
CHC assessments within 28 days		80%		22%			43%			74%			62%	
CHC assessments in acute setting		<15%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
MH: Out of Area bed days			not yet published											
Planned Levels of Activity (specific a		2016/17	Plan											
Total Elective Admissions		18,994	19,418	1725	1957	2003	1913	1934	1932	2162	2060	1632	1880	1687	2002
Non-elective FFCE activity		18,657	19,012	1422	1544	1526	1516	1491	1460	1619	1642	1612	1730	1523	1692
First Outpatient activity		67,675	66,170	4893	5674	5575	5329	5073	5290	5421	5452	4230	5667	5209	5605
Follow-up Outpatient Activity		101,564	99,280	6717	8294	8120	8057	7656	7975	8300	8337	5821	8023	7276	7482
New RTT Pathways		50,273	50,829	4132	4256	4372	4199	4280	4518	4187	5101	3340	4686	4407	4560

CCG improvement and assessment framework 2017/18

In addition, the CCG itself is monitored by NHS England (via an annual assurance meeting) to assess how well it is performing as a commissioner of services for the people of Telford and Wrekin, and we are required to demonstrate progress against five key domains. Further information about this monitoring can be found at https://www.england.nhs.uk/commissioning/ccg-assess/

The outcomes of the annual meeting for 2017/18 with NHS England had not been published in time for the publication of this annual report, but can be viewed on the CCG website at http://www.telfordccg.nhs.uk/who-we-are/publications/performance

The CCG will use the feedback from this annual assurance, regular meetings with NHS England during the financial year and the 360 degree stakeholder survey, to assess its own effectiveness and to agree actions to enhance its performance.

Performance analysis

Primary care

Primary care is the first point of entry for most patients in diagnosing and treating health problems. GPs and other staff play a crucial role in diagnosis and treatment of most medical conditions, managing patients' long-term conditions in the community and referring them for hospital treatment, social care and so on, as appropriate.

Telford and Wrekin CCG currently has 14 GP practices, all of which work under a general medical services (GMS) contract. The CCG is now in the third year of full delegation and has concentrated on the key priorities it set in 2016/17. It continues to strengthen the foundations to secure resilient and sustainable primary care services for our patient population in the future. The key areas of work during the year have been:

- development of a primary care workforce plan
- delivery of IT innovations and development of the primary care estate
- delivery of the General Practice Forward View (GPFV) year one plans to ensure sustainability and resilience for future primary care services
- delivery of improved access and improved patient survey results
- improved engagement and communication with our communities
- to support neighbourhood working and to continue with planning in preparation for any movement of activity from a hospital to a community setting.

Below are some of the specific areas of the primary care work programme that have been progressed this year:

Improving access

Everyone should have access to 'good' GP services to meet locally determined demand, alongside effective access to out of hours and urgent care services. The CCG is committed to the provision of equitable access for all patients and believes that good access to a GP is important to patients. This is, therefore, one of the primary care key strategic priorities. Poor access can cause stress and frustration for both clinical staff and patients at a time when they may already be worried.

All but two of the 14 GP practices across Telford and Wrekin now provide services outside their core working hours – either as part of the Extended Hours Direct Enhanced Service (DES) or the Primary Care Access Fund – providing extended hours access to appointments to nearly 90 per cent of the population.

Eleven practices now also participate in the Extended Hours DES providing an additional 76 hours of appointment capacity per week (or approximately 450 additional appointments per week).

Five practices are also part of the Primary Care Access Fund scheme which delivers access to additional appointment capacity available from 12 locations across Telford and Wrekin, Shropshire and Staffordshire. This scheme can be accessed by over 50 per cent of the Telford and Wrekin population.

After patient consultation, and CCG board approval in January 2017, it was decided not to renew or extend the contract held by the provider of the walk-in centre beyond its natural end date of July 2017. During the period from January 2017 to July 2017 the registered patients (circa 8,000) were dispersed to other GP practices across Telford and Wrekin and the CCG, the provider of the walk-in

centre and the GP practices worked together to ensure a smooth transition for all patients, especially those who had been identified as being potentially vulnerable.

Prior to the closure of the walk-in centre, the CCG commissioned additional services to provide for those patients visiting from outside the CCG area and also those with no fixed abode. A primary care streaming service was also commissioned at the front door of the A&E at the Princess Royal Hospital designed to treat patients attending with minor illnesses and minor injuries and help reduce the impact on the emergency department.

GP patient survey

The GP patient survey results were released in July 2017 and showed a slight decrease in satisfaction for responses to the question 'o*verall experience of your GP practice*' (from 82 per cent in July 2016 to 80 per cent in July 2017) and a decrease in satisfaction in regard to '*overall experience of booking an appointment*' (from 70 per cent in July 2016 to 66 per cent by July 2017).

The main reason for the decline in results was attributed to the poor performance of four practices. One of these was the walk-in centre, which was closed in July 2017. Two of the practices were merged into the new 45,000 patient super-practice, TelDoc, from April 2017. The remaining practice was the subject of a significant turnaround exercise (involving colleagues from the CCG and NHS England) and was recently rated as 'good' by the CQC.

Without the effect from the above practices, the results would have looked much different – with an improvement to 84 per cent for the '*overall experience of your GP practice*' question and a further improvement to 73 per cent for '*overall experience of booking an appointment*' question.

GP Forward View (GPFV)

The GPFV, published in April 2016, sets out the plan, supported by national investment, to help stabilise and transform general practice. Shropshire and Telford and Wrekin CCGs submitted a joint plan to deliver the GPFV and the plan has now been approved by NHS England.

The CCG primary care team has been working collaboratively with colleagues in Shropshire CCG and GP practices to share best practice and provide a joint approach to delivering the GPFV, supporting practices in the delivery of the core requirements, including improved access, 10 High Impact Actions, active signposting, workforce, productive workflows and reducing did not attend (DNA) rates.

The CCG is supporting practices to deliver the innovations such as 10 High Impact Actions. These are included in the diagram below and were identified following evidence gathered through the Making Time in General Practice report and the GP Access Fund. The aim is that by implementing these actions practices will free up capacity to focus on patients who need them most – resulting in direct improvement for the patient.

The results of the study are available at www.nhsalliance.org/making-time-in-general-practice/

Ten high impact actions to release time to care (source: NHS England www.bit.ly/gpcapacityforum)

Workforce

Workforce is the biggest issue for general practice with demand on services continuing to grow. Overall there are not enough doctors entering general practice and retention is a major issue. In addition, the number of GP partners is falling, and the use of GP locums is increasing. This is not a sustainable or affordable model for the future.

The commitments made in the GPFV were to aspire to double the growth rate in GP numbers through new incentives for training, recruitment, retention and return to practice. The pledge was to build on the previous ten years' achievements of increasing around 5,000 full time equivalent GPs across England by 2020.

NHS England has estimated that, by September 2020, Shropshire will need 306 GPs and 261 non-doctor clinicians. Shropshire CCG and Telford and Wrekin CCG submitted a joint workforce plan containing a series of 15 individual delivery plans, designed to deliver against these targets.

Shropshire CCG and Telford and Wrekin CCG, general practices, GP localities, Health Education England (HEE) and local stakeholders are working together with patient groups and voluntary organisations to identify new ways of working that will provide a sustainable primary care workforce. Using the principles within the GPFV, local initiatives have already commenced including applications for international GP recruitment, clinical pharmacist recruitment, an increase in the number of student nurses in general practice, support for a Physio First project and training for practice managers.

IT – Voice over internet protocol (VOIP) (for example, Skype), WiFi, online consultations

CCG projects include:

- a common phone system for all practices will provide easier access for patients, better business continuity and scalability

- a WiFi network will be provided to patients and clinical staff across all GP practices. Patients will access healthcare services within surgery via health apps and websites, patient campaigns will be communicated to patients when they are connected to the network in their practice
- virtualised desktop infrastructure (VDI) will enable a GP to work away from the practice (for example, in a care home environment) with just the need for a WiFi/4G data connection on any portable device
- online (e-consult) using a mobile app or online portal to contact the GP. This may be a follow-up or a new consultation. The e-consultation system may be largely passive, providing a means to pass on unstructured input from the patient, or include specific prompts in response to symptoms described. It may offer advice about self-care and other sources of help, as well as the option to send information to the GP for a response.

Primary care estates

The CCG currently has 14 practices delivering general medical services from 26 premises across Telford and Wrekin. The CCG has been working closely with various practices, including on new build projects, extensions to existing premises, improvements within existing buildings and utilisation of the current estate.

The CCG is now also an active member of the Local Estates Forum that includes colleagues from Shropshire CCG as well as NHS England, the local authorities for Telford and Shropshire, the local community trust (Shropshire Community Health NHS Trust) and local hospital trusts (including both Shrewsbury and Telford Hospital NHS Trust and the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust).

In addition, the CCG has been reviewing the existing estate and is currently developing plans around opportunities for rationalisation of the premises as practices begin to operate at scale under new models of care.

This year the primary care estates QIPP finished the year at just short of £200,000 against an original target of £84,000. These savings will be reinvested towards making further improvements to the primary care estate across Telford and Wrekin.

Neighbourhood working programme

Primary care at scale will safeguard primary care itself, maintaining practices in localities, and providing improved access. Current evidence suggests that building primary care at scale will improve the ability to retain workforce.

Neighbourhood working is an approach to developing community-centred approaches, being led collaboratively by the CCG and the council together with the people of Telford and Wrekin. The programme has been in development for approximately 18 months and includes initiatives that range from the development of peer-led roles right through to the design and implementation of specialist services in community settings. It is anticipated to be a long-term programme.

Why has neighbourhood working been developed and what is it?

This approach evolved naturally in response to a number of issues. One of the most significant of these was to challenge the current deficit-based model of care, which promotes dependency. In addition, budget cuts, coupled with increased demand, have created significant financial pressures within the health economy. There has also been a call to reverse the trend that has led to the creation of an acute/hospital-dominated local system of care.

In answer the council and CCG would like to seize the opportunities associated with more innovative and creative solutions, co-produced by those who are most affected by the changes. These solutions will address people's individual goals and support the growth of vibrant and healthy communities which empower people through the promotion of independence. Where possible, specialist services will be replaced with community-based services, delivered in people's homes.

Neighbourhood working is a complex (but intuitive) collection of activities embracing all aspects of community-centred approaches. It brings together existing and new projects into a coherent programme. The programme has now been adopted as a workstream within the health economy Sustainability and Transformation Plan and is sponsored by the managing director of the council.

There is no 'one size fits all' approach with this programme, projects have developed 'bottom up' and are tailored to the needs of the CCG neighbourhoods with the ability to be different. Whilst projects have developed organically, there is a governance and reporting structure in place alongside a standard operating procedure.

The programme has £4.5m QIPP savings associated with it and is linked to a reduction of over 2,000 admissions to hospital. This programme has been adopted as a workstream by the STP and a description of the programme, together with five years' activity profiling, has gone into the pre-consultation business case for Future Fit.

Progress so far

There are nearly 40 projects up and running. Examples of progress so far:

Dedicated care homes team: The CCG has commissioned a dedicated multidisciplinary team to support care homes to improve quality of care and reduce the risk of residents going into hospital. This team is nearly fully recruited and will be fully operational over the coming months.

Respiratory education and improving pathways: The CCG has two aims for the respiratory work. The first is to reduce inappropriate non-elective admissions to hospital by supporting patients who are frequently being admitted, and achieve a best practice service model to enable optimal support for patients living with a respiratory condition.

To support frequent attenders to hospital, additional self-management, coaching and workshops (British Lung Foundation Programme) have been commissioned and delivered, for those patients with COPD at the greatest risk of admission. Two additional respiratory nurses have been recruited to deliver the BLF training, enabling ongoing support for patients. Ninety additional patients have been supported by the programme.

To achieve a best practice model, IAPT workers have been trained and recruited to work as part of the integrated Respiratory Team, to support patient's psychological wellbeing and this work has been ongoing throughout the year.

The CCG is currently considering options for post exacerbation pulmonary rehab (domiciliary) and a centralised Spirometry service, both of which are required to achieve the best practice model.

Learning for Wellbeing: This offers short courses of learning to adults with mild to moderate mental health issues, for example 'Understanding Anger' and 'Singing the Blues Away'.

Hypertension: A significant amount of work has been undertaken to improve the detection and management of hypertension in people living and working in Telford and Wrekin, including raising awareness via increased uptake in blood pressure checks in various settings around the area, including health centres, supermarkets, work places.

Health champions: The project recruits local community volunteers who care about the health and wellbeing of those around them. Their role is to help start up small community projects such as walks, drop-in sessions and social groups. In all, 25 health champions have been recruited and are actively supporting community projects.

Future leaders: The intention is to develop a self-help online tool that enables people to find out information on everything happening in Telford and Wrekin. Users will be able to access advice and guidance on things like community groups, activities, health services and general advice.

Dementia: Implementation of a new model of care, dementia companion and memory service based in the neighbourhoods.

Integration of citizens advice in health settings

Branches: This Mental Health Hub opened in May 2017. This is a drop-in service which provides counselling and listening services for individuals experiencing mental health crisis. The service is also supported by volunteers who are trained in mental health, addiction and boundaries. The service currently sees an average of 700 service user visits per month. Please see Mental Health section of annual report for more detail.

Safe Place: Opened at the police station on 31 August, available Thursday to Sunday 9pm to 2am. This is a place for police officers to bring individuals as an alternative to detaining under Section 136 of the Mental Health Act. There are mental health professionals from Branches on site to support individuals who offer counselling, guidance and support.

Making every contact count (MECC): MECC training has been delivered to over 150 reception staff. The fundamental idea underpinning the MECC approach is simple. It recognises that staff across health, local authority and the voluntary sector have thousands of contacts every day with individuals and are ideally placed to promote health and healthy lifestyles. MECC focuses on the lifestyle issues that, when addressed, can make the greatest improvement to an individual's health, such as smoking, alcohol, healthy eating and improving mental health and wellbeing.

Citizen's Advice: Clinics are now taking place within GP practices. They provide support with debt, benefits and housing issues. The outcomes achieved include an estimated £15,200 in welfare benefit gains. Feedback shows that patients are finding the service helpful and that resolving their issue has improved their health/wellbeing.

Feed the Birds: Tackling social isolation by connecting vulnerable people with local volunteers who visit once a week to feed the birds in their garden. Volunteers have completed compassionate communities training which focuses on communication skills, bereavement, boundaries and confidentiality as well as practical bird feeding tips, and have been successfully matched with vulnerable adults and are undertaking weekly visits.

Bench to Bench and Nordic Walking: Local residents have now qualified as Nordic Walk leaders to organise weekly walks, and local walks have been established in neighbourhoods with volunteer leaders.

Words on the Water: This is a course of creative writing inspired by Newport Canal, in support of social prescribing through GP surgeries. Every week a group of friendly people meet at Cosy Hall on Water Lane before setting off down the towpath to observe, talk and make notes about what they see. The group then goes for coffee and writes poetry about what they have seen.

Diabetes: The percentage of patients with diabetes who achieve all three targets – blood pressure (BP), cholesterol, HbA1c (blood glucose levels) – in Telford and Wrekin has increased. This is because patients are being managed more optimally; additional specialist support and advice via neighbourhood level MDT (support to primary care), structured patient education and an incentive

scheme to improve all three targets. Work continues to improve the overall level on this measure while also reducing inter-practice variation.

The CCG has improved from 34.8 per cent (2,419 patients) to 37.5 per cent (2,965), which means that 546 more people have achieved all three target values and are now at reduced risk of diabetes-related complications, for example amputations.

Case study

John, 39, was referred into service after several admissions into SaTH for diabetic ketoacidosis (DKA). The gentleman had type one diabetes since his teens and had been poorly managed. During the six months leading up to his referral he had been admitted to SaTH eight times in DKA.*

John lived in a nursing home and relied on the nursing staff to give him his insulin, which had been written up in conjunction with a consultant/GP. When the team first met John, his insulin regime was 'completely inappropriate' resulting in multiple problems, and he was being fed via a percutaneous endoscopic gastrostomy (PEG) tube.

When the team became involved, they changed his background insulin to a more appropriate one, but more importantly, taught John to give his QA insulin in conjunction with a dose advising meter, and empowered John to take control of his diabetes. Over a six-month period, John had not had a single admission with DKA, he was able to tolerate a normal diet, his PEG had been removed, and he became fit enough to undergo a pancreas/kidney transplant. John is now living an independent life in his own home.

**Diabetic ketoacidosis (DKA) is a dangerous complication faced by people with diabetes which happens when the body starts running out of insulin. It is a serious short-term complication which can result in coma or even death if it is not treated quickly.*

Dementia: A virtual team has now come together to support patients with dementia. This includes:

- memory service
- dementia companions (a paid role commissioned from the Alzheimer's Society to support patients through their dementia journey and help them to stay well for as long as possible)
- community matrons
- home treatment team (specialist crisis support)
- Admiral nurses
- speech and language therapy
- dietetics

By bringing these people together it increases the skills and knowledge of the professionals by working in a shared way.

Social care early help and support: Early help and support workers are now present in some GP practices with directly bookable slots to support individuals who are seeing the GP with non-medical issues that impact on their health and wellbeing.

Development of integrated teams: This is the development of dedicated integrated teams wrapped around the neighbourhood populations. This is a radically different approach to proactively support patients with long-term conditions. It brings professionals together around the patient holistically, promoting resilience (as opposed to dependence), and includes community matrons,

nurses, physiotherapists, occupational therapists, health care assistants and phlebotomists plus new roles including advanced clinical practitioners, associate nurses and therapists. A wider virtual team that will includes practice teams, Early Help and Support, social workers, specialist teams and third sector. The main functions of these teams are to provide:

- a single point of contact for the neighbourhood
- clinical triage and system navigation
- holistic assessment
- multi-disciplinary review of at-risk patients
- support for the total needs of patients during exacerbations to prevent hospital admission.

Staff have been coming together within the neighbourhoods, with multi-disciplinary team meetings now up and running in two of the four neighbourhoods. Full alignment of health and social care staff is due to be completed early in 2018/19.

Primary care priorities for 2018/19

For 2018/19 the CCG will continue to support practice resilience and access as two of our key priority areas from the GP Forward View.

In terms of access, NHS England announced an additional fund to support seven-day access to general medical services, which will see the CCG commissioning additional appointment capacity from October 2018 onwards. Already, we are working with practices and patient representatives to ensure that our plans meet local need and ensure that we are able to deliver the access without impacting on current capacity.

We are also undertaking a regional re-procurement of the out of hours service – improving the service specification to ensure patients continue to receive high quality primary care 24 hours a day. Our current out of hours number is also moving to NHS 111 as part of the national mandate for urgent care collaboration and we are working with current providers to ensure that the transfer goes ahead smoothly for all.

Workforce gaps are being addressed through effective planning and again working closely with practices – ensuring that there are plans in place to address the future GP, nursing and allied healthcare gaps while working with our neighbourhood multi-disciplinary teams to strengthen the delivery of care out of hospital.

New telephone systems will be in place in all practices by the summer of 2018 which will also support improved access for patients but also improved systems for practice teams. There are plans for further investment, targeting GP IT systems to improve the quality of care records and investment plans for practice premises.

The CCG is also committing additional funding to support the commissioning of non-core contractual services from practices – again enabling more care to be received closer to people's homes and delivering care at neighbourhood level as well as directly from patient's own GP practices.

The Primary Care Commissioning Committee continues to meet regularly to oversee the CCGs primary care work programme and investment and we are meeting regularly with patient

participation groups, minority group representatives and lay members to ensure that patients are receiving the benefits of this additional investment in primary care.

Integrated care

Better Care Fund

The Better Care Fund (BCF) is a nationally-directed programme to enable local health and social care systems develop integrated services through the pooling of financial resources and integrated teams. BCF promotes joined up health and care services so that people can manage their own health and wellbeing, have integrated care services when individuals needs care, treatment or support so they can live independently in their communities for as long as possible. The programme includes development and implementation of a Frailty programme and Intermediate Care Team.

Frailty

The Frailty programme recognises that 25 per cent of admissions are identified as frail and 75 per cent of all bed occupied days in hospital. There is also a recognition that developing a range of preventative interventions – both the number of admissions and length of time in hospital could be reduced while improving outcomes for those frail individuals. There are 11 inter-connected projects that link across:

1. primary care and integrated teams within neighbourhoods
2. an integrated team that provides alternative care and treatment to individuals who may otherwise be admitted and supports early discharge from hospital
3. improving flow through the acute hospital and early discharge to step-down treatments
4. developing end of life care so individuals can die in dignity at home or where they choose.

Progress so far

Identification of frailty patients: Standardised tools to identify individuals who are frail have been developed and utilised in primary care and the acute hospital. This is supporting preventative care planning and ensuring the right level of support is provided to individuals who have higher levels of need.

My Health Record (Frailty card): This is being developed which will hold baseline information of patients' conditions and choices which will support decision-making to appropriate clinical care. These will be piloted during April 2018 before wider utilisation.

Comprehensive Frailty Assessment: This is being developed as part of the integrated frailty team within Royal Shrewsbury Hospital. This is a detailed assessment of individuals' needs by an integrated team to identify preventative support and maintain independence.

Trusted Assessor approach: This has been implemented to enable the acute hospital staff to identify the level and type of step-down support that is needed so that there is little delay to transfer to follow-up care.

Delayed Transfers of Care: This measures how quickly individuals with complex ongoing care or support needs are discharged into step-down care at home or into an intermediate care bed. Telford and Wrekin CCG were ranked 16th nationally in completing this. Reducing delays is important is enabling frail patients to recover and remain at home after hospital care.

Intermediate Care Team

This is the further development of a dedicated integrated team that offers a range of care options and clinical interventions to individuals who may have been considered for admission to hospital. This approach proactively supports patients with escalating conditions and which brings professionals together around the patient holistically, developing an immediate plan to promoting future resilience.

The team includes a consultant nurse, specialist community nurses, physiotherapists, occupational therapists, health care assistants, social workers, early help practitioners and carer support. The team can ensure domiciliary care where needed or a short stay in a step-up bed for further rehabilitation and enablement.

The team are an integral part of the acute hospital support that enables early discharge from hospital.

Progress so far

Promoting Home First from hospital: Discharging to home to have further rehabilitation and re-ablement is shown to maximise impendence for frail individuals. We have been achieving nearly 60 per cent discharged home in care, which is seen as best practice.

End of Life Care

There was recognition that end of life care for frail patients, as part of advanced care planning, needed to be developed as part of an individual patient's journey. This was not fully recognised as an end of life care need for cancer patients**.** This led to increased admissions to hospital at the end of a patient's life when alternatives could have been utilised.

An end of life strategy has been developed that seeks to:

- facilitate effective personalised care planning and support of those important to the dying person
- ensure equal access to palliative and end of life care
- establish the 'Living Well' concept: support advanced and anticipatory care planning and timely access to services
- work in partnership to ensure that care is coordinated between services
- ensure a competent workforce
- recognise compassionate communities voluntary support as an extension to services.

Progress for far

Development of a whole-economy end of life strategy: The strategy and key actions are in line with the national guidance.

Development of shared documentation: This is to ensure implementation of the agreed end of life plan.

BCF priorities for 2018/19: These include full implementation of the My Health Record and development of an integrated frailty approach at Princess Royal Hospital that includes a comprehensive frailty assessment.

Mental health

The CCG have continued to work with Telford and Wrekin Council on the action plan to support our mental health strategy, designed with service users and professionals. This focuses on early intervention and helping people to help themselves. The work we have undertaken this year has focused on these areas.

Branches

Branches is a mental health service jointly commissioned by the CCG and the council. It is run by a team of 18 people who know what it feels like to have issues with your mental health and 48 volunteers whose roles range from meeting and greeting service users to administration duties and listening to those who have accessed the centre. It provides a drop- in service six days a week at Strickland House in Wellington as well as outreach services weekly at Madeley, Dawley, Park Lane and Donnington. The ethos of the service is to support individuals to help themselves and, on average, 180 individuals access the service each week. The service offers a range of courses including understanding anxiety and mental health, dealing with loss, mental health first aid, arts and crafts and a singing group. Branches also run a crisis support service four evenings a week from 6pm to 2am and provide support to individuals in distress. This was accessed by more than 50 people between September and December 2017. The team has also started working to support the mental health needs of the homeless in the borough as well as providing peer support in the accident and emergency department for two evenings a week.

Case study

A lady came into our service with Bipolar and other mental health issues. She also had a heroin and alcohol addiction, and was homeless. We made the relevant referrals to get her support with her addiction and we worked with her to stabilise her mental health. She continued to get support and we on many occasions helped her find shelter. As a result of the support she is now clean of drugs and sober, living in a dry house and on medication for her mental health issues.

Telford Adult Autism Hub

The Adult Autism Hub, which is based at The Glebe in Wellington, provides assessment, diagnosis and support for people with autism who are aged over 16. The service, which subcontracts specialist support from Autism West Midlands, accepts self-referrals from individuals as well as referrals from GPs and other health services.

Individuals are assessed by a multi-disciplinary team and support plans are put in place to focus on their aspirations and goals, aiming to support and enable those living with autism to be independent and access community-based activities.

The hub is also working towards training members of the community in becoming autism champions who are able to understand the issues of autism and to support individuals. More than 60 staff members at Telford Shopping Centre have received training to date and the centre has received an autism-friendly status as a result.

The service has received excellent feedback and during the year has seen:

- an increase in people supported into meaningful volunteer and employment placements

- an increase in people supported into the next steps of independent living
- an increase in people who live with autism achieving healthier lifestyles.

Attention deficit hyperactivity disorder (ADHD) service

The ADHD service was set up in late 2016 and allows GPs to refer patients for support in getting a diagnosis and treatment where needed. A weekly clinic is run that provides:

- diagnostic assessment for new patients
- review of care including prescribing for current patients
- a person-centred care approach
- signposting to other agencies.

During 2017 and early 2018 more than 70 patients have been referred to the service. The feedback from patients has been excellent, with individuals happy to have a local service and to be treated with care and respect.

Telford Mental Health Forum

The Telford Mental Health Forum (TMHF) was developed from a small working group created to help the Telford Crisis Network during 2016. They were tasked with developing an overview of support networks for service users and carers across the Borough of Telford and Wrekin. The working group procured funding from South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT), Telford and Wrekin CCG and NHS Commissioning to organise a conference entitled 'Mental Health Works' to draw together the sectors mentioned above, including strong representation from service users and carers. Building on this successful conference the group formed Telford Mental Health Forum in January 2017.

The forum holds bi-monthly meetings bringing stakeholders, service users and carers together in a single group to identify opportunities to improve networking between the three sectors to bring about improvements to the patient experience. Meetings are well attended with an average of 25 to 30 participants per meeting. They are conducted by an independent chair and on a limited amount of funding to cover the costs, which the CCG contributes to.

During 2017, TMHF began to establish specific interest groups in order for service improvements to be discussed and addressed outside of the bi-monthly forum meetings. The interest groups include homelessness, offending/criminal justice, carers and young people, and these groups met in between the main forum meetings to address issues.

The young people's sub group has developed a new peer support group for 14 to 24-year-olds and is actively seeking charitable status as a community interest organisation. The lead for this group, who is also a service user, received recognition for his work in developing a creative arts-based model of peer support when we won the Thrive Mental Health Commission Star Award for Telford and Wrekin.

Collaboration between TMHF, SSSFT and Telford and Wrekin Carers Centre has resulted in improved promotion of support services for carers via a bookmark distributed to all pharmacies in the borough.

The forum also has representation on the Suicide Prevention Strategic Development Group for Telford and Wrekin, and the Chief Officers Group for the borough's voluntary sector.

Forum members clearly recognise the value of the meetings since, in addition to information sharing, the forum provides an invaluable opportunity for stakeholder, service users and carers to network and collaborate by reconnecting those involved.

NHS RightCare

RightCare is an NHS England supported programme that is helping to reduce unwarranted variation across the NHS. The CCG started working with NHS RightCare in December 2016. RightCare allows the CCG to compare itself to ten demographically similar (in terms of age, deprivation and other measures) CCGs in other areas of the country. This information is being used by the CCG to identify areas for improvement, in terms of both quality and spend. RightCare is enabling the CCG to identify areas where we may be overusing resources, leading to waste and potential harm, and areas where we may be underusing resources, leading to failure to prevent disease and inequality and potentially leading to poor clinical outcomes. By reducing both underuse and overuse of healthcare resources we aim to develop better, more sustainable systems.

During 2017/18 the CCG's RightCare programmes of work included:

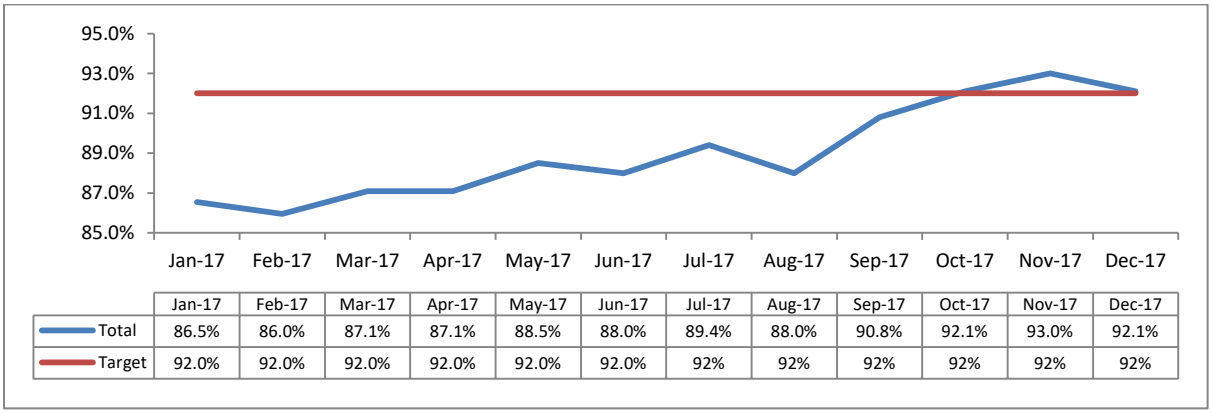
- cardiology – focusing on identifying and improving the management of hypertension (high blood pressure)
- diabetes – focusing on type two diabetes prevention, identification and management
- respiratory – focusing on asthma and chronic obstructive pulmonary disease (COPD), particularly diagnosis and management
- mental health – focusing on child and adult services and improving access to psychological therapies.

During 2018/19 the CCG's RightCare programmes will be expanded to cover neurology and gastroenterology.

Secondary care

One of the key areas of work for the secondary care team is planned care within the hospital and community settings. The measure that relates to this area is that patients should not wait longer than 18 weeks from referral to treatment. Performance against this has significantly improved from 86.5 per cent in January 2017 to 92.1 per cent in December 2017.

Telford and Wrekin CCG Referral to Treatment (RTT) monthly performance 2017



	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total	86.5%	86.0%	87.1%	87.1%	88.5%	88.0%	89.4%	88.0%	90.8%	92.1%	93.0%	92.1%
Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92%	92%	92%	92%	92%	92%

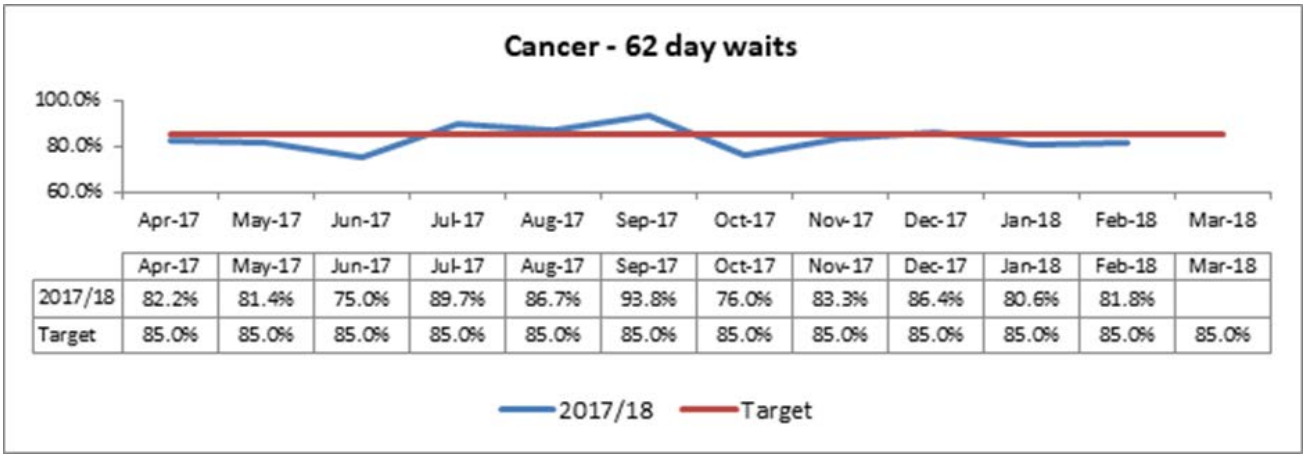
A key development within planned care was the introduction of a new community ophthalmology provider in June 2017 to support people with eye problems. This has shown an increase from 98 new patients per month being seen by the community provider to 181 per month, ensuring patients with eye conditions are supported closer to home.

There have been challenges with both ophthalmology and neurology services due to the local hospital closing to new referrals because of capacity issues. During this difficult period Telford and

Wrekin CCG, Shropshire CCG and Shrewsbury and Telford Hospital (SaTH) have worked in close partnership to ensure patients have not been disadvantaged and to develop services that can meet the needs of the local population going forward. As a result of this excellent partnership working both services are in the process of re-opening to new referrals.

The team has continued to build on the good work of 2016/17 in relation to cancer services during the last year. The main measure for this area of work relates to patients being treated within 62 days of referral. Performance in this area has been changeable throughout the year but the latest available performance in December shows the CCG achieving the target.

Telford and Wrekin CCG 62 day Referral to Treatment (RTT) for cancer 2017/18



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
2017/18	82.2%	81.4%	75.0%	89.7%	86.7%	93.8%	76.0%	83.3%	86.4%	80.6%	81.8%	
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Work being progressed this year includes the development of a Telford, Shropshire and Powys cancer strategy and the introduction of a project team to lead the development of a cancer recovery package across the region.

The NHS has been working towards switching off paper referrals for planned care. The national deadline for hospitals to move to electronic referrals is 1 October 2018. The CCG has been working closely with the local trusts to ensure processes are in place to move to electronic referrals. There has been significant progress with an increase from 35 per cent of referrals in December 2016 to 71 per cent of referrals in November 2017. The move to electronic referrals will give patients more choice and control over their healthcare and enable trusts to reduce DNA rates, saving the health service valuable time, money and resource.

A&E within the health economy continues to be a challenge with SaTH performance failing to achieve the 95 per cent standard for patients waiting less than four hours. Telford and Wrekin CCG, Shropshire CCG and SaTH continue to work closely together to identify ways to address this shortfall. During the year Telford and Wrekin CCG has introduced a GP streaming service as an alternative within A&E at Princess Royal Hospital, commissioned the local rapid response team to support patients due to be discharged from A&E and funded handover nurses in A&E to enable swift transfer of patients who arrive via ambulance. The CCG will continue to investigate ways to address issues within A&E during the coming year.

In 2018/19 the team will continue to manage the providers we have, hold them to account on the services they deliver and focus on improving service provision for Telford and Wrekin patients. Key areas of focus will be:

- improving patient journeys in relation to outpatient appointments in hospitals
- improving patient journeys for children attending A&E
- improving transportation for both emergency and non-emergency situations
- further improvements in supporting patients with eye conditions
- further improvements in supporting patients with musculoskeletal conditions.

Medicines management

Medicines optimisation

Across the UK:

- one quarter of the population has a long-term condition
- one quarter of people over 60 have two or more long-term conditions
- with an ageing population, the use of multiple medicines (known as polypharmacy) is increasing
- 30-50 per cent of medicines prescribed for long-term conditions are not taken as intended.

Medicines optimisation looks at the value that medicines offer, making sure they are clinically-effective (that is, they improve outcomes for the person taking them) and cost-effective (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.

The goal of medicines optimisation is to help patients to:

- improve their outcomes
- take their medicines correctly
- avoid taking unnecessary medicines
- reduce waste of medicines
- improve medicines safety.

The CCG's medicines optimisation team works closely with patients and members of the public, clinicians, commissioners and managers to help achieve these goals. Here is some background information and details about some of the things that we have done during 2017/18.

Prescribing budget, commissioning policies and individual funding requests

The budget allocated to primary care prescribing during 2017/18 was approximately £28.9 million. This budget only covers prescriptions that are issued in general practice - hospital prescribing is covered by a separate budget. The demands on the primary care prescribing budget will always exceed the funding available and therefore the CCG has to make some difficult decisions about what will and will not be funded. There is no duty on the CCG to provide every treatment that an individual may demand. The CCG has to prioritise the demands on its budget. Our commissioning policies (http://www.telfordccg.nhs.uk/your-health/medicines-management/policies) are published on the CCG's website and where a patient falls outside the criteria for which funding is routinely made

available, clinicians may submit an Individual Funding Request (IFR) (http://www.telfordccg.nhs.uk/your-health/medicines-management/individual-funding-requests) to the CCG if there are grounds for an exception.

The prescription ordering department (POD)

This was first launched in October 2016. It is a centralised call centre used by patients to order repeat prescriptions. The POD was introduced to reduce medicines waste and also to empower patients to take more responsibility for their prescription medicines.

The POD service is currently available to patients registered with the following practices:

- Charlton Medical Practice
- Dawley Medical Practice
- Donnington Medical Practice
- Linden Hall Surgery
- Shawbirch Medical Practice
- Sutton Hill Medical practice
- TelDoc.

The introduction of the POD has not been without its challenges. As the number of patients using the service increased, our telephone system failed to meet the demand. This caused frustration for patients, practices, pharmacies and the CCG. A POD email address and mobile phone number, both introduced as an interim measure, provided little relief to the problem. Our new telephone system was installed at the end of February 2018 and we hope that our previous problems are now solved. Please accept our sincere apologies if you experienced problems with our old telephone system.

Between April and December 2017 (the latest data available at the time of writing the report), the CCG saw prescribing costs associated with practices using the POD service decline (compared to the same period in 2016-18), whereas costs rose in the practices that did not have access to the POD.

If prescribing costs in the practices using the POD service had grown at the same rate as that seen in the practices that were not using the POD, the CCG would have spent an additional £500,000 between April and December 2017.

In addition to the financial benefits, the POD is helping to improve quality and safety for our patients. The service highlights patients who are either over- or under-ordering their medicines, provides a prompt response to new safety warnings (ensuring that appropriate action is taken as soon as possible) and it identifies patients who may need a clinical review.

During 2018/19 the CCG plans to make the POD service available to all patients registered with Telford and Wrekin GP practices.

Medicines optimisation in care homes

In June 2017 a pharmacy technician joined the CCG's medicines optimisation team to work closely with care homes to improve medicine- related systems and processes, particularly those that result in harm and waste.

Telford and Wrekin care homes provide a valuable service to our population, but they require a great deal of support to ensure that the care they provide is safe, effective and sustainable. Medicines management concerns have frequently been the subject of safeguarding concerns in our care homes.

Since the pharmacy technician was recruited, substantial improvements have been made. The existing relationships that we had with our care homes have been developed and we are now able to offer proactive support to help reduce the risk of medicines- related incidents, rather than a reactive response when things have gone wrong.

Medicines optimisation in hospitals

In November 2017 the CCG recruited a pharmaceutical adviser to focus on hospital medicines optimisation issues. This role involves working closely with pharmacy teams, clinicians, contract managers and finance leads to ensure that the CCG gets the best value for money (in other words, evidence-based, cost-effective treatment) from the services it commissions from our hospitals.

The pharmaceutical adviser is also working closely with our hospitals and Shropshire CCG to develop a country-wide medicines formulary. This will enable a consistent approach to prescribing across Shropshire and Telford and Wrekin. The full formulary should be published in September 2018.

Regional medicines optimisation committees (RMOCs)

RMOCs were introduced by NHS England in April 2017. They provide advice and make recommendations on the optimal use of medicines for the benefit of patients and the NHS. They bring together decision makers and clinicians across the four regions of England to share best practice, understand the evidence base, coordinate action and so reduce variation – thus improving outcomes and value.

The CCG now routinely uses RMOC advice to support local decision-making and commissioning decisions.

Encouraging self-care

In April 2017 the CCG introduced a new policy on the prescribing of medicines that are available over-the-counter (OTC). Anyone with a short-term, self-limiting condition that can be managed with a drug/product available OTC is now asked to purchase the product rather than approaching their GP for a prescription. Although not everyone has welcomed this policy, most people understand that the NHS is under significant financial pressure and the time has come for us to take responsibility ourselves for managing minor illnesses rather than relying on the NHS to issue prescriptions.

People who do not routinely pay for prescriptions and those who hold a valid pre-payment certificate can access many over-the-counter medicines, free of charge, through the ‘Pharmacy First Scheme’. This scheme covers 28 minor ailments (from bites and stings to warts and verrucas). Ask your local pharmacist for more information about the ‘Pharmacy First Scheme’.

During 2017/18 the CCG has continued to encourage people to be prepared for most common ailments such as colds, headaches and diarrhoea, by keeping a well-stocked medicine cabinet at home. Advice on what to keep in your medicines cabinet is published on the CCG’s website at http://www.telfordccg.nhs.uk/who-we-are/publications/publications/medicines-

management/information-for-patients/1296-what-to-keep-in-your-medicines-cabinet-september-2015/file

Improving access to medicines

Most people would prefer to be managed at home rather than being admitted to hospital and therefore, wherever possible and safe to do so, the CCG is securing access to medicines in the community that would previously only have been administered in hospital (for example, intravenous antibiotics, subcutaneous fluids, intravenous diuretics).

The CCG is working closely with our community trust to ensure that the clinical team providing services to patients in their own homes have the required skills to administer these drugs.

Improving patient safety

The CCG has continued to strengthen the governance arrangements around medication error incident reporting and learning. The medicines safety group has continued to meet on a quarterly basis to discuss medicine- related incidents to ensure that learning is cascaded across the CCG.

Medicines in schools

The CCG has continued to work with schools during 2017/18. Relationships with the school nursing team have been developed, as have the relationships with the schools team within the local authority.

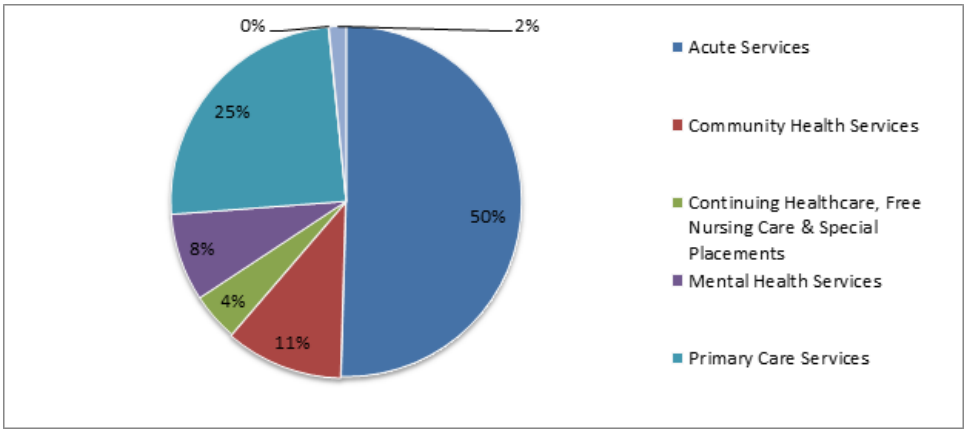
The medicines optimisation team, in collaboration with Telford and Wrekin Council, has continued to encourage schools to stock emergency salbutamol inhaler kits and, with the change in legislation, we are now encouraging schools to stock emergency adrenaline kits.

Over the coming months the CCG will be supporting a review of the local authority's policy aimed at supporting children with medical needs in school.

Finance

In 2017/18 the CCG received a total allocation of £238.8m to spend on the healthcare of local residents. The chart below shows a breakdown of the CCG's expenditure for 2017/18 by spend type:

Telford and Wrekin CCG Expenditure 2017/18 (£m)



For 2017/18, based upon NHS England Business Rules, the CCG has achieved an in year surplus of £1.273m. The cumulative surplus should be at least one per cent, Telford and Wrekin CCG will have a cumulative surplus of £6.958m by the end of 2017/18 which represents 2.9 per cent of the total allocation.

In 2017/18 NHS England required all CCGs to maintain an uncommitted non-recurrent reserve of 0.5 per cent to contribute to an NHS national risk reserve. This represents £1.048m within the in year surplus achieved.

Quality, innovation, productivity and prevention (QIPP)

QIPP is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver, while making efficiency savings that can be reinvested in the NHS.

In order to fund increases in activity, demography and any additional cost pressures the CCG will need to deliver recurrent QIPP plans year on year. In 2017/18 the CCG successfully delivered a QIPP programme of £4.2m against a target of £6.8m. Although the CCG is able to hit its control total in 2017/18, any underperformance on QIPP will provide a recurrent cost pressure going forward. The 2018/19 QIPP requirement for Telford and Wrekin CCG is currently a £9.2m target and an average QIPP target of approximately £7m for future years. It is important to note that, as time goes on, QIPP savings are becoming increasingly difficult to achieve as many of the 'quick wins' have already been identified. Given the challenging financial environment in which the CCG operates it has taken a robust approach to ensuring QIPP schemes that require investment will deliver a good return in terms of both patient and financial benefits.

Sustainable development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by using 2013-14 as the baseline year.

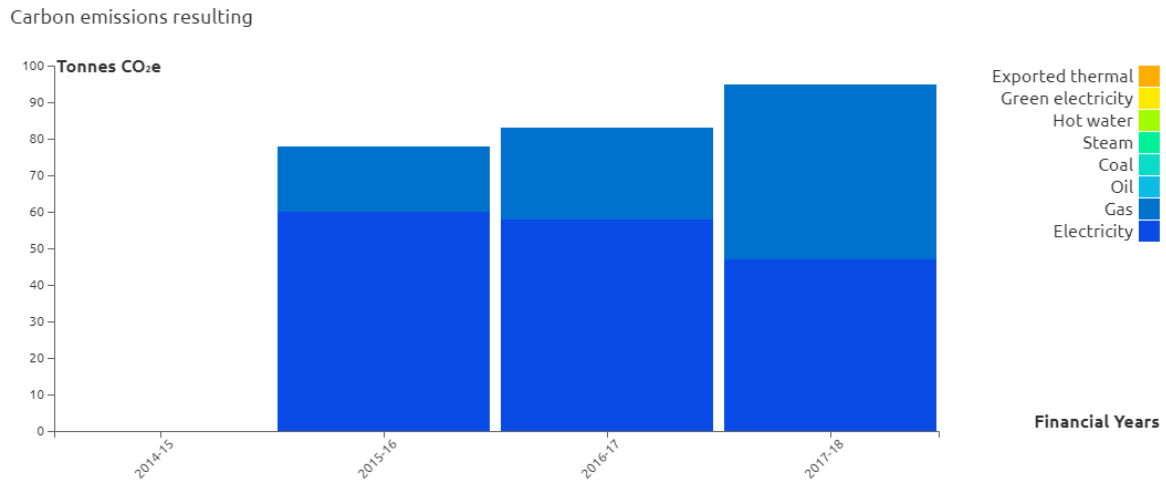
For commissioned services here is the sustainability comparator for our providers; *please note this is published a year in arrears*:

Organisation Name	SDMP	Adaptation	on track for 34% reduction	SDAT	Healthy transport plan	SD Reporting score
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	No	No	2. Target included but not on track to be met	65	No	Poor
SHROPSHIRE COMMUNITY HEALTH NHS TRUST	No	No	4. No Sustainable Development Management Plan	n/a	No	Poor
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	No	No	4. No Sustainable Development Management Plan	n/a	No	Excellent
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	No	No	1. On track to meet target	n/a	No	Minimum
UNIVERSITY HOSPITAL OF NORTH MIDLANDS NHS TRUST	No	No	1. On track to meet target	n/a	No	Minimum
WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST	No	No	1. On track to meet target	n/a	No	Minimum

More information on these measures is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

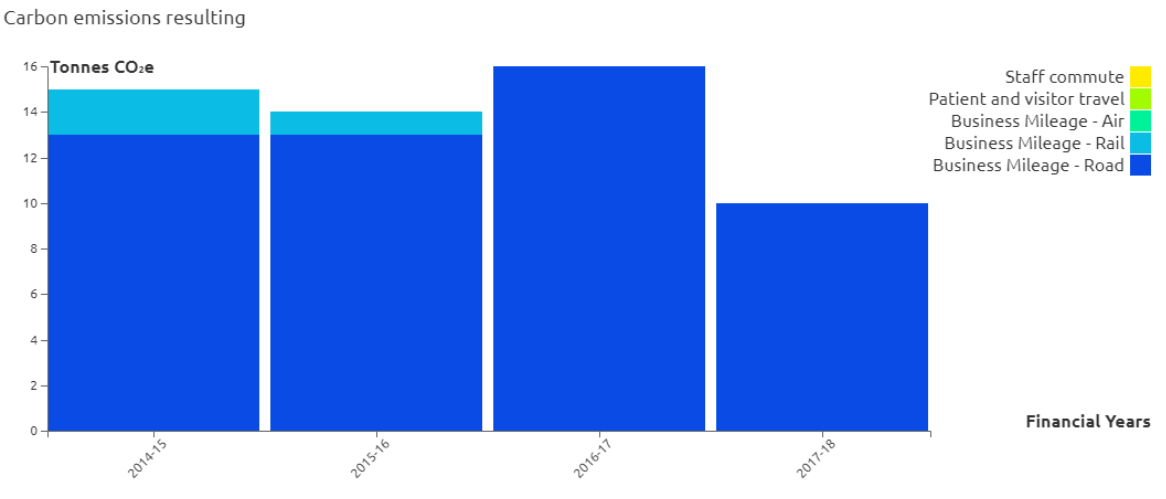
The CCG's energy use is shown below and will be used as a baseline for future plans.

Energy



NHS Property Services were unable to provide comparator figures for 2014/15.

Travel



The CCG's carbon emissions resulting from business mileage is shown above. The CCG's use of phone and video conferencing technology has resulted in a reduction in business travel in 2017/18.

In order to take this forward into 2018/19 and beyond the CCG has now appointed a Board level lead for sustainability.

My NHS ratings

My NHS gathers data from across the system into one place so professionals and the public can easily compare the performance of health and care services over a range of measures. Please see https://www.nhs.uk/service-search/Performance/Search

Monitoring the quality of services

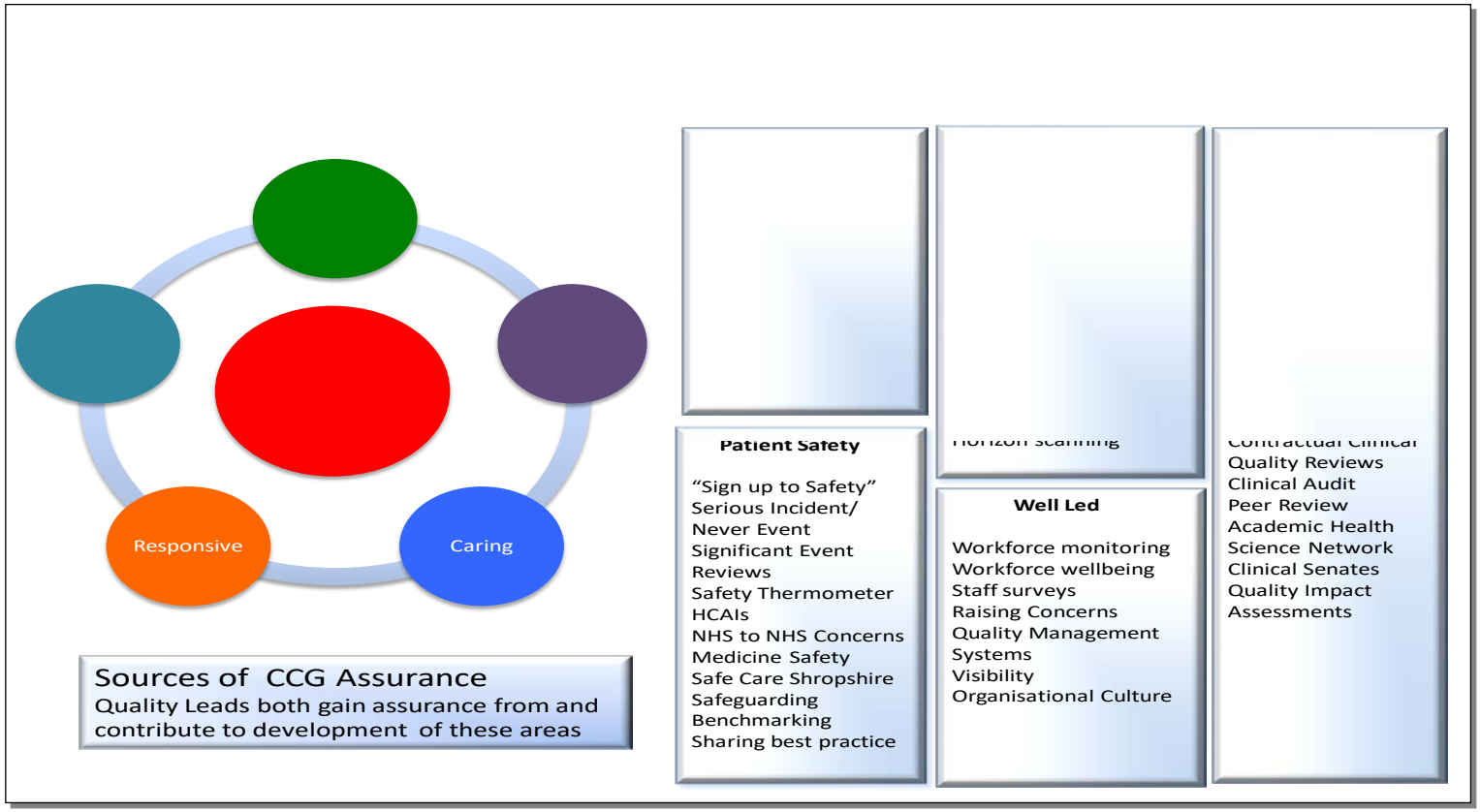
A key duty for the CCG, under section 14R of the Health and Social Care Act 2012, is to ensure that the services it commissions for the population of Telford and Wrekin are of the best possible quality, providing the level of patient experience we would want for our own families. Our starting point for this is through establishing the quality schedules of the national NHS contracts and ensuring that local priorities are incorporated.

Throughout 2017/18, the CCG quality team monitored and sought assurances on the quality of the services provided, and worked in partnership with providers to act where necessary. The CCG has strengthened its quality team, which has enabled us to provide greater scrutiny across the range of smaller contracts commissioned by the CCG.

We continue to use the quality assurance framework developed during 2016/17 with the emphasis on the three elements of quality as defined within the Health and Social Care Act 2012. The elements are patient safety, clinical effectiveness, and patient experience.

The CCG has continued to focus on these elements and consider the five areas of questioning of quality utilised by the updated Care Quality Commission (CQC) assurance framework. This decision reflects the learning from national enquiries, which have identified the importance of culture and strong leadership to create an environment where quality can flourish.

The five areas and sources of CCG assurance



Promoting and driving quality improvements in 2017/18

The CCG has worked with local providers to implement the national two-year Clinical Quality Indicators Scheme (CQUIN).

The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. It is designed to support the ambitions of the Five Year Forward View and directly link to the NHS Mandate. In contrast to previous years, where local schemes were developed, the schemes are now national and focus on two areas:

1. **Clinical quality and transformational indicators:**
   13 indicators have been defined which aim to improve quality and outcomes for patients including reducing health inequalities, encouraging collaboration across different providers and improving the working lives of NHS staff.
2. **Supporting local areas:**
   - Sustainability and Transformation Plans (STPs) – reinforcing the critical role providers have in developing and implementing local STPs
   - Local financial sustainability – encouraging providers and commissioners to work together to achieve financial balance.

The CCG continues to monitor all providers to ensure that workforce requirements are met wherever possible and that potential risks to patient safety are considered when looking at workforce resources. We have supported different ways of working to increase skill mix. The CCG incentivises providers to monitor and work with their workforces to ensure people feel supported in their roles. We believe that well supported staff deliver better patient care and enhance patient experiences.

A continued key focus is on the quality of care for those patients with long waiting times in A&E and those who have been placed on a 'fit to discharge ward', to ensure they receive equity of care, delivered with dignity and privacy, while they await the arrangements necessary for their discharge. During 2017/18 the CCG has also introduced GP streaming to assist in reducing waiting times for patients in A&E departments.

The CCG quality team has embedded quality across all workstreams which cover primary care, integrated care and secondary care.

The quality lead for primary care continues to support the GP Forward View agenda to deliver high quality sustainable services in primary care which meet the local population's needs.

As part of GP Forward View Telford and Wrekin CCG in conjunction with Shropshire CCG, the sustainability and transformation plan workforce group, Health Education England and NHS England – are working together to create a primary care workforce plan. This will focus on new ways of working and introducing new roles into general practice. Moving forward during 2018/19 both CCGs, with support from NHS England, plan to continue to engage with GPs, practice nurses and practice managers.

The CCG is aware of the need to encourage more people to participate in cancer screening. We know earlier diagnosis helps save lives. As part of this work, quality and commissioning leads are working with Public Health England and Cancer Research UK to promote the benefits of cervical screening, including ensuring that practice nurses are up to date on their training.

Protected learning time (PLT) events

During 2017/18 there were three afternoon PLT events for practice nurses and health care assistants (HCAs). The table below summarises the events and the actions/learning identified. The focus on the training, which is organised by the CCG, is to ensure improvements in care especially in the promotion of self-care for patients in Telford and Wrekin.

Date of PLT	Summary of event	Actions/learning
10 May 2017	Managing infectious diseases including: • tuberculosis (TB) update • sexual health update • paediatric asthma.	Nurses were reminded of the online training for both TB and sexual health and plan to access the training. The presentations increased the nurses' knowledge of TB and sexual health services available locally. This will help them to provide up to date information to patients and ensure referral to the most appropriate service. A number of nurses recognised that they need to improve their knowledge on the topic of paediatric asthma to assist in enabling patients and their families to better manage the condition.
18 October 2017	Hidden diseases including: • promoting physical activity primary care wellbeing service • early identification and management of hypertension • new COPD guidelines.	A presentation by the British Heart Foundation (BHF) reminded nurses of the need to remind patients to regularly check their blood pressure. They learnt that early detection reduces the risk of long-term effects of high blood pressure. They will take this message back to practices including the promotion of the self-monitoring blood pressure machines in many surgeries. They identified how the BHF works with primary care to support patients. Nurses were told about the new recommendations for the use of inhalers with people with COPD. This best practice will support patient care and the management of COPD effectively. HCAs had a presentation on the importance of discussing with patients the ways in which they can change their lifestyle to improve their health. It can be seen as a difficult subject to approach and this provided advice on how to start a conversation with a patient and what are realistic goals that will have an effect on health.

25 January 2018	Diabetes update including: • developments in the diabetic service • infection prevention control • early intervention to prevent lower limb amputations • psychological support • role of Diabetes UK.	Nurses were taught the importance of regular monitoring to ensure the early detection of changes to the feet and legs of people with diabetes, which require intervention to prevent future complications. Nurses will take back this knowledge to practices and one has already informed their quality lead of a situation when they recognised the need to seek onward referral for a patient. New guidelines on the referral to vascular surgeons will allow the nurses to feel more confident to refer early for an opinion. HCAs learnt about the new psychological support service. This allows them to provide holistic support for people with diabetes. A presentation by Diabetes UK gave national statistics on the disease and locally the new self-management courses being developed for people at risk of developing diabetes. Nurses plan to consider who in their practice would benefit from the course when available, and provide advice to people to think about lifestyle changes to reduce risk of diabetes.

Throughout the year the quality lead provides individual support to practice nurses regarding accessing training to maintain their clinical skills in conjunction with the community education provider network (CEPN) and the practice nurse facilitators. The facilitators have worked with local universities and practice nurses to increase the number of student nurse placements in primary care. They also support new practice nurses when undertaking their general practice nurse training. The quality lead will meet with nurses and HCAs in each of their practices, gain feedback and identify the areas to focus on for the next year.

Following completion of last year's practice visits by the quality and commissioning leads for primary care, a review was undertaken by the team to identify moving forward improvements which could be made in preparation for this year's visits. One of the key areas that needed to change was to make the visit more specific to each practice to ensure their practice population's needs were discussed.

Prior to each visit the team, made up of representatives from the CCG, data quality and NHS England, meet to review the practice using four key area of focus:

- Patient experience and engagement – including feedback from GP survey, Friends and Family Test data, patient participation group(PPG) engagement, compliments and complaints

- Quality indicators – including Quality Outcome Framework data, cancer screening uptake, use of acute services, referrals to other services, CQC inspections
- GP Forward View – including workforce changes, new developments and ways of working to enhance patient care
- RightCare agenda – including improving diabetes and respiratory management.

Information shared at the meeting is then used to create a targeted agenda for the visit, which results in a number of actions for the practice and/or CCG to take forward. Examples of areas discussed include concerns raised about accessing the practice for appointments, PPG newsletter, use of website and online access, feedback from Healthwatch England and NHS Choices.

The quality lead actively engaged with practices on an individual level as required. Practices experiencing difficulties with workforce, leading to patients finding it difficult to access appointments, were supported to look at different roles within the practice to allow patients to be seen by a professional with the skills to manage their health need. This new way of working, plus changes to appointment systems, has reduced the number of complaints received in relation to this area. In line with the CCG values of promoting patient involvement in their care, the quality lead liaises with practices and voluntary organisations to promote local self-management training courses for people with diabetes and chronic obstructive pulmonary disease (COPD).

Out of hours services are evolving in Telford with increased use of the NHS 111 service to gain access to out of hours urgent care. The quality lead works closely with colleagues across the region to gain assurance about the quality of the interventions and that all out of hours services work closely to provide a seamless service. This involves supporting local joint meetings between local out of hours providers.

The quality lead nurse for intermediate care services has worked closely with providers of care, in particular South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT), Shropshire Community Health NHS Trust, and nursing home providers. Significant collaborative work has been undertaken in respect of review of serious incidents and root cause analysis reports. This is important because it supports a culture of learning from when things do not happen as planned, and it can assist in preventing reoccurrence. This will benefit future patients and improve the quality of services that individuals receive.

SSSFT was awarded the contract to provide the redesigned emotional health and wellbeing service for children and young people aged 0-25 years, commissioned using a prime provider model. The initial service review and redesign processes have proved beneficial in ensuring that the factors identified by patients and other stakeholders in the co-production of the new model are being put into place in the new service.

Neighbourhood working is a large component of work carried out by the integrated care team and partner organisations. The quality lead has worked with the commissioning managers to ensure that the quality of care and the experience of patients are considered within the new models of care as they are developed. To support this, the patient engagement lead has linked in with the development of the first neighbourhood projects in Newport.

Quality has been monitored formally through a number of assurance frameworks, such as the Clinical Quality Review Meeting (CQRM) and ongoing scheduled meetings with the executive nurse

from each provider. All discussions and queries have been managed formally through the contractual route supported by the contract management team.

The quality lead nurse for secondary care has continued to work closely with all providers of care, in particular the two main providers of care, SaTH and Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) to ensure that patients are receiving high quality clinical care. Quality has been monitored formally through a number of assurance frameworks, such as the CQRM and ongoing scheduled meetings with the executive nurse from each provider. All discussions and queries have been managed formally through the contractual route with the presence of the CCG contract manager.

A number of announced and unannounced visits to providers to obtain assurance have taken place throughout 2017/18, and the outcome of each visit has been discussed and monitored through the CQRM process. Due to increased capacity demands within SaTH A&E departments, a number of CCG quality visits were undertaken to ensure that patients were not being 'harmed' due to long waiting times. Also, the CCG is continuing to support SaTH to ensure that the quality and safety of care are maintained at all times.

Serious incidents/never events have been monitored formally by the CCG using the NHS Outcomes Framework 2015 and, in 2017/18, the CCG reviewed its internal management processes. There have been considerable challenges with a total of three never events reported across SaTH and Shropshire Community Health NHS Trust. The CCG has worked closely with the providers and NHS England to ensure that all appropriate measures have been addressed and a number of monitoring processes are ongoing.

The quality team has been working collaboratively with Staffordshire University and in February 2018 we welcomed student nurses on formal placement within the CCG. The introduction of student nurses will see the CCG develop as a centre for learning excellence.

Safeguarding

The executive nurse continues to provide strategic leadership to safeguarding children, young people and adults, working with multi-agency partners to ensure the highest possible standards are achieved for our population. In addition, she has supported all CCG board members including non-executives to undertake national safeguarding training by Sandstories[1].

Designated nurse for safeguarding children

The designated nurse for safeguarding children offers advice, guidance, and training across the health economy to professionals including dentists and GPs. A new pharmacists e-learning package for safeguarding has been developed. A new named GP for safeguarding has been appointed and is devising a GP newsletter to ensure our GPs are supported to assist in identifying and reporting issues relating to child safeguarding.

The unannounced Care Quality Commission (CQC) inspection reviewing local safeguarding systems and processes at Telford and Wrekin CCG with health NHS provider partner agencies was

[1] Sandstories is a training tool that brings insight into the maltreatment of infants and children http://www.sandstories.co.uk/introduction/

implemented in September 2016. The final report was published by CQC in January 2017 and shared with Telford and Wrekin Local Safeguarding Children Board (LSCB) and NHS Providers. A total of 66 health safeguarding recommendations were identified, requiring further improvement with local health action plans produced. This has been quality monitored via CQRMs and LSCB quality, performance and operation sub group during 2017/18. The LSCB Ofsted action plans continue to be updated.

The safeguarding lead has worked with commissioning colleagues to ensure the quality of care delivered to patients. An example of this in 2017/18 was the work undertaken with the charity Marie Stopes International following CQC identification of issues with providing some services for vulnerable women seeking terminations of pregnancy. Marie Stopes is providing the CCG with updates on improving quality and performance, including improvements for younger individuals seeking terminations and child sexual exploitation training for frontline practitioners.

Safeguarding work plans have been completed for the relevant LSCB sub groups and are updated throughout the year. Work is ongoing to monitor the annual learning and improvement framework, deliver the core training learning outcomes for single agency child protection (including child sexual exploitation and female genital mutilation) and to develop the training plans around LSCB priority areas. During 2017/18 the three priority areas are missing; children, domestic abuse and neglect, with consideration also given in-year to children harming children (CHC).

The designated nurse for safeguarding children continues to be involved in the national review of LSCBs and child death overview panels (CDOPs) by contributing to the national Designated Safeguarding Network of Doctors and Nurses. The Alan Wood review (2016) sets out recommendations for making LSCBs more effective. The Government's response to the review authorised the new Children and Social Work legislation amendment which stated that this is the beginning of a time of considerable change in safeguarding.

The Designated Nurse for Safeguarding Children and CDOP Chair has presented the Child Death Overview Panel (CDOP) annual report, action plan and update reports for Shropshire and Telford and Wrekin to both Local Safeguarding Children's Boards (LSCBs). The CDOP continues to review local cases of reported deaths to date for this year.

The CCG appointed a designated looked-after children nurse to support both Shropshire CCG and Telford and Wrekin CCG during 2016/17. During 2017/18 the key areas of focus in terms of improvements for services for looked-after children have related to the CQC action plan that resulted from the review of health services for looked-after children and safeguarding. The CCG has worked closely with Shropshire Community Health NHS Trust to improve the health needs assessment process for looked-after children.

Designated nurse for safeguarding adults

The adult safeguarding lead nurse has developed effective working practices with the Telford and Wrekin Council. Together, they ensure that timely responses to requests for Section 42 enquiries and 'other' non-statutory enquiries are attended to by the CCG or – alternatively – that advice is offered in relation to the appropriate enquiry organisation.

The adult safeguarding lead nurse also continues to support the Telford and Wrekin Council by providing a monitoring role in respect of local provider enquiry responses. Ongoing provider meetings held with the provider safeguarding leads and the safeguarding lead for Shropshire CCG

outside of the CQRM processes, allow for the sharing of best practice and for response to legislation or guidance change, and also assist in identifying emerging trends and themes. This assists in proactive practice to understand emerging patterns, should they be identified. The team is also a regular member of quality assurance visits at local care homes and an ongoing timetable of visits is scheduled over the coming months.

The adult safeguarding lead nurse has input into both the formal pan-Shropshire and Telford local provider information sharing meetings (formerly the CQC liaison meetings) and the local Telford provider information sharing meeting. The lead attends the safeguarding adults board meetings, and currently chairs the quality, performance and operational (QPO) subgroup. The lead also sits on the partnership, training, learning and development (PTLD), the SAR and the domestic violence subgroup meetings and attends two further thematic subgroups – financial abuse and joint exploitation. The team has completed an independent management review to contribute to a domestic homicide review which is awaiting publication and it is currently assisting with a further safeguarding adults review, started in December 2017. A further SAR has been identified, awaiting a commencement date, and two further cases are under consideration. An ongoing programme of Mental Capacity Act (MCA)/deprivation of liberty safeguards (DoLS) training is in place to assist in providing support to the local care homes and GP practices in the area. Additionally, the team is currently assisting with audits of MCA recording within SaTH, SSSFT, RJAH and Shropshire Community Health NHS Trust. An audit in respect of MCA/DoLS and adult safeguarding has been conducted in local care homes to understand how effective training has been and to identify any changes required to the training programmes accessed across the wider community.

In June 2017, the team contributed to a GP safeguarding training conference which addressed child sexual exploitation, the Prevent agenda and domestic violence. They are currently planning a GP training event for May 2018.

Complex care

During 2017/18 the CCG's complex care team has achieved a number of key objectives:

- NHS England has introduced continuing healthcare assurance meetings. The outcome of the meetings has been that the Regional Director of Commissioning Operations team are assured that Telford and Wrekin CCG are operating NHS continuing healthcare in accordance with the national service framework
- two quality premiums were set by NHS England around CHC:
    1. under 15 per cent of multi-disciplinary assessments for CHC to be undertaken in an acute setting. The CCG has achieved this standard throughout the year with no CHC assessments being undertaken in an acute setting
    2. 80 per cent of assessments should be completed within 28 days of receiving a checklist. Between April and January, the CCG improved its performance against this target from a baseline of seven per cent in 2016/17 to achieving 80 per cent of assessments in January 2018.

The complex care team has become a member of NHS England's strategic improvement collaborative test and scale group. This aims to test the prospective future changes to the way in which NHS CHC is delivered to ensure it is fair and equitable, and that there is less variance in the application of the National Service Framework.

Telford and Wrekin CCG has developed a methodology for joint funding that is being trialled in several other CCG areas as it is recognised as good practice.

Personal health budgets remain available for all people who are assessed as needing continuing healthcare (CHC), are not living in care homes, and are not fast track. Currently 33 per cent of eligible patients are in receipt of CHC via a personal health budget.

The complex care team has recruited a children's nurse whose role is to case-manage children who are in receipt of children's continuing care and to undertake the role of designated clinical officer for special educational needs and disability (SEND). The CCG is therefore able to assure the quality of care to children with SEND who have associated health needs.

Infection prevention and control

Reducing and preventing healthcare associated infections are fundamental to the safety and quality of care delivered to patients and they remain a high priority for the CCG. The CCG reshaped the infection prevention and control (IPC) function in 2017/18 and appointed a dedicated internal lead to work with partners across the health economy.

As we continue to work towards implementing our three-year infection prevention and control strategy (2015-18), our overall vision remains that no person in Telford and Wrekin is harmed by a preventable infection.

We have worked collaboratively with partners throughout the year to maintain the low levels of methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection. While the CCG has made great strides in reducing the numbers of Clostridium difficile infections since 2008, when specific reduction targets for commissioning organisations were first introduced, the rate of improvement has slowed over recent years and it has been a significant challenge for the CCG to achieve the ambitious 2017/18 target. The Clostridium difficile action plan has been regularly reviewed by the local health economy infection prevention and control group to ensure it continues to provide focus and remains responsive to change. In addition, as a health community, robust root cause analysis has been applied to all cases of MRSA bloodstream infection and Clostridium difficile infections, and learning has been identified and disseminated to mitigate against recurrence.

As a local health economy there has been a drive to reduce the incidence of Escherichia coli (E.coli) bloodstream infections. The infection prevention and control team is working with partners across Telford and Wrekin with a particular focus on hydration and urinary catheter care. This work will continue into 2018/19.

In 2018/19 we will build on assurance processes currently in place and continue to lead on influencing the strategy in provider organisations with a focus on minimising the risk of infection, on ensuring that people are cared for in a safe clean environment and on making sure they are protected from avoidable harm.

Patient and public involvement (PPI)

The CCG's constitution sets out how it will make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting commissioning arrangements: https://www.telfordccg.nhs.uk/who-we-are/publications/constitution/3337-nhs-tw-ccg-constitution-version-12-0/file

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

At the beginning of 2016/17, the CCG approved a new communications and engagement strategy 2016-19, which can be found on the CCG's website http://www.telfordccg.nhs.uk/who-we-are/publications/strategies-and-plans/strategies/25-communciation-and-engagement-strategy-v1-3-april-2016-2/file

This strategy sets out the principles that will govern how the CCG will communicate and involve, internally and externally. It identifies key objectives and also acts as a reference document for CCG staff who are embarking on communication or involvement activities. We have continued to deliver against that strategy in 2017/18.

We have a clear governance process for ensuring that we involve patients in service redesign or planning for new services. The planning, performance and quality committee provides oversight of patient involvement activity via a quarterly report, with exception reporting to the CCG governance board by the chair. This committee also scrutinises individual service redesign plans, and patient involvement forms one element within these.

We have employed the following mechanisms for receiving and providing ongoing feedback and involvement:

Health Roundtable

During the earlier part of 2017/18, the Health Roundtable continued to meet and members were heavily involved, in partnership with the CCG, in promoting and supporting individual GP practices to develop their patient participation groups (PPGs). This resulted in all of the 14 GP practices having a PPG. Members of the Health Roundtable continue to be involved in various pieces of work including the NHS Future Fit process and the Pharmacy First scheme linking in with the CCG's medicines management team.

A large part of their work during the year was undertaking a review of their own terms of reference. When considering emerging new and existing voluntary sector organisations, PPGs and Healthwatch Telford and Wrekin, the Health Roundtable members concluded that their work often duplicated much of the engagement work these forums also undertook.

The Health Roundtable then made a recommendation to the CCG governance board that it should cease to operate and a new committee with more focused terms of reference should be formed. The new committee should act as a critical friend to the CCG to ensure that it appropriately engaged with its population when redesigning services, particularly for the nine protected characteristics under the Equality Act 2010.

The Health Roundtable was instrumental in developing the new assuring involvement committee's terms of reference and job descriptions for the publicly appointed members.

The Health Roundtable ceased to function as a committee in August 2017 and the CCG would like to express its gratitude to the members who gave their time and expertise.

Reading group

The patients reading group has been involved in checking the documents in preparation for the NHS Future Fit consultation. The feedback they have given has been invaluable in making sure that the document is in plain English and easy to understand.

Membership scheme

The membership scheme has settled to around 500 members. A quarterly newsletter is sent out with details of the CCG activities, invitations to get involved and information on national initiatives. The CCG would like to grow its membership, so that more patients have the opportunity to take part in engagement activities - for example, completing surveys, attending focus groups or just helping to spread the word about its role. Anyone interested in having their voice heard is invited to sign up at https://www.telfordccg.nhs.uk/get-involved/become-a-member and to encourage their family and friends to sign up too.

A strong membership will help the CCG to learn more about what people in Telford and Wrekin want from their health services and how improvements can be made to local healthcare.

During 2018/19 the CCG will be reviewing the current membership scheme to see how it could be improved. Any suggestions on how the CCG can encourage more people to get involved are welcomed – please get in touch with the CCG.

Patient engagement lead

In addition to the patient and public engagement processes described, the CCG's patient engagement lead continues to meet with targeted groups of individuals who are potentially excluded or disadvantaged. These have included those who support patients with a learning disability, patients whose first language is not English, voluntary sector organisations who support individuals with mental health issues, groups who encourage people to have a healthy lifestyle and those who support vulnerable young people.

During the summer, the patient services team attended a number of events throughout the borough including the Carnival of Giants, a police open day and a local open coffee morning. The team were able to speak to people at these events about their local health services and assist them with enquiries. People were also given the opportunity to complete feedback cards, which were shared with commissioners of services. Examples of changes to services are given on page 50.

During 2017/18 we have been developing our website to ensure that we provide feedback to members of the public about how their queries at these roadshows and community events have been utilised within the commissioning processes.

Support has continued to be offered to GP practices who wish to develop their PPGs. GP practices are encouraging patients to participate in the work of their own PPG and if you would like to know more about this please contact your practice manager.

During February 2018, the CCG ran a very successful Dignity Day campaign focusing on social inclusion with the emphasis on taking the time to say hello or to give someone a wave, so that they know you care. #makingwaves included CCG staff and their colleagues completing a 'Mexican wave' and encouraging other organisations to join us.

There has been a focus on local maternity services this year and a number of focus groups were held. This included looking at the Women's and Children's Unit as part of NHS Future Fit and the local review of midwife-led units. Both were well attended by mothers and their partners, who were given the opportunity to speak about maternity services.

The CCG invests some of its resources in engaging with patients and the public to ensure that we are providing high-quality services. We recognise that there are many ways to engage with people and we try to use as many mechanisms as possible, recognising that people have different preferences. During 2017/18 we have increased the use of social media to get messages out to the general public.

Of course, we not only need to deliver our messages to patients and the public, we must also ensure that we listen to what they have said and act on feedback where this is possible.

During 2017/18, the CCG undertook the following engagement and consultation activities to support service redesign and planning. We have provided a summary of the feedback and how that influenced the decision made:

- **Pharmacy needs assessment survey and consultation document**
  The CCG, with the help of the individual PPGs and local Healthwatch, encouraged patients and the public to complete the pharmacy needs assessment survey which was accessible both on-line and in paper format. The information was gathered from all the surveys and the local authority produced the pharmacy needs assessment. The document went out to the patients and public of the borough for consultation
- **Take Care Telford – signposting campaign**
  The CCG has worked closely with its commissioning support colleagues and patients to create a marketing campaign that helps people to access support when they need it. Patients helped to develop 'Take Care Telford' with the emphasis on right care, right time. Posters, leaflets and bus panels have been seen across the borough promoting access to pharmacies, GP surgeries and NHS 111. The campaign will be reviewed to see if it has been successful. If you have seen any of the posters or leaflets, then please let us know. Leaflets have been translated into Polish and placed in Polish shops throughout the borough and in churches.
- **Midwife-led unit (MLU) review**
  Shropshire and Telford and Wrekin CCGs conducted a review of its midwife- led units. This was done via small focus groups across the county. Groups were held in Telford and Wrekin and were well attended by mothers, their partners and family members including children. The feedback was used to complete the final report, which went to both CCG boards. This review will be included in the local maternity review.
- **Diabetes care pathway**
  The CCG is working on developing the care pathway for people who have diabetes. Patient events were held during July and August 2017, and the feedback has been used to help in developing a new diabetes pathway, which began implementation in April 2018.
- **Closure of Malling Health Wrekin GP practice**
  During the planning of the dispersal of patients from the closed GP practice, it was identified that a number of these patients could be vulnerable and may not understand the process of re-registration at another GP practice. With help from members of the reading group, a letter was written and sent to all those patients offering a point of

contact within the CCG to help them to make the move to their new practice. A letter was also sent to a number of support organisations, (Red Cross, Age UK, Kip, Stay, Telford After Care Team) informing them of the closure of the practice, and that they may have patients contacting them directly for assistance. They were asked to pass on the contact details of the officer within the CCG that could help them.

The CCG also receives ad hoc feedback via its ongoing feedback mechanisms or as supplementary information provided during specific involvement activities and some examples have been provided below to show how this feedback has influenced the CCG to change how services are delivered:

Patient Feedback	Actions to address	Change
'Ladies in the group find it difficult to trust GPs and therefore will not find out about cancer.' Asian women's group	• contact made with engagement lead for Macmillan Cancer Support to ask her to visit the group • discussion with the CCG cancer lead on engaging with patients.	• the Macmillan Cancer Support engagement lead visited the group and took leaflets that were in appropriate languages • the CCG cancer lead continues to engage with a number of groups.
'There have been problems in some GP surgeries where guide dogs are not being allowed onto the premises or into consultation rooms.'	• discussion with primary care commissioners about access for patients who are blind or partially sighted	• all GP surgeries were reminded, via the GP newsletter, of their duty as part of the Equality Act to allow guide dogs to access all areas
'What's happening in Telford – discussion around the A&E situation. Was not aware of what is happening in the neighbourhoods, did not know about extended GP hours or NHS 111. Patient went to A&E with a wasp sting as it was at a weekend and didn't know who to contact.'	• discussion with the primary care commissioners about access to the right services at the right time • CCG commissioned MLCSU to engage with patients and develop a marketing campaign • MLCSU delivered the signposting campaign • MLCSU to evaluate the effectiveness of the campaign	• This will continue to be an all year round campaign which supports patients to access health services (GP, pharmacy, NHS 111) other than A&E
Following a complaint from a patient that they had been chasing for an appointment, it was discovered that they had contacted the wrong service because it had not been made clear to them who the service provider was. The consultant involved worked for more than one provider.	• The service was contacted to advise them of the issue and ask them to ensure that in future they have processes in place to keep patients informed	• change in provider process
Feedback received regarding a GP practice, in relation to getting through on the telephone and access to appointments.	• CCG met with the GP practice to discuss their telephone and appointment system • suggestion to GP practice to use its PPG for gathering feedback	• the CCG implemented a new telephone system. • The GP practice changed the way it runs its appointment system

Patient Advice and Liaison Services (PALS)

PALS is integral to Telford and Wrekin CCG's commitment to working closely with patients and staff to improve services.

All enquiries received through PALS are recorded on a database. PALS 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.

During 2017/18, a total of 606 contacts were received through PALS, an increase in enquiries compared to the previous year. These included:

- a high number of enquiries related to the closure of a GP practice or walk-in centre
- a number of enquiries around one GP practice and access

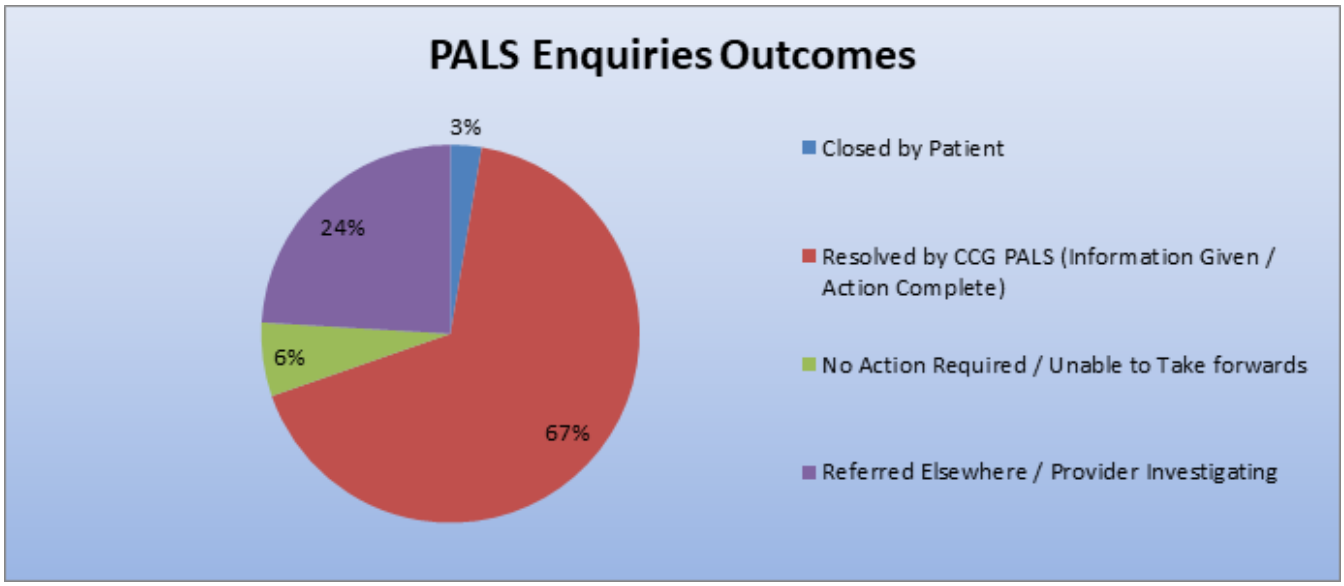
Problems with access to CCG services via the telephone have impacted on the number of enquiries received. To help address these issues the CCG commissioned a new telephone system in February 2018.

A total of 75 per cent of the PALS queries received related to access to services or appointments.

PALS enquiries by subject area

Of the 606 contacts received, 67 per cent were resolved by the CCG PALS and 24 per cent were referred to providers for the matter to be resolved directly.

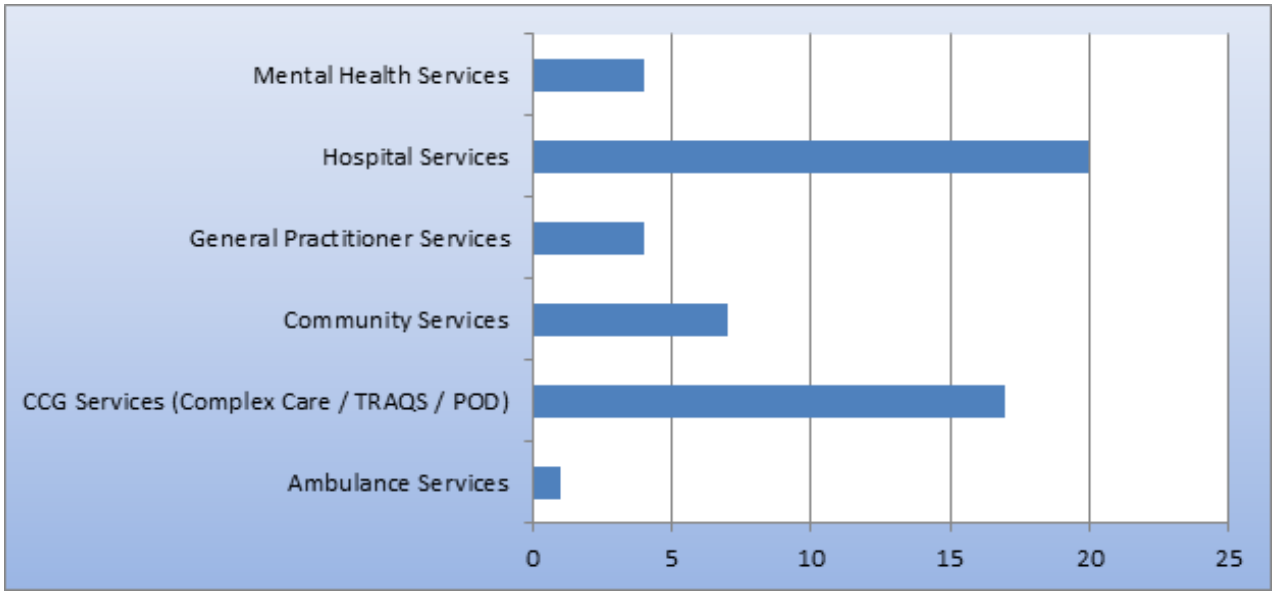
PALS enquiries outcomes



Complaints

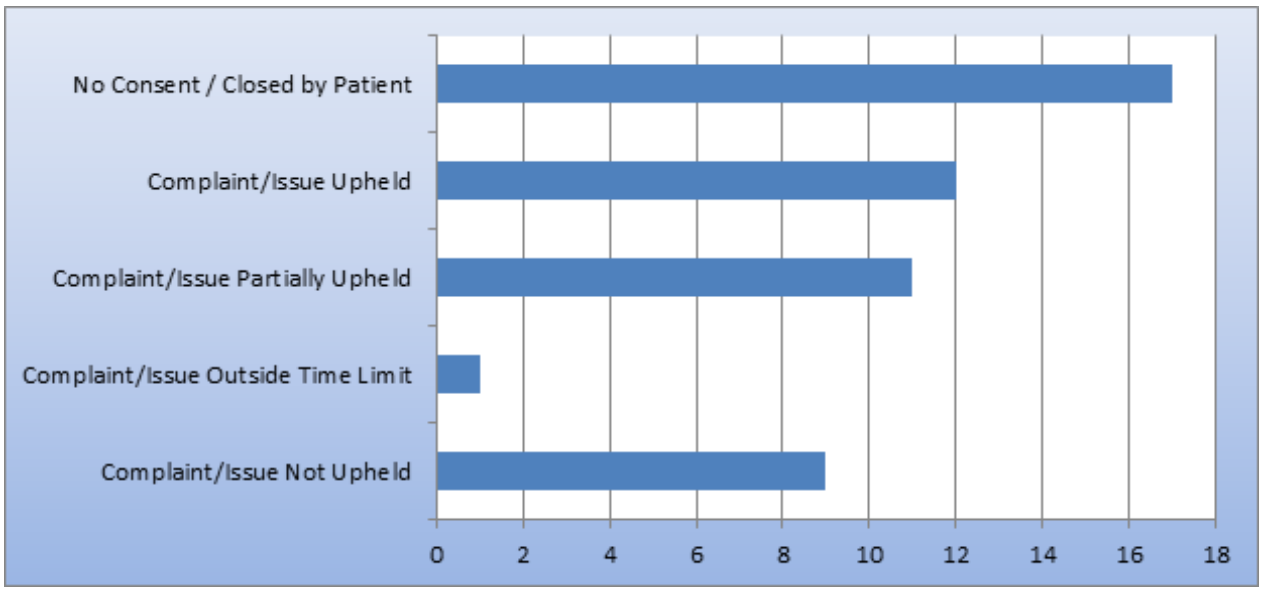
During 2017/18 Telford and Wrekin CCG received 53 complaints, which relate to a variety of providers of healthcare that the CCG commissions. This is slightly higher than last year.

Complaints by service area



Out of the 53 complaints received, three cases are ongoing, and 50 cases have been closed.

Completed complaints outcomes



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

- there have been a couple of concerns around the content of letters when services have been communicating with patients. In these cases, changes were made to the letters and to processes to ensure more effective communication in future
- a couple of concerns were received around lung cancer, as families believed that opportunities had been missed to diagnose the cancer earlier, which may have led to a better outcome. Although in both instances the actions taken at the time were appropriate, the details of the concerns were shared with the quality team to review to understand if there were any themes that could be taken forwards

- issues were raised around services having information/processes that could be considered discriminatory. In these instances, systems and processes have been changed and a provider website was also amended to ensure information about the service is more inclusive
- following concerns about access to services at a local GP practice, the GP now has a new telephone system and changes have been made to processes to make accessing appointments easier
- in more than one case guidance has been reiterated with staff, or additional training provided, to ensure that appropriate process is being followed, improving overall patient experience.

Members of parliament (MP) letters

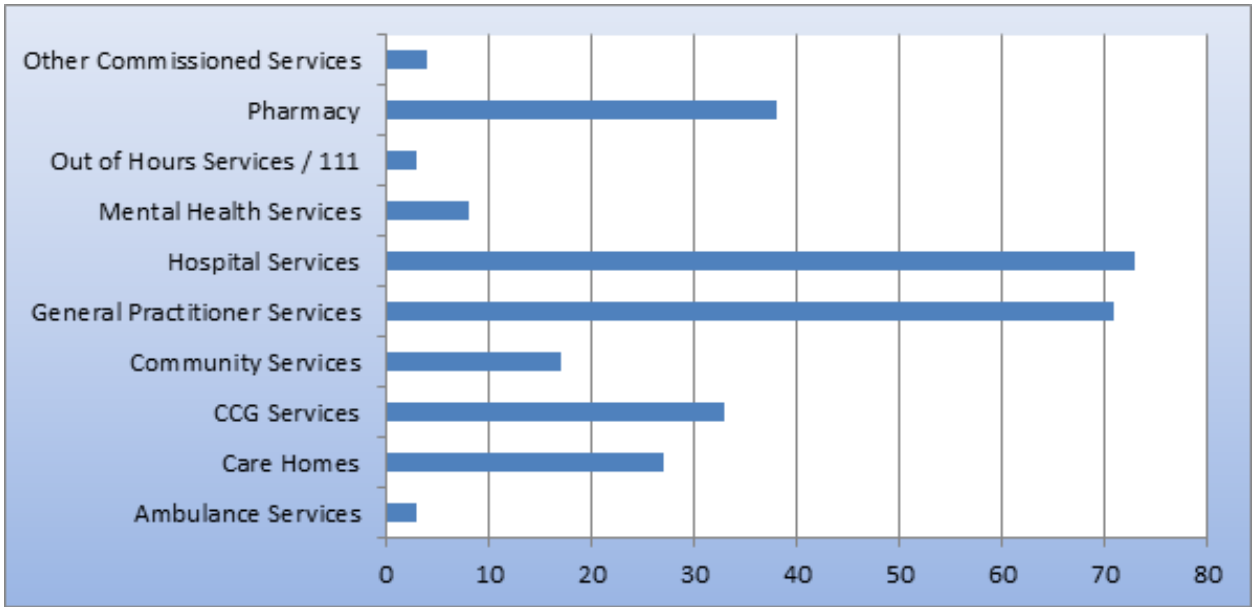
Last year, Telford and Wrekin CCG received 13 letters/emails from MPs that related to the care that constituents were receiving; eight of these related to care provided by commissioned services, three were around CCG commissioning decisions and two related to services not commissioned by Telford and Wrekin CCG. The majority of concerns that were raised related to access to services.

NHS to NHS (N2N) concerns

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

In 2017/18, Telford and Wrekin CCG received 277 N2N concerns, 175 of these were medication issues, which are managed separately by the medicines management team.

NHS to NHS concerns by service area



Below are examples of where N2N concerns have led to improvements in services:

- a concern was raised about delays for an assessment for pressure- relieving equipment. The service reviewed its processes for receipt of referrals and a more robust process has been put in place
- following the implementation of a new reporting system at a provider organisation, it was discovered that there were some issues around how the system transferred information. It was raised with the CCG that this had caused a delay in communicating the results of investigations. Since discovering this, a failsafe has been put in place to prevent future reoccurrence
- a provider organisation had to transfer patients to another provider due to staffing issues. During this process a patient's information was missed leading to delays in arranging appointments. This was an unusual situation, but the providers have indicated that if this situation were to occur again in the future, the process would be changed to ensure patients cannot get lost in the system
- a letter was sent to a patient's previous address. This issue was related to a referral being sent over with an old address on it and the service that received the referral was unable to change the details on its system. To prevent this issue reoccurring, the service put an interim process in place and the issue will be resolved more permanently following a system update in April 2018.

Reducing health inequalities

The CCG has a duty to reduce health inequality outcomes for its population, working with Telford and Wrekin Health and Wellbeing Board. The CCG has addressed health inequalities in several commissioning workstreams, for example:

We have used the Joint Strategic Needs Assessment (JSNA) and RightCare data to identify the impact of health inequalities on prevalence of certain health conditions. We have then brought in additional resources and devised specific work programmes to tackle them.

For example, we know from our JSNA that the prevalence of coronary heart disease, respiratory conditions, diabetes, cancer, and mental health problems is greater in some population groups than in others, and that this contributes to a difference in life expectancy between more affluent and disadvantaged communities.

Through the RightCare programme we focused initially on the redesign of three initial priorities, and we are implementing plans to improve prevention, patient education and support, and delivery of more effective efficient care and treatment services in:

- respiratory
- diabetes
- mental health.

Work is now beginning on the next priorities – neurology and gastrology.

We have continued to focus on cancer (aided by Macmillan Cancer Support) and the performance of key performance indicators (KPIs). For example, we have anticipated meeting the 62-day treatment target by the end of 2017/18. We are on trajectory to improve cancer survivorship rates as planned.

Similarly, after considerable engagement with people of all ages who are affected by mental health problems, we have commissioned a new emotional wellbeing service for young people up to 25 years old and recommissioned a range of mental health services, which increasingly involve community voluntary partners who work with our disadvantaged groups. For example, after consultation with mental health users, we recognised that we needed a more effective response to people in crisis. So, we have commissioned a crisis hub, which will offer an alternative to the use of Section 136 suite beds and/or police custody/emergency department dispositions, which can be traumatic experiences adding more stress to already distressed people. Use of the 136 suite has dropped considerably over the past 12 months reflecting the success of the crisis arrangements.

We are working in collaboration with NHS Shropshire CCG and both of our respective local authorities to improve the physical and mental health of people with learning disabilities, also recognised as at risk of lower life expectancy.

The CCG works closely with Telford and Wrekin Council to address the lifestyle causes of poor health. We have had a particular focus on reducing smoking at the time of a baby's delivery and, while rates can vary from month-to-month, the overall trend continues to go down. This alone will have a major impact on children who otherwise would suffer from the impact of living with smoke from pre-birth into childhood and beyond.

The aim of our neighbourhood programme is to empower people who otherwise may feel dependent on the NHS and other public services to improve lifestyles and self-manage long-term conditions through education, support, and, increasingly, the use of telehealth and technology. While much remains to be done, we are creating a social movement and communities, voluntary organisations and individuals are getting behind it.

Prevention of poor health is critical and the CCG, as an employer, has been leading by example, encouraging our staff to get more exercise and to limit the time they spend sitting at their desks. This has gone from strength to strength with a group graduating from the 0-5K training to running the 5K parkrun on 14 October 2017; weekly yoga, cycling and walking activities and additional activities including a trip to the Manchester Velodrome one Saturday morning for enthusiasts, in their own time. We have also held mindfulness sessions and the 2017 activity advent calendar was a huge success with staff completing fun festive activities including table tennis round the world, singing, and our very own version of circuit training.

Equality report

The CCG is committed to ensuring equality and diversity is a priority when planning and commissioning healthcare services in our area. Under the Equality Act 2010 and the Public Sector General Equality Duty, organisations must publish sufficient information to demonstrate that, in the exercise of its functions, it has a due regard to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a relevant protected characteristic and those who do not.

To help monitor how the NHS as a whole was working towards these functions, the refreshed NHS Equality Delivery System (EDS2) was launched in November 2013. It is a toolkit designed to help

NHS organisations and staff review their performance for people with characteristics protected by the Equality Act 2010, and identify how improvements may be made.

The protected characteristics are as follows:

- age
- disability
- gender re-assignment
- marriage and civil partnership
- 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 four main goals. Go to the following NHS England link for more information on the scoring mechanisms: https://www.england.nhs.uk/about/equality/equality-hub/eds/

The results of the CCG assessment can be found on the equality and diversity page of the CCG website: https://www.telfordccg.nhs.uk/who-we-are/publications/publications/equality-and-diversity/2663-eds2-summary-report-jan-2017-1/file

The CCG has rated itself as 'developing' across the majority of goals. We recognise that, to progress from this level, we need to understand the needs of individuals accessing healthcare services and ensure we can evidence how we have acted to promote equalities. We have made targeted efforts throughout 2017/18 to engage with groups who make up some (or all) of the nine protected characteristics, and have received and acted upon some valuable feedback on services. For example:

- black and minority ethnic (BME) faith or religion – Noor Women's Group, Shropshire and Telford Women Unite Group
- age – Morris Care Home, Recharge, Juniper Training
- disabilities – Shropshire Down's syndrome group, The Arts Centre Telford (TACT), Branches drop-in centre
- sexual orientation – Safe Ageing, No Discrimination Shropshire (SAND)
- sex – Jayne Sargent Foundation, Telford Patients First group, Nordic Walking Group, Gorge Women's Institute
- carers – Shropshire Partners in Care (SPIC)
- pregnancy and maternity – women's and children's focus group, MLU focus groups.

Implementing the Accessible Information Standard (AIS) by the introduction of a new policy to help ensure that those people suffering from a visual or sensory impairment are able to specify how the

CCG will communicate with them about their medical treatment: http://www.telfordccg.nhs.uk/who-we-are/publications/policies/corporate-1/46-accessible-information-policy-version-1/file

We will continue to build on our aim to make strong links with those groups that make up the nine protected characteristics, as well as other groups such as people suffering from mental health problems, substance misuse, and so on.

As commissioners of services, we have contracts with the organisations that provide services. As part of that contract it is a national requirement that providers publish data about how they are performing under the equality delivery system.

Under the EDS2 equality performance toolkit, the CCG is required to set itself equality objectives at least every four years. The CCG objectives are:

- improving lives of local people and patients
- inclusive leadership and representative and supported workforce.

The Workplace Race Equality Standard (WRES) requires the CCG to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Our current workforce representativeness of ethnicity is shown below and can be compared to a BME percentage of 10.5 per cent in the Telford and Wrekin Population, as published by Telford and Wrekin Council in June 2016:

https://www.telford.gov.uk/downloads/file/4595/telford_and_wrekin_key_facts_-_june_2016

www.telford.gov.uk

Telford and Wrekin CCG percentage of staff by pay band and ethnicity as at 31 March 2018 –

Pay Band	BME	Unknown / Not Stated	White	Average Total
Band 2	33.33%	0.00%	66.67%	**100.00%**
Band 3	9.09%	4.55%	86.36%	**100.00%**
Band 4	0.00%	11.11%	88.89%	**100.00%**
Band 5	0.00%	0.00%	100.00%	**100.00%**
Band 6	11.11%	0.00%	88.89%	**100.00%**
Band 7	0.00%	0.00%	100.00%	**100.00%**
Band 8 - Range A	0.00%	0.00%	100.00%	**100.00%**
Band 8 - Range B	27.27%	0.00%	72.73%	**100.00%**
Band 8 - Range C	0.00%	0.00%	100.00%	**100.00%**
Band 8 - Range D	0.00%	0.00%	100.00%	**100.00%**
VSM	0.00%	0.00%	100.00%	**100.00%**
Medical Payscale	23.08%	15.38%	61.54%	**100.00%**
Gov Body (off payroll)	0.00%	100.00%	0.00%	**100.00%**
Grand Total	**9.26%**	**6.48%**	**84.26%**	**100.00%**

The CCG's self-certification statements can be found at:
http://www.telfordccg.nhs.uk/who-we-are/equality-and-diversity

Based upon the CCG's analysis of its WRES data it has identified three key actions:

- request and collation of ethnicity data on its governance board members which has now been completed and is reflected in the table above
- ensure that local staff survey has ethnicity data requested
- analyse the likelihood of BME candidates being appointed from shortlisting data.

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

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

The CCG remains committed to ensuring that staff receive up-to-date and relevant equalities and inclusion training, which is described in the equality and inclusion report above. This is further supported by the CCG's equal opportunities policy, which sets out the CCG's vision that all employees should follow.

Health and wellbeing strategy

The shared aim articulated in our health and wellbeing plan is: 'Together we will work to enable people in Telford and Wrekin to enjoy healthier, happier, and longer lives.' The CCG has embraced this in its own strapline: 'Healthier, Happier, Longer.'

Following considerable organisational development supported by external facilitation in 2015/16, the partners agreed to focus on the following three priorities through the 2016-19 health and wellbeing strategy:

- encourage healthier lifestyles
- improve mental wellbeing and mental health
- strengthen our communities and community-based support.

There has been considerable progress on all three priorities during 2017/18 and on our joint work with the council on neighbourhood development:

- the CCG and Telford and Wrekin Council are committed to promoting healthier lifestyles by creating a social movement, so that local people are increasingly empowered to change their own lifestyle and support community change. The movement around, for example, the 5K parkrun has been organic and represents just one area where 'people' rather than statutory bodies are creating change

- the Health and Wellbeing Board has approved a shared mental health strategy, and considerable progress has been made this year procuring a ‘crisis hub’ led and managed by voluntary sector partners. Telford and Wrekin CCG led the consortium of four commissioning organisations (two CCGs and two councils) to redesign and procure a new model of an emotional health and wellbeing service for children and young people to replace the existing Child and Adolescent Mental Health Service (CAMHS). We are currently leading the Transforming Care programme to improve care and support arrangements for people with learning disabilities, and in the process of developing a joint commissioning strategy
- the priority to strengthen communities and community-based support has been embraced by the STP, and the plan is firmly based on a commitment to a ‘left shift’ to achieve care closer to home through the development of neighbourhood working. Working closely with Telford and Wrekin Council, the CCG and primary care providers have agreed a configuration of four neighbourhood groupings of primary care practices. Next steps include designing integrated structures so that health, social care and mental health services work in a more localised ‘patch’ in close collaboration with local voluntary organisations to prevent poor health and support people who need more professional or clinical support.

Accountability report

SIGNATURE 

David Evans

Accountable Officer

DATE 24th May 2018

Members' report

The CCG is a membership organisation composed of the 14 GP practices located within the geographical area of Telford and Wrekin. During 2017/18, the CCG saw the closure of one GP practice reducing the total from 17 down to 16 and also a merger of three practices. When the members of the group meet to conduct business as the CCG, this is known as the CCG Practice Forum. Each member practice will nominate one GP representative to represent the practice in all matters considered at the practice forum, and if necessary exercise a vote. The practice forum delegates the majority of decision-making to the CCG governance board and this is outlined in the CCG Constitution.

Telford and Wrekin CCG member practices

GP practice	Address
Charlton Medical Centre	Lion Street, Oakengates, Telford, TF2 6AQ
Court Street Medical Practice	Court Street Medical Centre, Court Street, Madeley, Telford, TF7 5DZ
Dawley Medical Practice	Webb House, King Street, Dawley, Telford, TF4 2AA
Donnington Medical Practice	Wrekin Drive, Donnington, Telford, TF2 8EA
Hollinswood and Priorslee Medical Practice	Downemead, Hollinswood, Telford, TF3 2EW
Ironbridge Medical Practice	Trinity Hall, Dale Road, Coalbrookdale, Telford, TF8 7DT
Linden Hall	Station Road, Newport, near Telford, TF10 7EN
Shawbirch Medical Practice	5 Acorn Way, Shawbirch, Telford, TF5 0LW
Stirchley Medical Practice	Sandino Road, Stirchley, Telford, TF3 1FB
Sutton Hill Medical Practice	The Medical Centre, Maythorne Close, Sutton Hill, Telford, TF7 4DH
TelDoc	Malinslee Surgery, Church Road, Malinslee, Telford, TF32JZ
The Surgery	Wellington Road, Newport, near Telford, TF10 7HG
Wellington Medical Practice	The Health Centre, Victoria Avenue, Wellington, Telford, TF1 1PZ
Woodside Medical Practice	Woodside Health Centre, Wensley Green, Woodside, Telford, TF7 5NR

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

Telford and Wrekin CCG governance board composition during 2017/18

CCG governance board members	Role
Dr Jo Leahy (voting)	GP Chair
Dr Jim Hudson (voting)	GP/primary care health professional member
Dr Andy Inglis (voting)	GP/primary care health professional member
Mrs Carolyn Fenton West (voting)	GP/primary care health professional member
Dr Adam Pringle (voting) Appointed from 1 July 2017	GP/primary care health professional member
Dr Martin Allen (voting)	Secondary doctor member
Mrs Tracy Slater (voting) Appointed from 1 April 2017	Secondary nurse member
Mr Geoff Braden (voting)	Lay member - governance
Mr Neil Maybury (voting) Appointed from 1 August 2016	Lay member – PPI
Mr Peter Eastaugh (voting)	Lay member – primary care
Mr David Evans (voting)	Chief Officer
Mrs Laura Clare (voting) Appointed to 2 April 2017	Interim Chief Finance Officer
Mr Jon Cooke (voting) Appointed from 3 April 2017	Chief Finance Officer
Mrs Christine Morris (voting)	Executive Lead Quality, Nursing and Safety
Mrs Liz Noakes (voting)	Statutory Director of Public Health
Mrs Fran Beck (non-voting)	Executive Lead Commissioning
Miss Alison Smith (non-voting)	Executive Lead Governance and Engagement
Mrs Christine Choudhary (non-voting) Appointed to 10 October 2017	Health roundtable member – observer
Mr Patrick Spreadbury (non-voting) Appointed from 1 January 2018	Chair of the assuring involvement committee – observer
Mr Clive Jones (non-voting)	Local authority member – observer

CCG governance board committees

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

The composition of the audit committee:

- Mr Geoff Braden – Committee Chair and lay member – governance
- Mr Neil Maybury – Lay member – PPI
- Mrs Carolyn Fenton West – GP/primary care health professional board member
- Vacancy – Practice manager member

The role of each CCG governance 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 CCG governance board members and other committees where membership is different can be found on the CCG's website: http://www.telfordccg.nhs.uk/who-we-are/conflicts-of-interest

Personal data-related incidents

Information on data security performance is shown in the annual governance statement section later in the report.

Statement of disclosure to auditors

Each individual who is a member of the CCG at the time the members' report is approved confirms:

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

Modern Slavery Act

NHS Telford and Wrekin CCG fully supports the government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual slavery and human trafficking statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's responsibilities

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

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

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

- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

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

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

I also confirm that:

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

Governance statement

Introduction and context

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

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

As at 1 April 2017, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The CCG includes 14 practices across the Telford and Wrekin area, and has a head count of 108 members of staff, based at our headquarters at Halesfield 6, Telford TF7 4BF.

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

NHS Telford and Wrekin Clinical Commissioning Group is a clinically-led membership organisation made up of general practices within the geographical area of Telford and Wrekin and which is also coterminous with Telford and Wrekin Council. The CCG was established under the Health and Social Care Act 2012 and is a statutory body which has the function of commissioning services for the purposes of the health service in England. The members of the CCG are responsible for determining the governing arrangements of the organisation, which they are required to set out in the CCG's Constitution which can be found on the CCG's website at https://www.telfordccg.nhs.uk/who-we-are/publications/constitution/3337-nhs-tw-ccg-constitution-version-12-0/file

The membership of the CCG is made up of 14 practices which are outlined in the Constitution. When the members of the group meet to conduct business as a group, this is known as the Clinical Commissioning Group Practice Forum**.** Each member of the group has nominated one practice representative to represent the practice in all matters, and vote on behalf of the practice at CCG Practice Forum meetings.

The Practice Forum met 12 times during the year. Practice Forum members and attendance are listed below:

GP practices	**Practice forum members**	**Meetings attended during 2017/18**
Charlton Medical Practice	Dr D Sharp	2
Charlton Medical Practice	Deseny Lucas	9
Court Street	Dr Teresa McDonnell	11
Court Street	Maria Humphries	11
Dawley Medical Practice	Dr H Bufton	5

Dawley Medical Practice	Jude Williams	2
Donnington Medical Practice	Dr J Hudson (Chair)	8
Donnington Medical Practice	Angela Crompton	11
Hollinswood / Priorslee MP	Dr R Mishra	8
Hollinswood / Priorslee MP	Mala Mishra	4
Ironbridge Medical Practice	Dr M Garland	10
Ironbridge Medical Practice	Christine Parker	11
Linden Hall, Newport	Dr S Waldendorf	9
Linden Hall, Newport	Karen Sloan	8
Malling Wrekin (Practice closed end July 2017)	Dr E Steedman	2 (out of 4)
Shawbirch Medical Practice	Dr C Freeman / Dr P Coventry / Dr C Garrington / Dr P Davies	Dr Freeman: 1 Dr Coventry: 3 Dr Garrington: 3 Dr Davies: 2
Shawbirch Medical Practice	Ruth Waldendorf	6
Stirchley Medical Practice	Dr M Innes	10
Stirchley Medical Practice	Tracie Craddock	12
Sutton Hill	Dr A Inglis	8
Sutton Hill	Hollie Sheldon / Tracy Oliver	Tracy Oliver: 4 Hollie Sheldon: 4
TelDoc	Dr I Chan	9
TelDoc	Wayne Cooper	10
Wellington Medical Practice	Dr D Ebenezer	11
Wellington Medical Practice	Steph Wellsted	4
Wellington Road, Newport	Dr A Egleston	11
Wellington Road, Newport	Lynn Kupiec	10
Woodside Medical Practice	Dr M Awty / Dr D Adnitt	Dr Awty: 9 Dr Adnitt: 1
Woodside Medical Practice	Kirsty Arkinstall	9

As set out in the constitution the CCG has delegated the majority of its decision-making to the CCG governance board and has specific functions conferred on it by section 25 in the 2012 Act.

The composition of the CCG governance board is made up of GP board members drawn from the CCG membership, executive officers, other clinical representation, practice manager, lay members and local authority and patient representative observers. The full composition is outlined in full within the constitution.

CCG governance board met a total of 15 times and the names of members and their attendance are listed below:

Governance board members	Board role	Meetings attended during 2017/18
Dr Jo Leahy (voting)	GP Chair	14
Dr Jim Hudson (voting)	GP member	13
Dr Andy Inglis (voting)	GP member	10
Mrs Carolyn Fenton West (voting)	GP member	13
Dr Adam Pringle (voting)	GP member From 1 July 2017	7 (out of 10)
Dr Martin Allen (voting)	Secondary doctor member	4
Mrs Tracy Slater (voting)	Secondary nurse member From 1 April 2017	12
Mr Geoff Braden (voting)	Lay member – governance	12
Mr Neil Maybury (voting)	Lay member – patient and public involvement	13
Mr Peter Eastaugh (voting)	Lay member – primary care	11
Mr David Evans (voting)	Chief Officer	15
Mrs Laura Clare (nee Boden) (voting)	Interim Chief Finance Officer To 2 April 2017	1 (out of 1)
Mr Jon Cooke (voting)	Chief Finance Officer From 3 April 2017	13 (out of 14)
Mrs Christine Morris (voting)	Executive Lead Quality, Nursing and Safety	11
Mrs Liz Noakes (voting)	Statutory Director of Public Health	11
Mrs Fran Beck (non-voting)	Executive Lead Commissioning	15
Miss Alison Smith (non-voting)	Executive Lead Governance and Engagement	13
Mrs Christine Choudhary (non-voting) Appointed to 10 October 2017	Chair of the health roundtable member – observer	10
Mr Patrick Spreadbury (non-voting) Appointed from 1 January 2018	Chair of the assuring involvement committee – observer	2 (out of 2)
Mr Clive Jones (non-voting)	Local authority member – observer	4

The CCG governance board has appointed the following committees and sub-committees:

Audit committee provides assurance to the CCG governance 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 on risk management and quality governance controls. The committee met eight times during the year.

Audit committee members	Meetings attended during 2017/18
Mr Geoff Braden (Chair)	5
Mr Neil Maybury	6
Mrs Carolyn Fenton West	6
Substitutes:	
Mr Jim Hudson	1

Dr Adam Pringle Appointed from 1 July 2017	3

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

- assurance gained from further development of the board assurance framework and executive risk register
- assurance gained from overseeing the development and recommendation of corporate and HR policies
- assurance gained from overseeing the continued development and self-certification of the CCG against the information governance (IG) toolkit
- assurance on quality process for triangulating information to monitor provider quality and ensuring high standards of safeguarding
- assurance on the CCG's emergency planning and business continuity processes
- assurance on the counter-fraud measures in place and on continuing work around preventing and addressing fraud
- assurance on financial systems of MLCSU
- assurance gained from internal/external audit reports
- assurance on the CCG's plan for implementing the new General Data Protection Regulation (GDPR) information governance legislation
- assurance on quality systems employed by the CCG
- assurance on processes in place to manage conflicts of interest, gifts, hospitality and sponsorship and procurement decisions taken.

The audit committee undertakes an annual self-assessment of its own effectiveness to help inform its own programme of work and presents its report to the CCG governance board annually.

The remuneration committee recommends to the board appropriate salaries, payments and terms and conditions of employment and it met twice during 2017/18.

Remuneration committee members	**Meetings attended during 2017/18**
Mr Geoff Braden (Chair)	2
Dr Jo Leahy	1
Mr Neil Maybury	2
Mr Peter Eastaugh	2

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

- review and recommendation on remuneration policies
- review of continuous service audit action implementation
- review of performance-related remuneration for VSM and policy development.

The planning, performance and quality committee (PPQ) oversees and provides assurance on the performance and quality of commissioned services. It also oversees financial and QIPP performance of the CCG, as oppose to the audit committee which oversees the processes in place for robust financial governance. The committee has met 11 times during the year.

Planning, performance and quality committee members	Meetings attended during 2017/18
Mr Neil Maybury (Chair)	8
Dr Andy Inglis	8
Dr Jim Hudson	9
Mrs Liz Noakes	0
Mrs Tracy Slater Appointed from 1 October 2017	3 (out of 3)
Mrs Carolyn Fenton West	9
Dr Adam Pringle Appointed from 1 July 2017	3 (out of 8)
Substitutes:	
Mr Geoff Braden (for Mr Neil Maybury)	1
Mrs Helen Onions (for Mrs Liz Noakes)	4
Dr Jo Leahy	1

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

- assurance on financial performance
- assurance on QIPP delivery
- assurance on quality and performance outcomes
- assurance on safeguarding and continuing healthcare
- assurance on patient involvement
- reporting by exception on Shrewsbury and Telford Hospital A&E/cancer under-performance
- reporting by exception on under-performance against target for referral to treatment within 18 weeks at Shrewsbury and Telford Hospital and Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH)
- assurance on specific procurement projects
- assurance on medicines management commissioning policies
- assurance on particular services by exception: ophthalmology, emotional and health and wellbeing services 0-25, local maternity services, cancer survivorship, speech and language therapy (SALT,) dementia and SALT services, SEND, West Midlands Quality Review Service (WMQRS) reviews, dermatology services, end of life, community paediatric phlebotomy, community urgent response service, pain management service, care home admissions avoidance, review of health service looked-after children and safeguarding, wound healing service, MLU review and Telehealth.

The individual funding committee (IFC) approves commissioning decisions for individual funding requests on behalf of the group and 12 meetings were held between 1 April 2017 and 31 March 2018.

Individual funding committee members	Meetings attended during 2017/18
Mr Neil Maybury (Chair)	11
Dr Jim Hudson	8

Mrs Helen Onions	9
Mrs Jacqui Seaton	10
Mr Mike Grogan	3
Dr Adam Pringle (substitute for Dr Hudson) Appointed from September 2017	3
Mrs Fran Beck (when required)	0

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

- an analysis of activity between 1 April 2017 to 31 March 2018 shows the number of cases taken to IFC for consideration was 33 and from this the number of cases approved by IFC was 18
- the IFC has had no reviews (appeals) held to date during 2017/18.

The health roundtable oversaw involvement of patients and the public in the redesign and delivery of services commissioned by the group. The committee met a total of four times during the year and the Board Lay Member for PPI also attended two of these meetings. The Committee was discontinued following a review of the terms of reference of the committee by its members and a recommendation made to the CCG governance board to reconfigure a new committee with more focused terms of reference.

Health roundtable members	**Meetings attended during 2017/18**
Christine Choudhary (Chair)	4
Ms Jayne Stevens	0
Mr Patrick Spreadbury	4
Ms Sian Hallewell	1
Mrs Janet O'Loughlin	2
Ms Maria Raisbeck	3
Mrs Lynn Pickavance	4
Mr Derek Hall	2
Ms Eleanor Roberts	3
Ms Denise Jackson Appointed from 1 May 2016	3

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

- during the earlier part of 2017/18, the health roundtable continued to meet, and members were heavily involved, in partnership with the CCG, in promoting and supporting individual GP practices to develop their patient participation groups (PPGs). This resulted in all of the 14 GP practices having a PPG
- members of the roundtable continue to be involved in various pieces of work including the NHS Future Fit process and the Pharmacy First scheme linking in with the CCG's medicines management team

- a number of meetings were held where members of the roundtable developed the terms of reference for the new assuring involvement committee.

Following the review of this committee's scope it was agreed that the CCG required a new committee with a more focused oversight of how the CCG involves patients and the public in designing services – and particularly the involvement of groups who make up the nine protected characteristics outlined in the Equality Act 2010. The new assuring involvement committee has met twice during the year.

The assuring involvement committee is composed of a number of members of the public who submitted expressions of interest via an advertisement. The Committee was created in autumn 2017. Its first meeting included a number of presentations outlining the role and function of the CCG and an opportunity for members to meet CCG senior management and commissioners. The second meeting received communication and engagement plans for Future Fit reconfiguration consultation and for engagement on changing to the NHS 111 number.

Assuring involvement committee members	Meetings attended during 2017/18
Mr Patrick Spreadbury (Chair)	2
Mrs Christine Choudhary (Vice Chair)	2
Mrs Beverley Ashton	2
Mrs Valerie Dawson	2
Mr Neil Maybury	2

The personal health budget risk and scrutiny committee approves all personal health budget support plans that have been highlighted as high risk. The committee has not convened during 2017/18 as the personal health budget support plans contained no identifiable risks as determined by the complex care clinicians and so none were escalated to the committee.

The joint commissioning policies advisory committee provided a horizon-scanning function jointly with Shropshire CCG by identifying potentially high cost or controversial interventions and developing policies on these issues. No meetings were held during 2016/17 and 2017/18 and consequently this committee has now been discontinued.

The programme management sub-committee oversees the delivery of the CCG's own QIPP targets and the development of new QIPP schemes for consideration. The sub-committee has met a total of 12 times during the year.

Programme management subcommittee members	Meetings attended during 2017/18
Dr Jim Hudson	8
Mr David Evans	7
Mrs Laura Clare Appointed to 2 April 2017	8
Mr Jon Cooke Appointed from 3 April 2017	9
Mrs Fran Beck	10

Mrs Chris Morris	4
Miss Alison Smith	0

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

- performance monitoring delivery of 2017/18 QIPP targets
- considering QIPP plans for 2018/19 for recommendation to PPQ and board.

The medicines safety sub-committee oversees the effective reporting and learning from medication safety incidents. The sub-committee has met twice during the year.

Medicines safety sub-committee members	Meetings attended during 2017/18
Dr Aidan Egleston (GP)	2
Jacqui Seaton (Head of Medicines Management and Medicines Safety Officer)	2
Mike Grogan (Pharmaceutical Adviser)	2
Patsy Clifton (Nurse Prescriber, Wellington Medical Practice)	2
Patrick Spreadbury (Patient Representative)	1
Sharon Smith (Patient Engagement Lead)	1
Kathy George (Adult Safeguarding Lead)	2
Vicky Clayton (Pharmacy Technician)	0
Linda Geddes	2

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

- the sub-committee receives details of all medicines safety incident reports received by the CCG and ensures that learning is cascaded throughout the CCG
- since the formation of the CCG's medicines safety sub-committee and the inclusion of medication safety incidents in the prescribing incentive scheme, progress has been made in detection, reporting and learning from patient safety incidents
- incident reporting has decreased from 170 in 2016/17 to approximately 146 in 2017/18.

The clinical pathways sub-committee oversees the development of clinical pathways to enable clarity for general practice in how to make referrals in areas of clinical complexity or disease rarity. There were eight meetings held from 1 April 2017 to 31 March 2018.

Clinical pathways sub-committee members	Meetings attended during 2017/18
Dr Andy Inglis (Chair)	7
Dr Jim Hudson	1
Dr Adam Pringle Appointed from September 2017	3
Ms Helen Onions	0

Mrs Jacqui Seaton	0
Mrs Sharon Clennell	0
Mr Paul Gibara Appointed to July 2017	0
Mrs Angie Parkes Appointed from November 2017	0
Mr Mike Grogan (substitute for Mrs Jacqui Seaton)	7
Ms Ann-Marie McShane (substitute for Ms Onions)	6

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

- During 2017/18 the clinical pathways sub-committee approved, under delegation from the CCG governance board, seven clinical pathways which included fibromyalgia, hyperthyroidism, COPD, Transanal Endoscopic MicroSurgery (TeMS), hypertension, transient ischemic attack (TIA) and bronchiolitis.

The primary care commissioning committee oversees the commissioning of primary care under delegated decision-making authority from NHS England and was a new committee introduced in April 2015 following amendments to the CCG Constitution. The committee met a total of 11 times during the year.

Primary care commissioning committee members	**Meetings attended during 2017/18**
Mr Peter Eastaugh (Voting)	10
Dr Carl Elson (Voting)	7
Dr Martin Allen (Voting)	0
Mr David Evans (Voting)	5
Mrs Laura Clare (nee Boden) (Voting) Appointed to 2 April 2017	1 (out of 1)
Mr Jon Cooke (Voting) Appointed from 3 April 2017	6 (out of 10)
Mrs Christine Morris (Voting)	7
Mrs Fran Beck (Voting)	9
Miss Alison Smith (Voting)	8
Mrs Rebecca Woods (Voting to 16 May 2017) Mr Geoff Braden (Substitute for Mr Peter Eastaugh)	7 1

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

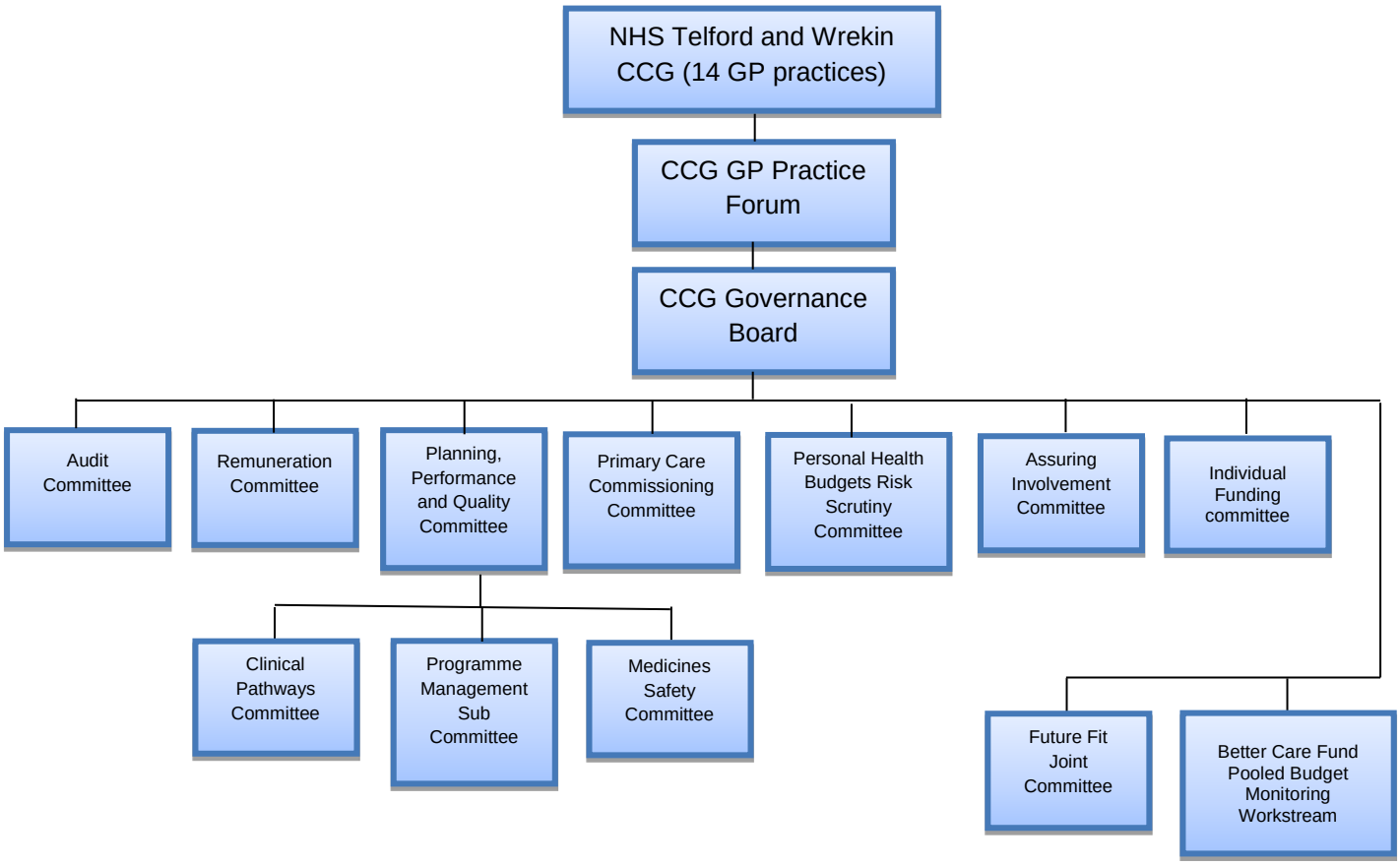
- it has overseen development of the governance processes to support robust decision-making, established clear expectations regarding declarations of interest, quarterly assurance reports completed and submitted to NHS England and a risk register for primary care commissioning

- primary care performance reporting which includes financial performance reporting, quality and performance monitoring, Quarterly Assurance and Primary Care Information Technology.

In addition, the primary care committee has overseen the development and implementation of the following during 2017/18:

- primary care resilience (including planning for winter)
- Care Quality Commission (CQC) report updates
- primary care estates plan
- primary care strategy delivery
- primary care workforce strategy
- practice mergers and changes of practice boundaries
- patient participation group (PPG) development
- service improvement scheme (LES)
- GP Forward View delivery plan
- access to GP practices
- Quality Outcomes Framework (QOF)
- service signposting campaign
- GP patient survey results
- GP A&E streaming service

Telford and Wrekin CCG governance structure (as described in the Constitution)



Membership of the committees and sub committees of the CCG governance board is outlined in respective terms of reference which are included in the CCG's Constitution, and attendance at these meeting is recorded in the minutes of each meeting.

The CCG has reflected on its own effectiveness and performance as part of the action plan developed from the IPSOS MORI survey from stakeholders and the monthly assurance checkpoints undertaken by NHS England for all CCGs during 2017/18, the outcomes of which are reported to the CCG governance board and Practice Forum by the Chief Officer and published on the CCG's website as a year-end statement. The CCG governance board has also been working with an organisational development partner to help identify where the board can improve its effectiveness. This has included structuring its own discussions, focusing on partner development and also looking at individual resilience. The CCG governance board receives regular reporting from committees via chairs' reports and – for those committees with delegated decision-making – an annual report that summarise that committee's effectiveness in discharging its duties.

UK Corporate Governance Code

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

However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

For the financial year ended 31 March 2018, and up to the date of signing this statement, we complied with the provisions set out in the code, and applied its principles except as follows:

- Directors of the CCG are appointed and not elected as per NHS England guidance on appointing CCG governing bodies. GP board representatives are elected.

Discharge of statutory functions

During establishment, the arrangements put in place by the CCG and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with all the relevant legislation. That legal advice also informed the matters reserved for membership body and governing body decision and the scheme of delegation.

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

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

Risk management arrangements and effectiveness

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

organisation in a coordinated way. The co-ordinating body for receiving assurance on these strands of governance is the audit committee, which oversees integrated governance on behalf of the CCG governance board. In addition, the other committees also oversee the risks within their specific remits, providing assurance to the audit committee where appropriate.

The CCG will, wherever possible, prevent risk arising – by applying policies and procedures for staff and contractors to follow (including the CCG Constitution, standing orders and prime financial policies), by making use of technical support from outside the CCG (for example legal advice, information governance advice, HR advice), and through internal audit. The CCG will also employ deterrents to risk arising, for example fraud and IT deterrents.

The system of risk control forms part of the CCG'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 CCG'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
- managing them efficiently, effectively and economically.

The risk management strategy applies to all risks, whether these are financial, quality, performance, governance and so on.

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 executive risk register 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 health care from
- but 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 risk 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 see quality and innovation towards best practice in patient-centred care.

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

- completion of equality impact assessments for reviewed or new policies
- incident and serious incident reporting, which is encouraged by the CCG and evident through the Datix reporting system

- information governance (IG), whistleblowing and fraud awareness training, which has been provided to senior managers and staff
- training for staff and board members, which is mandated for particular areas: health and safety, IG, safeguarding, safer recruitment, fire safety, business continuity/emergency planning, the integrated single finance environment (ISFE) finance system and (newly introduced) conflicts of interest
- intelligence gathering through quality and performance contracting processes with providers
- complaints and PALs enquiries
- NHS to NHS concerns reporting via Datix
- national reviews/inspections/guidance.

Risks are identified, assessed and recorded in accordance with the risk management strategy and risk assessment code of practice. The principle processes and the matrix described in these documents are applied to all risk registers, incident management and risk assessment activity across NHS Telford and Wrekin CCG. These processes are used to identify risks:

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

It is acknowledged that risks may be shared with other organisations that the CCG works with jointly to deliver services. Consequently, the board assurance framework is discussed with risk management leads and reflects the identified strategic risks of these organisations where appropriate.

The following details are recorded for each risk recorded 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 CCG has given due regard to all national findings from quality reviews undertaken.

Capacity to handle risk

Leadership is given to the risk management process by the chief officer, whose role is to own the board assurance framework. The board assurance framework, which documents the principle risks to the CCG's objectives not being delivered, is underpinned by the executive risk register. This outlines the lower level risks to each executive lead not meeting the specific remit objectives, and specifically risks to the CCG not fully discharging primary care commissioning under its delegation from NHS England. Each executive lead, or members of their respective teams, will inform the executive risk register. The chief officer and executive leads are supported by the executive lead for governance and engagement. CCG staff are provided with a risk assessment code of practice and

receive support and training on risk management from the executive lead for governance and engagement where required.

Risk assessment

A summary of the major risks identified, during 2017/18, in the board assurance framework is set out below. The major risks to the CCG were revised wholesale by the CCG governance board in May 2017 and, as a result, there have been no further emerging strategic risks to identify.

Description of major risks added to the board assurance framework during 2017/18	Existing controls	Further actions
1. Risk is that the organisation is distracted from addressing the health inequalities needs of the population as identified by the JSNA	STP priority – managing director of the Council chairing the local neighbourhood board CCG operational plan JSNA Additional project management support, Undertaking modelling of left shift of activity from acute setting to community, Paper on RightCare approach regarding diabetes to PPQ (August 2017) and also STP board STP board to finalise governance structure and reporting processes July 2017	Chief executive officer (CEO) of hospice collaborating with neighbourhood board to facilitate compassionate communities in Telford and Wrekin – two communities identified for launch Consider through neighbourhood board a set of proxy measures initially Board keen to support proposals to rationalise formal meetings to allow for more constructive strategic planning
2. Risk that SaTH is unable to provide good quality, sustainable services	Escalation processes embedded in the contract governance processes NHS England assurance meetings Contract mechanisms – CQRM, SPF Joint commissioning board with SCCG Activity and finance meetings Planned care working group Cancer assurance board Executive team - reporting weekly	Risk review was held in August 2017 with a follow up meeting on 31 October 2017. All actions addressed without the need for escalation to risk summit. Workforce was a considerable risk. This is now more visible to the CCG executives though remains fragile across a number of service areas. Plans are in place within the trust to manage these risks, however these may change at short notice leading to required changes to services.
3. Risk that the traditional model of primary care is unsustainable	STP plan Joint GP Forward view strategy with Shropshire CCG CCG plan	CCG needs to consider options for sustainable primary care – for example, vanguard pilots, integrated structures – and incorporate opportunities that changing

	Individual practices running successful recruitment drives and redesigning internal processes to improve access Successful for bidding for improvement grant funding to expand primary care infrastructure STP estates group will lead an exercise to rationalise community and primary care estate PCC has driven economies of scale to reduce overall practice numbers from 22 to 14. Practice support team supporting vulnerable Telford and Wrekin practices NHS England developing workforce strategy across Staffordshire, Shropshire and Telford and Wrekin	technology, workforce and rationalisation of estate can offer. Head of primary care post now appointed. PCC will oversee development of revised GPFV strategy and action plan
4. Risk that strategic proposals are not viable	STP plan STP governance structure Board reporting STP plan predicated on each individual NHS organisation's medium-term financial plan Financial modelling review by CCG chief finance officer July 2017 STP director appointed and PMO resource in place Prevention and self-management now forms part of neighbourhoods	STP finance workstream undertaking ongoing review of activity modelling
5. Risk that the CCG's financial position worsens	Medium-term financial plan Robust management budgets signed off by budget holders Audit committee Positive internal audit report on financial controls – significant assurance	QIPP – no agreement on system-wide savings which leaves only alternative of decommissioning services to make up shortfall. Board workshop planned to discuss decommissioning further

	Standing financial instructions Operational policies Financial modelling of neighbourhood plans - high level end of June and detail plans end of September 2017 completed	
6. Risk that external factors may influence the CCG's ability to deliver its core objectives	Planned surplus – provides financial buffer CCG commissioning and medium-term financial plans scrutinised by NHS England STP scrutinised by NHS Improvement	Monitor of key objectives including finance – regular updates to board QIPP – no agreement on system-wide savings which leaves only alternative of decommissioning services to make up shortfall. Board workshop planned to discuss decommissioning further
7. Risk of failure of CCG commissioner quality systems to either predict or identify quality failure by providers	Contractual processes CQRM for all providers Announced and unannounced visits Triangulation of soft intelligence with complaints information Review of external inspections/assessments – WMQRS, CQC and Healthwatch NHS England Quality Surveillance Group Dedicated quality resource Established working with coordinating commissioner to triangulate information Dedicated resource for infection control and safeguarding Oversight of serious incidents NHS to NHS concerns Infection controls and systems Safeguarding board for adults and children Safeguarding leads across all commissioner	Escalating when we have gaps in assurance using escalation processes to seek further assurances SaTH remains on enhanced rating at QSG. Unable to deliver mandated PREVENT training. This being explored with the trust. Recurrent quality surveillance group (QSG) never event in ophthalmology under review

	areas	
8. Risk that CCG leadership fails to influence local health economy	Organisational Development (OD) plan Health and wellbeing board representation A&E delivery board representation STP representation Deputy AO on STP leadership programme Executive to executive meeting with SCCG held in February 2018 Leadership courses Clinical leadership – PAEN Succession planning Partnership working Board to board with SaTH September 2017 Board to board with SCCG April 2018	Board to board arranged with SCCG – April 2018 OD work plan with board executives and GPs begun in February 2018 due to continue through to May 2018 360 degree survey results due April 2018 – action plan will be required in response to results STP organisational development support arranged for December 2017 facilitated by the King's Fund with more workshops planned in 2018

The CCG's continuing major risks during 2017/18 can be summarised as:

1. **Risk that SaTH is unable to provide good quality sustainable services**
   The CCG has continued to work with SaTH regarding under-performance on constitutional targets for A&E four-hour waiting time and cancer targets for 62 days and two weeks.

   A nationally mandated GP streaming service has been introduced to help manage activity through A&E. This has been supported further with the appointment of an urgent care director across the local health economy to drive these actions forward. From our CCG point of view, we have been working closely with our local authority and continuing to support the acute daily capacity hub to facilitate capacity flow and taking part in a daily local health economy conference call. This has helped to maintain a very low rate of delayed transfer of care (DTOC) for Telford and Wrekin patients.

   In terms of cancer waiting times, exception reporting takes place at the planned care working group held jointly with Shropshire CCG on a monthly basis. In addition, there is a monthly contractual meeting between commissioners and SaTH.

   The trust has also signalled that an emergency decision may be forthcoming with regard to closure of one A&E unit overnight due to lack of consultant cover as a direct result of workforce recruitment issues. The trust is currently reviewing both its contingency plan for closure and generally its consultant workforce to look at other options.

2. **Risk of failure of CCG commissioner quality systems to predict or identify quality failure by providers**
   There has been variable assurance on standards of quality at the main acute provider during 2017/18. The CCG has undertaken a robust contractual performance and delivery of quality standards via escalation through CQRM to the CCG joint commissioning board with Shropshire CCG as the co-ordinating commissioner for the acute provider contract and then on to the acute trust. Further escalation to QSG and risks reviews to address significant concerns relating to patient safety and experience. Action plans are in place for service improvement across all requisite areas and these are monitored through CQRM and corporate assurance processes through PPQ to board.

   The CCG has also had under-performance on a number of constitutional targets:
   - referral to treatment within 18 weeks – this area has come under increased scrutiny during 2017/18 and this has resulted in an increase in performance with the October 2017 figure of 92.1 per cent exceeding the national target since May 2016. There are some specialties still not achieving target: trauma and orthopaedics(T&O), ophthalmology, cardiology and thoracic medicine, although all have improved when compared with month six performance out turn
   - mental health – first episode of psychosis started within two weeks of referral. The numbers of people treated has risen but the proportion seen within two weeks has dropped. Work is being undertaken to understand in more detail the cause of this reduced performance
   - dementia diagnosed in two thirds of estimated prevalence. To address this under-performance practice-based memory clinics are being piloted and one town in the area has become a dementia-friendly town

- ambulance waiting times have not improved and challenges to the provider have been raised by the West Midlands Integrated Urgent Care Transformation Directorate
- diabetes patients achieving all National Institute for Health and Care Excellence (NICE) recommended treatment targets. A significant piece of work is being undertaken at STP level on service transformation. Latest figures suggest more patients are meeting the target
- target for Clostridium difficile. The CCG has continued to enact a number of actions to help achieve the target. However, the target is based upon previous performance and is very challenging
- Never events. In response to a number of never events reported by providers, the CCG has undertaken unannounced inspections to monitor root cause analysis (RCA) action plans. The CCG also attends a provider RCA panel review, and we have commissioned RCA training across the system for providers and commissioners with a focus on learning from incidents.

3. Risk that strategic proposals are not viable

Concerns about the viability of strategic plans enshrined in the local health economy's STP plan and Future Fit Programme were expressed by the board during 2017/18. This led to modelling work being led by the CCG's chief finance officer, which provided assurance. A Programme Management Office (PMO) has been created to oversee the STP programme of work and the various workstreams making up the governance structure.

4. Risk that the CCG's financial position worsens

The CCG is currently on track to achieve the in-year 2017/18 control total of break even. However, within the position the CCG is currently managing a number of significant cost pressures:

- hospital contracts are showing a significant over-trade particularly in relation to emergency costs. In line with other CCGs there appears to be a significant upward shift in urgent care activity costs that are not represented by activity changes. These are being investigated with the trust and a number of contract challenges have been raised. In addition, there is a significant potential pressure associated with sepsis, which is still awaiting national resolution between NHS England and NHS Improvement. Outpatient and A&E activity has also significantly risen compared to the same period last financial year. In line with national guidance the hospital trust has established a GP streaming service in the A&E department at Princess Royal Hospital. While this is meant to be self-financing, there is non-recurrent pressure as discussions continue to address financial pressures across the whole of urgent care including agreement of a local tariff for ambulatory care. In addition to the cost pressures and activity rises above there has been a significant increase in the volume of T&O elective activity that has been seen in year across all providers, including those in the private sector
- ambulance costs and activity have also significantly risen during 2017/18
- in prescribing, cost pressures exist in relation to NCSO
- the CCG is under-delivering significantly against the 2017/18 QIPP target. This is currently being mitigated using contingencies and reserves. The CCG programme management committee continues to work on contingency schemes and acceleration of 2018/19 schemes.

The pressures identified in 2017/18 will result in a significantly higher QIPP requirement for 2018/19 than previously identified. The CCG is focusing senior management and clinical resource to identify areas to consider in development of the 2018/19 QIPP programme and is fully considering opportunities identified through Right Care and the Menu of Opportunities. In addition, we are working across the STP patch to identify and accelerate transformational QIPP programmes. There is a significant risk that local plans and STP transformation will not identify sufficient schemes to deliver the increased saving requirement.

It is likely that these risks will not change substantially and will remain on the board assurance framework (BAF) for 2018/19.

Other sources of assurance

Internal control framework

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

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

The following control mechanisms are in place:

- constitution
- risk management
- security management
- counter-fraud annual plan
- internal audit annual plan
- performance monitoring of CCG providers and the CCG itself
- IG toolkit submission
- incident and serious incident reporting
- quality and financial reporting
- contract/quality performance monitoring arrangements with providers
- policies and procedures
- risk assessments
- governance reporting between the board and its committees/sub committees
- equality delivery system
- safeguarding annual report
- emergency and business continuity planning/core standards.

Annual audit of conflicts of interest management

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

The CCG has carried out its annual internal audit of conflicts of interest and the audit provided significant assurance, with some actions agreed as shown below:

- some declarations had not been signed by the line manager
- some declarations had not had the individual's permission to publish the information on the register
- one declaration had not been signed by the individual.

There has been one breach of the conflicts of interest policy, which was reported to the audit committee and designated as not material in nature. All breaches are anonymised and published on the CCG's website to assist in learning dissemination.

Data quality

The board relies on the data quality elements in its contracts with providers, requiring them to quality assure their data prior to submission. The CCG also uses MLCSU for provider information performance, quality and finance and therefore the CCG's contract with MLCSU outlines information reporting expectations. The data sources used by MLCSU are the national UNIFY system and Secondary Uses Service (SUS) data which is verified via the contracting process with providers.

Information Governance (IG)

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. Telford and Wrekin CCG are currently achieving level two and level three 91% compliance as evidenced within the IG toolkit.

The CCG has reported 14 data incidents during 17/18. Eleven of which were graded as level 0 - very low risk, and three incidents reported as level 2.

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

There are processes in place for incident reporting and investigation of serious incidents. We have developed an information asset register which enables the CCG to identify high risk assets through data flow mapping and we ensure that an information risk culture is embedded throughout the organisation.

The CCG receives a full, specialised IG service from MLCSU. As a small organisation we could not reproduce this in-house. A work programme has been undertaken by MLCSU to ensure that the CCG is fully prepared for the General Data Protection Regulation (GDPR) when it comes into force on 25 May 2018. As part of this work the CCG's information has been audited, fair processing notice has been revised, staff training has been delivered and the CCG has been advised of the requirement for a data protection officer to be nominated.

During 2018/19 the CCG will continue to move towards having a fully embedded information risk culture throughout the organisation.

Business critical models

The CCG relies on centrally provided NHS business planning models, to help it plan future strategy. The CCG has no business-critical models that are required to be shared with the analytical oversight committee.

Third party assurances

Third party assurances are received annually from MLCSU for particular financial functions which are part of a service level agreement (SLA). Processes are in place to ensure that the MLCSU internal audit function shares its own audit findings of these functions with the CCG's internal auditor who includes a summary of the findings in the 'head of internal audit opinion' which is part of this statement. There have been no limited findings from last year's reports that would require remedial action.

Control issues

No significant control issues have arisen during 2017/18 that would require reporting in this annual governance statement.

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

The planning, performance and quality (PPQ) committee gives detailed consideration to the CCG's financial and performance issues, to provide the CCG board with assurance that all issues are being appropriately managed and escalated where necessary. This includes the determination of key financial assumptions to underpin the CCG's medium-term financial strategy and scrutiny of monthly financial reporting, including delivery of QIPP schemes through the programme management sub-committee, performance against central management costs and efficiency controls. PPQ reports to board via a chair's exception report on a monthly basis.

The board also receives summary financial reporting at each meeting. The current rating for the quality of leadership indicator of the CCG improvement and assessment framework was last rated by NHS England for 2016/17 as amber/green. The updated rating for 2017/18 is not expected to be released until after the CCG's annual report is approved.

The internal audit plan also provides reports to audit committee throughout the year on financial systems and financial management provided by the CCG and supported by the CSU. Outcomes from these internal audit reviews are detailed in the head of internal audit opinion.

Delegation of functions

The CCG has a scheme of delegation that sets out 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 it ensures that there are sufficient safeguards and management mechanisms in place to maintain high standards in terms of effective, efficient and economic operation of the group. The scheme captures the decision-making roles of the CCG accountable officer, executive leads, governing body and committees, and is linked to the terms of reference of each committee.

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

The CCG, in accordance with its Constitution, reviews its scheme of delegation annually. Amendments are taken to the governance board in the first instance and any required changes to the overarching scheme of delegation must be approved by the CCG's practice forum. The CCG remains accountable for all of its functions, including those that it has delegated.

Counter-fraud arrangements

Counter-fraud arrangements are contracted by the CCG from CW Audit Services, an accredited counter- fraud specialist, contracted to undertake work proportionate to the CCG's identified risks.

The CCG audit committee receives a report from the counter-fraud specialist against each of the standards for commissioners at least annually and there is executive support and direction for a proportionate proactive work plan to address identified risks.

The chief finance officer, who is a member of the CCG governance board, is proactively and demonstrably responsible for tackling fraud, bribery and corruption and oversees that appropriate action is taken regarding any NHS Protect quality assurance recommendations.

During 2017/18 NHS Protect undertook a quality inspection of the CCG which comprised an assessment of compliance against two of the NHS Protect standards, these being strategic governance and inform and involve, consisting of 13 standards in all. The CCG was assessed as compliant with eleven standards and partially compliant with two standards. An action plan was agreed to address the two partially compliant standards rated as amber, and this has now been completed.

Head of Internal Audit Opinion

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

Roles and responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

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

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HOIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

Limitations inherent to the internal auditor's work

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of a risk-based plan generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

The 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 Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Governing Body in the completion of its Annual Governance Statement.

My **overall opinion** is that:

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

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

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

2. An assessment of the range of individual opinions arising from risk based audit assignments, contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

3. Any reliance that is being placed upon third party assurances.

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

The design and operation of the assurance framework and associated processes

I have reviewed the overall arrangements the Governing Body has in place to conduct its review of the system of internal control. This has entailed reviewing the way in which the Governing Body has identified the principal risks to achieving its objectives, the identification of controls in operation to mitigate against these risks and the degree to which the organisation has received assurances that these risks are being effectively managed. I have approached this by examining the Assurance Framework documents that you have in place and also by giving consideration to the wider reporting to the Governing Body that informs the Governing Body's assessment of the effectiveness of the organisation's the system of internal control.

It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2017/18 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The system of internal control based on internal audit work undertaken

My opinion also takes into account the range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. An internal audit plan for 2017/18 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. I am satisfied that we have completed sufficient work during the course of the year to provide my Head of Internal Audit Opinion.

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

Significant assurance	• budget setting including QIPP • financial reporting • financial systems • performance reporting including action plans • conflicts of interest management • pharmacy prescription ordering
Moderate assurance	• primary care commissioning return • non GMS payments review

The following non-assurance assignments have also been completed:

- Board Assurance Framework [BAF] – interim and final review; a 'Level A' conclusion statement was given.
- Information Governance Toolkit Compliance; an 'Action Required' position statement was given.

I have set out summary details of the reviews where we did not provide significant or full assurance below:

Moderate assurance

Primary care commissioning return

The 2017/18 quarter 1 submission was not completed due to an oversight relating to staffing changes. The quarter 2 submission was completed comprehensively and submitted to NHSE seven days after the deadline, following changes requested by the Primary Care Committee. Further staffing changes at a senior level mean that interim arrangements have been put in place to ensure the quarter 3 return is submitted in line with the required deadline.

Review of Non GMS Payments

The CCG makes payments to GP Practices for non GMS services across a range of different initiatives including incentive and training schemes, winter pressure payments and various local enhanced schemes (LES). The CCG also makes payments to support Practices which fall outside of GMS, which are not paid directly to them, but fund support arrangements commissioned by the CCG e.g. IT support.

The CCG needs to formalise arrangements to enable them to demonstrate that CCG investment in non GMS services is appropriate, with GP's delivering services appropriately and in line with the investment made. Going forward, the CCG will need to consider how it is delivering non GMS within the context of changed arrangements.

The CCG has systems and processes in place to monitor, review and report non GMS activity and finance which could be refined. It also has other primary care processes in place to deliver for

example, patient engagement and investment sign off, which inherently covers non GMS activity as well, but these need to better distinguish non GMS, to demonstrate the CCG has a clear assessment of this area.

There is opportunity for the CCG to identify areas where it can benchmark against other CCGs, particularly around the level of investment and outcomes. For 2018/19, plans were being developed to reinvest savings which are primary care related into new areas, including non GMS.

Following up of actions arising from our work

For all reviews we have agreed action plans with management and will continue to monitor the implementation of these plans over the coming months. Outstanding actions are reported at each meeting of the audit committee and they take a proactive approach to monitoring them and requesting follow up audit work where there are areas of concern. The status of agreed actions as at 31 March 2018 is as follows:

Summary	1 Critical	2 High	3 Medium	4 Low	Total
Overdue	0	0	0	0	0
Deferred – Overdue	0	0	0	0	0
Deferred	0	1	0	0	1
Total	**0**	**1**	**0**	**0**	**1**

Time overdue for actions deferred	1	2	3	4	
Less than 3 months	0	0	0	0	0
3 – 6 months	0	1	0	0	1
Greater than 6 months	0	0	0	0	0
Total	**0**	**1**	**0**	**0**	**1**

In year the CCG has made excellent progress ensuring actions are completed on a timely basis. As at 31 Mach 2018 there was only one action in progress and this related to the ongoing review of the scheme of delegation.

Reliance on third party assurances

We have received and considered the Type II ISAE 3000 and 3402 reports on Internal Control for the Finance and Payroll service provided by the CSU for the CCG there are no areas of significant weakness that I wish to highlight in my opinion.

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive leads and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review 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 CCG achieving its principles objectives have been reviewed.

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

- the governance board – strategic oversight
- the audit committee – effectiveness of the control framework of the CCG
- the planning, performance and quality committee – oversight of performance of quality, contracts and finance
- internal audit – testing controls in place.

I have confidence that the systems we deploy ensure that I would be aware of (and would therefore respond to) the implications of deficiencies in effectiveness of the system of internal control by the CCG and through its operation the work of the governance board, the audit committee, the planning, performance and quality committee and the remuneration committee.

The CCG has in place a reliable governance framework with robust plans, policies and processes to enable effective delivery of its strategic priorities and, over time, to secure sound financial health.

The governance board and committees of the CCG are structured effectively to provide assurance over the wide range of business activities progressed by the CCG. In particular, the planning, performance and quality committee and the programme management sub-committee provide an overview of financial activity and a sound understanding of costs, performance and achieving efficiencies through reliable and timely financial reporting that meets the needs of internal users, stakeholders and local people.

Conclusion

The chief officer can give assurance that no significant internal control issues have been identified that would require reporting in the annual governance statement.

SIGNATURE

Mr David Evans

Accounting Officer

DATE 24th May 2018

Remuneration and staff report

This section of the annual report is subject to audit and will be referred to in the audit opinion.

Remuneration report

Remuneration committee

The remuneration committee was established by the CCG to approve the remuneration and terms of service for the executive directors, other staff employed with very senior manager (VSM) pay terms, and the conditions and lay appointments to the CCG board.

The composition and responsibilities of the CCG's remuneration committee can be found in the governance statement.

Policy on the remuneration of senior managers

For 2017/18, pay for board members was mainly on nationally determined pay rates.

A consolidated pay award was made to senior staff in line with the pay awards made to staff on Agenda for Change as per the nationally negotiated pay award for 2017/18.

Remuneration report tables – pension and salary

These tables are subject to audit by our external auditor.

Salaries and allowances

Table below represents Directors / Non Executives total pay

2017/18									
	Name	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments taxable (bands of £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)
	Jon Cooke	Chief Finance Officer	17/04/17 to 31/03/18	90-95	0	0	0	20-25	110-115
	David Evans	Chief Officer	01/04/17 to 31/03/18	110-115	0	0	0	15-20	125-130
	Fran Beck	Executive Lead Commissioning	01/04/17 to 31/03/18	85-90	0	0	0	20-25	110-115
	Christine Morris	Executive Lead Quality Nursing and Safety	01/04/17 to 31/03/18	95-100	0	0	0	65-70	160-165
	Alison Smith	Executive Lead Corporate Governance and Performance	01/04/17 to 31/03/18	85-90	0	0	0	25-30	115-120
	Dr Martin Allen	Board Secondary Care Clinician	01/04/17 to 31/03/18	5-10	0	0	0	0	5-10
	Mr Geoff Braden	Board Lay Member Governance	01/04/17 to 31/03/18	5-10	0	0	0	0	5-10
	Dr James Hudson	Board GP Member	01/04/17 to 31/03/18	35-40	0	0	0	5-10	40-45
	Dr Andy Inglis	Board GP Member	01/04/17 to 31/03/18	30-35	0	0	0	0	30-35
	Dr Jo Leahy	Board GP Member	01/04/17 to 31/03/18	90-95	0	0	0	0	90-95
	Laura Clare	Interim Chief Finance Officer	01/04/17 to 31/03/18	80-85	0	0	0	(15)-(20)	60-65
	Tracey Slater	Board Secondary Care Nurse	01/04/17 to 31/03/18	10-15	0	0	0	20-25	35-40
	Peter Easthaugh	Board Lay Member - Primary Care	01/04/17 to 31/03/18	5-10	0	0	0	0	5-10
	Carolyn Fenton-West	GP/Primary Care Health	01/04/17 to 31/03/18	35-40	0	0	0	60-65	100-105
	Shalienda Allen	Board GP Member	01/04/17 to 07/04/17	0-5	0	0	0	5-10	5-10
	Neil Maybury	Board Lay Member - PPI	01/04/17 to 31/03/18	5-10	0	0	0	0	5-10
	Dr Adam Pringle	Board GP Member	21/06/17 to 31/03/18	25-30	0	0	0	185-190	215-220

2016/17

Name	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments taxable (bands of £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)
Andrew Nash	Chief Finance Officer	01/04/16 to 30/04/16	5-10	0	0	0	0	5-10
David Evans *	Chief Officer	01/04/16 to 31/03/17	110-115	0	0	0	40-45	150-155
Fran Beck *	Executive Lead Commissioning	01/04/16 to 31/03/17	85-90	0	0	0	30-35	120-125
Christine Morris *	Executive Lead Quality Nursing and Safety	01/04/16 to 31/03/17	85-90	0	0	0	30-35	120-125
Alison Smith *	Executive Lead Corporate Governance and Performance	01/04/16 to 31/03/17	85-90	0	0	0	35-40	125-130
Dr Martin Allen	Board Secondary Care Clinician	01/04/16 to 31/03/17	5-10	0	0	0	0	5-10
Mr Geoff Braden	Board Lay Member Governance	01/04/16 to 31/03/17	5-10	0	0	0	0	5-10
Mr Dylan Harrison	Board Lay Member - PPI	01/04/16 to 31/07/16	0-5	0	0	0	0	0-5
Dr James Hudson	Board GP Member	01/04/16 to 31/03/17	35-40	0	0	0	0	35-40
Dr Andy Inglis	Board GP Member	01/04/16 to 31/03/17	35-40	0	0	0	0	35-40
Dr Jo Leahy	Board GP Member	01/04/16 to 31/03/17	80-85	0	0	0	0	80-85
Mrs Carol Wall	Board Practice Manager Representative	01/04/16 to 31/05/16	0-5	0	0	0	0	0-5
Laura Clare (nee Boden)	Interim Chief Finance Officer	01/05/16 to 31/03/17	90-95	0	0	0	85-90	175-180
Tracey Slater	Board Secondary Care Nurse	01/04/16 to 31/01/17	10-15	0	0	0	5-10	20-25
Peter Easthaugh	Board Lay Member - Primary Care	01/04/16 to 31/03/17	5-10	0	0	0	0	5-10
Carolyn Fenton-West	GP/Primary Care Health	01/04/16 to 31/03/17	30-35	0	0	0	0	30-35
Neil Maybury	Board Lay Member - PPI	01/08/16 to 31/03/17	5-10	0	0	0	0	5-10
Shalienda Allen	Board GP Member	01/10/16 to 31/03/17	15-20	0	0	0	75-80	95-100

Pension benefits

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

Pension Entitlements of Senior Managers

2017/18								
Name and Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age(bands of £2,500) £'000	Total accrued pension at pension age 31 March 2018 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2017 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000	Employers contribution to stakeholder pension
Jon Cooke - Chief Finance Officer	0.0-2.5	(0.0)-(2.5)	35-40	95-100	566	24	596	0
David Evans - Chief Officer	0.0-2.5	2.5-5.0	35-40	115-120	869	(869)	0	0
Fran Beck - Executive Lead Commissioning	0.0-2.5	2.5-5.0	40-45	120-125	0	0	0	0
Christine Morris - Executive Lead Quality Nursing and Safety	2.5-5.0	10.0-12.5	30-35	100-105	588	102	691	0
Alison Smith - Executive Lead Corporate Governance and Performance	0.0-2.5	0	25-30	0	286	40	326	0
Dr James Hudson Board GP Member	0.0-2.5	0.0-2.5	10-15	30-35	166	8	174	0
Tracey Slater - Board Secondary Care Nurse	0.0-2.5	0.0-2.5	10-15	25-30	191	22	213	0
Laura Clare - Interim Chief Finance Officer	(0.0)-(2.5)	(5.0)-(7.5)	15-20	30-35	167	(7)	160	0
Shalienda Allen - GP Board Member	(0.0)-(2.5)	7.5-10.0	0-5	10-15	12	48	60	0
Carolyn Fenton-West - GP Primary Care	2.5-5.0	0.0-2.5	15-20	45-50	274	50	325	0
Dr Adam Pringle - GP Board Member	7.5-10.0	15.0-17.5	10-15	20-25	62	121	183	0

2016/17

Name and Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age(bands of £2,500) £'000	Total accrued pension at pension age 31 March 2017 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2016 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2017 £'000	Employers contribution to stakeholder pension
David Evans - Chief Officer	0.0-2.5	5.0-7.5	35-40	110-115	805	65	869	0
Fran Beck - Executive Lead Commissioning	0.0-2.5	2.5-5.0	35-40	115-120	0	0	0	0
Christine Morris - Executive Lead Quality Nursing and Safety	0.0-2.5	2.5-5.0	30-35	90-95	547	42	588	0
Alison Smith - Executive Lead Corporate Governance and Performance	0.0-2.5	0	25-30	0	245	41	286	0
Dr James Hudson Board GP Member	(0.0)-(2.5)	0	10-15	30-35	160	5	166	0
Tracey Slater - Board Secondary Care Nurse	0.0-2.5	0	10-15	25-30	183	8	191	0
Laura Clare (nee Boden)- Interim Chief Finance Officer	2.5-5.0	5.0-7.5	15-20	35-40	117	51	167	0
Shalienda Allen - GP Board Member	2.5-5.0	0.0-2.5	0-5	0-5	0	12	12	0
Carolyn Fenton-West - GP primary Care Health	0	0	10-15	40-45	267	7	274	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 effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation on early retirement or for loss of office

Telford and Wrekin CCG does not have any compensation to report during 2017/18.

Payment to past members

Telford and Wrekin CCG does not have any payments to report during 2017/18.

Pay multiples

This section of the annual report is subject to audit and will be referred to in the audit opinion.

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

The banded remuneration of the highest paid member in the organisation in the financial year 2017/18 was £139,360 (2016/17, £130,357). This was 3.92 times (2016/17, 3.40) the median remuneration of the workforce, which was £35,577 (2016/17, £38,299).

In 2017/18, 0 (2016/17, 0) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £16,104 to £139,360 (2016/17 £15,516 to £130,357).

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

Staff report

The CCG has employed a headcount of 108 staff during 2017/18. This is equivalent to 82.18 whole time equivalent (WTE).

Number of senior managers

Staff composition

Gender analysis of CCG workforce as at 31 March 2018 (Headcount)

	Headcount by Gender			
Staff Grouping	**Female**	**Male**	**Unknown***	**Grand total**
governing body	6	9	3	18
other senior management	12	3	0	15
All other employees	63	12	0	75
Grand total	**81**	**24**	**3**	**108**

	% by Gender		
Staff Grouping	**Female**	**Male**	**Unknown**
All other	33.3%	50.0%	16.7%
Governing body	80.0%	20.0%	0.0%
Other senior management	84.0%	16.0%	0.0%
Grand Total	**75.00%**	**22.22%**	**2.78%**

Gender analysis of CCG workforce as at 31 March 2018 (WTE)

	Whole Time Equivalent (WTE) by Gender			
Staff Grouping	**Female**	**Male**	**Unknown***	**Grand total**
Governing body	4.21	3.05	0.00	7.26
Other senior management	7.76	1.17	0.00	8.93
All other employees	55.15	10.84	0.00	65.99
Grand total	**67.12**	**15.06**	**0.00**	**82.18**

	% by Gender		
Staff Grouping	**Female**	**Male**	**Unknown**
All other	58.0%	42.0%	0.0%
Governing body	86.9%	13.1%	0.0%
Other senior management	83.6%	16.4%	0.0%
Grand total	81.68%	18.32%	0.00%

** 'Unknown gender' pertains to governing body members without an entry in the CCG Electronic Staff Record (ESR) system*
Named individuals categorised as 'unknown' are:

- Clive Jones
- Liz Noakes
- Christine Choudhary
- Patrick Spreadbury

Staff numbers and cost

Staff composition – by pay band:

Pay band analysis of CCG workforce as at 31 March 2018 (Headcount)

Sum of headcount	
Pay Band	**Total**
Band 2	3
Band 3	22
Band 4	9
Band 5	5
Band 6	9
Band 7	9
Band 8 – Range A	8
Band 8 – Range B	11
Band 8 – Range C	2
Band 8 – Range D	2
VSM	12
Medical payscale	13
*Governing body (off payroll)	3
Grand total	**108**

**Governing Body (off payroll) pertains to Governing Body Members without a pay record. Names individuals categorised as such are:*

Mr Clive Jones
Mrs Liz Noakes
Mr Patrick Spreadbury

Pay band analysis of CCG workforce as at 31 March 2018 (WTE)

Sum of WTE	
Pay band	**Total**
Band 2	1.65
Band 3	18.53
Band 4	7.63
Band 5	4.70
Band 6	8.25
Band 7	9.00

Band 8 – Range A	7.80
Band 8 – Range B	8.65
Band 8 – Range C	2.00
Band 8 – Range D	2.00
VSM	8.91
Medical payscale	3.07
*Governing body (off payroll)	0.00
Grand total	**82.18**

** 'Governing body (off payroll)' pertains to governing body members without a pay record. Named individuals categorised as such are:*

- *Clive Jones*
- *Liz Noakes*
- *Patrick Spreadbury*

Sickness absence data

The sickness absence data for the CCG in 2017/18 was whole time equivalent (WTE) days available of 15699.18 and WTE days lost to sickness absence of 774.82, and average working days lost per employee was 11.10 which was managed through the absence management policy.

Employee consultation

We are committed to communicating and engaging with staff on a consistent and frequent basis, through one-to-ones, team meetings, staff consultation events, CCG staff briefings, staff newsletters, and our regional joint staff consultative committee (JSCC), which provides a forum for trade union staff representatives to meet and contribute to service change and development. Our chief officer holds drop-in sessions for staff to discuss issues and we also hold regular CCG team briefings with both our chief officer and chair.

We have continued to engage more proactively in 2017/18 with staff on helping them to become more active. This has included a number of activities being organised by members of staff for their colleagues; yoga, couch to 5K initiative, regular cycling outings, lunch time walk, and the CCG has purchased a table tennis table for staff to use in the rest area at break time.

Employees with a disability

Employing people with a disability is important for any 103 organisation providing services for the public, as they need to reflect the many and varied experiences of the public they serve. In the provision of health services, it is perhaps even more important, as people with disabilities make up a significant proportion of the population, and those with long-term medical conditions use the services of the NHS. The CCG's commitment to people with disabilities includes:

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

- the organisation ensures any employee who needs training, either because they work with people with disabilities, or because they have acquired an impairment or medical condition, receives the necessary training.

Trade Union Facility Time

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

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

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

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

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	*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

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

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

Expenditure on consultancy

Telford and Wrekin CCG spent £278K on consultancy services in 2017/18.

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, CCGs must publish information on their highly paid and/or senior off-payroll engagements.

The table below shows the existing arrangements as of 31 March 2018:

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	0
Of which, the 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 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: New off-payroll engagements

For all new off-payroll engagements between 01 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Total number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which….	
Number assessed caught by IR35	0
Number assessed as NOT caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on departmental payroll	0

Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018

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

Exit packages, including special (non-contractual) payments
Table 1: Exit Packages

Telford and Wrekin CCG does not have any to report during 2017/18.

Health and safety

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

There were two health and safety incidents reported in the year. Both were graded as low, due to the level of harm to staff. The incidents were investigated, one incident was a fall due to loss of balance and no mitigation could be identified. The second was an electric shock from a light switch and this has been reported to NHS Property Services for repair.

Fraud

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

The CCG employs the services of assurance provider CW Audit Services to provide its local counter-fraud specialist services. The CCG does not tolerate economic crime, the CCG has an anti-fraud, bribery and corruption response policy in place which is designed to make all staff aware of their responsibilities should they suspect that offences are being committed. When economic crime is suspected it is fully investigated in line with legislation, and appropriate action taken, which can result in criminal, disciplinary and civil sanctions being applied. This work is monitored by the audit committee as a standing agenda item at each meeting.

Emergency preparedness, resilience and response

As an NHS body the CCG is required to ensure it has processes in place to manage emergency situations that may occur within its boundaries.

Each year there is an expectation from NHS England that a self-assessment against the Standards for Emergency Preparedness, Resilience and Response (EPRR) is undertaken by all health care organisations. The CCG was rated with substantial assurance for 2017. All required actions have been taken to ensure the CCG can work with partners in Telford and Wrekin in the event of emergency situations.

Exit packages and severance payments

Telford and Wrekin CCG does not have any exit packages and severance payments to report during 2017/18.

External audit fees, work and independence

The CCG's external auditors are Grant Thornton UK LLP, Colmore Plaza, 20, Colmore Circus, Birmingham B4 6AT. The contract value was £37,000 excluding VAT. The contract included the core audit work of the financial statements and work to reach a conclusion on the economy, efficiency and effectiveness in the CCG's use of resources (value for money conclusion).

Statement as to disclosure to auditors

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

Parliamentary accountability and audit report

Telford and Wrekin CCG is not required to produce a parliamentary accountability and audit report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the financial statements of this report at page 109. An audit certificate and report is also included in this annual report at page 113.

Annual Accounts/ The Financial statements and notes

The financial statements

The four primary financial statements are included for information:

- Statement of comprehensive net expenditure
- Statement of financial position
- Statement of changes in taxpayers' equity
- Statement of cash flows

The supporting notes can be found in CCG Annual Accounts.

Full copies of these statements and supporting notes can be obtained from:

Chief Finance Officer
NHS Telford and Wrekin Clinical Commissioning Group
Halesfield 6
Telford
TF74BF

The financial statements below are subject to external audit approval.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(2,308)	(3,694)
Other operating income	2	(478)	(606)
Total operating income		**(2,786)**	**(4,300)**
Staff costs	4	3,940	3,573
Purchase of goods and services	5	236,069	229,606
Depreciation and impairment charges	5	45	42
Provision expense	5	(13)	290
Other Operating Expenditure	5	280	270
Total operating expenditure		**240,320**	**233,781**
Net Operating Expenditure		**237,534**	**229,482**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**237,534**	**229,482**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**237,534**	**229,482**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**237,534**	**229,482**

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	13	198	201
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		198	201
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	1,815	2,653
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	73	10
Total current assets		**1,888**	2,663
Non-current assets held for sale	21	0	0
Total current assets		**1,888**	2,663
Total assets		**2,086**	2,864
Current liabilities			
Trade and other payables	23	(20,166)	(18,028)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(219)	(232)
Total current liabilities		**(20,385)**	(18,260)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(18,299)**	(15,396)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(168)	(168)
Total non-current liabilities		**(168)**	(168)
Assets less Liabilities		**(18,467)**	(15,564)
Financed by Taxpayers' Equity			
General fund		(18,467)	(15,564)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(18,467)**	(15,564)

The notes on pages 5 to 33 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 24th May 2018 and signed on its behalf by:

Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2018

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(15,564)	0	0	**(15,564)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(15,564)**	**0**	**0**	**(15,564)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(237,534)	0	0	(237,534)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial	**(253,098)**	**0**	**0**	**(253,098)**
Net funding	234,631	0	0	234,631
Balance at 31 March 2018	**(18,467)**	**0**	**0**	**(18,467)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	**(12,361)**	**17**	**0**	**(12,344)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(12,361)**	**17**	**0**	**(12,344)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(229,482)	0	0	(229,482)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	17	(17)	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial	**(241,826)**	**0**	**0**	**(241,826)**
Net funding	226,262	0	0	226,262
Balance at 31 March 2017	**(15,564)**	**0**	**0**	**(15,564)**

The notes on pages 5 to 33 form part of this statement

External Audit Opinion and Report

Independent auditor's report to the members of the Governing Body of Telford and Wrekin CCG

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Telford and Wrekin CCG (the 'CCG') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure for the year ended 31 March 2018, the Statement of Financial Position as at 31 March 2018, the Statement of Changes in Taxpayers Equity for the year ended 31 March 2018, the Statement of Cash Flows for the year ended 31 March 2018 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 the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:

 give a true and fair view of the financial position of the CCG as at 31 March 2018 and of its expenditure and income for the year then ended; and

 have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and

 have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Who we are reporting to

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG 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 CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

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

 the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

 the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 1-107, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the CCG's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of 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 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

 the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012; and

 based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity required by the Code of Audit Practice

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

Matters on which we are required to report by exception

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

 we have reported a matter 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 have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had 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 have made a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

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

As explained more fully in the Statement of Accountable Officer's responsibilities set out on page(s) 64-65, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the CCG lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the CCG.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Matter on which we are required to report by exception - CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been

able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Telford and Wrekin CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Mark Stocks

Mark Stocks

Partner

for and on behalf of Grant Thornton UK LLP

Birmingham

24 May 2018

Data entered below will be used throughout the workbook:

Entity name:	NHS Telford and Wrekin Clinical Commissioning Group
This year	2017-18
Last year	2016-17
This year ended	31-March-2018
Last year ended	31-March-2017
This year commencing:	01-April-2017
Last year commencing:	01-April-2016

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(2,308)	(3,694)
Other operating income	2	(478)	(606)
Total operating income		**(2,786)**	**(4,300)**
Staff costs	4	3,940	3,573
Purchase of goods and services	5	236,069	229,606
Depreciation and impairment charges	5	45	42
Provision expense	5	(13)	290
Other Operating Expenditure	5	280	270
Total operating expenditure		**240,320**	**233,781**
Net Operating Expenditure		**237,534**	**229,482**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**237,534**	**229,482**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**237,534**	**229,482**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**237,534**	**229,482**

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	13	198	201
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		198	201
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	1,815	2,653
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	73	10
Total current assets		**1,888**	2,663
Non-current assets held for sale	21	0	0
Total current assets		**1,888**	2,663
Total assets		**2,086**	2,864
Current liabilities			
Trade and other payables	23	(20,166)	(18,028)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(219)	(232)
Total current liabilities		**(20,385)**	(18,260)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(18,299)**	(15,396)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(168)	(168)
Total non-current liabilities		**(168)**	(168)
Assets less Liabilities		**(18,467)**	(15,564)
Financed by Taxpayers' Equity			
General fund		(18,467)	(15,564)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(18,467)**	(15,564)

The notes on pages 5 to 33 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 24th May 2018 and signed on its behalf by:

Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2018

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(15,564)	0	0	**(15,564)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(15,564)**	**0**	**0**	**(15,564)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(237,534)	0	0	(237,534)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(253,098)**	**0**	**0**	**(253,098)**
Net funding	234,631	0	0	234,631
Balance at 31 March 2018	**(18,467)**	**0**	**0**	**(18,467)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	**(12,361)**	**17**	**0**	**(12,344)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(12,361)**	**17**	**0**	**(12,344)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(229,482)	0	0	(229,482)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	17	(17)	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(241,826)**	**0**	**0**	**(241,826)**
Net funding	226,262	0	0	226,262
Balance at 31 March 2017	**(15,564)**	**0**	**0**	**(15,564)**

The notes on pages 5 to 33 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(237,534)	(229,482)
Depreciation and amortisation	5	45	42
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	838	(1,305)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	2,138	4,066
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	(13)	290
Net Cash Inflow (Outflow) from Operating Activities		**(234,526)**	(226,389)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(41)	(39)
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(41)**	(39)
Net Cash Inflow (Outflow) before Financing		**(234,567)**	(226,428)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		234,631	226,262
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**234,631**	226,262
Net Increase (Decrease) in Cash & Cash Equivalents	20	**64**	(166)
Cash & Cash Equivalents at the Beginning of the Financial Year		**10**	176
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**74**	10

The notes on pages 5 to 33 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

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 **Pooled Budgets**

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group's share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

1.4 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

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

1.4.1 ***Critical Judgements in Applying Accounting Policies***

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

There are no critical judgements made

1.4.2 **Key Sources of Estimation Uncertainty**

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

An accrual for £4,661k has been included within the accounts for prescribing based upon an assessment by the CCG Management of expenditure to date, local knowledge and forecasts provided by NHS Prescription services. An accrual for £4,756k was included in the CCG accounts for 2016/17

1.5 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

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

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

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.7 **Other Expenses**

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

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Notes to the financial statements

1.8 **Property, Plant & Equipment**

1.8.1 **Recognition**

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives. The CCG does not hold any land or property as it is leased from NHS Property Services

1.8.2 **Valuation**

All property, plant and equipment are 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. All assets are measured subsequently at valuation.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

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. Fair values are determined as follows:

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

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

1.8.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 **Depreciation, Amortisation & Impairments**

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible 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

1.10 **Leases**

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

1.10.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10.2 **The Clinical Commissioning Group as Lessor**

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

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

The CCG is not a lessor for any finance or operational leases

1.11.1 **Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme**

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.11.2 **Other Assets Contributed by the Clinical Commissioning Group to the Operator**

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.12 **Cash & Cash Equivalents**

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

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

1.13 **Provisions**

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

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

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

Notes to the financial statements

1.14 **Clinical Negligence Costs**

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

1.15 **Non-clinical Risk Pooling**

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

1.16 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning group contribute annually to a pooled fund, which is used to settle the claims.

1.17 **Carbon Reduction Commitment Scheme**

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.18 **Contingencies**

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

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

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 **Financial Assets**

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

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.19.1 **Financial Assets 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 assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.19.2 **Held to Maturity Assets**

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.19.3 **Available For Sale Financial Assets**

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.19.4 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Notes to the financial statements

1.20 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. There are no financial liabilties being held.

1.20.1 **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.

1.20.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.20.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The CCG is not expecting these standards to impact on the accounts from an intial review, however the CCG will explore this to ensure that this is the case and act accordingly.

1.24 **Primary Care Co-Commissioning**

On 01/04/15, NHS England issued the delegation agreement to Telford and Wrekin CCG to assume delegated commissioning responsibilities for primary medical services. As a consequence, from 1 April 2015 the CCG took on delegated responsibilities for these functions. A Primary Care Commissioning Committee was set up to discharge the delegated responsibilities. In accounting for this expenditure, the CCG has worked closely with NHS England colleagues to assure integrity to the accounting records.

2 Other Operating Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	9	0	9	9
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	2,298	1	2,297	3,685
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Non cash apprenticeship training grants revenue	0	0	0	0
Other revenue	479	54	425	606
Total other operating revenue	**2,786**	**55**	**2,731**	**4,300**

3 Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
From rendering of services	2,786	55	2,731	4,300
From sale of goods	0	0	0	0
Total	**2,786**	**55**	**2,731**	**4,300**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	Total	
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	3,243	3,006	237
Social security costs	318	318	0
Employer Contributions to NHS Pension scheme	377	377	0
Other pension costs	0	0	0
Apprenticeship Levy	1	1	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**3,939**	**3,702**	**237**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**3,939**	**3,702**	**237**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,939**	**3,702**	**237**

4.1.1 Employee benefits

2016-17	Total	
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	2,952	2,686	266
Social security costs	285	285	0
Employer Contributions to NHS Pension scheme	336	336	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**3,573**	**3,307**	**266**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**3,573**	**3,307**	**266**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,573**	**3,307**	**266**

4.1.2 Recoveries in respect of employee benefits

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

4.2 Average number of people employed

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**77**	**73**	**4**	**75**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Exit packages agreed in the financial year

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2017-18 Departures where special payments have been made		2016-17 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2017-18 Other agreed departures		2016-17 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**0**	**0**	**0**	**0**

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 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £377k were payable to the NHS Pensions Scheme (2016-17: £336k) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1

5. Operating expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	3,357	1,195	2,162	3,035
Executive governing body members	583	417	166	538
Total gross employee benefits	**3,940**	**1,612**	**2,328**	**3,573**
Other costs				
Services from other CCGs and NHS England	2,188	1,047	1,141	2,491
Services from foundation trusts	31,576	0	31,576	30,847
Services from other NHS trusts	119,185	0	119,185	113,106
Sustainability Transformation Fund	0	0	0	0
Services from other WGA bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	26,647	0	26,647	26,256
Purchase of social care	0	0	0	0
Chair and Non Executive Members	280	280	0	270
Supplies and services – clinical	934	0	934	710
Supplies and services – general	615	211	404	107
Consultancy services	279	74	205	264
Establishment	648	170	478	1,488
Transport	0	0	0	1
Premises	619	169	450	629
Impairments and reversals of receivables	0	0	0	0
Inventories written down and consumed	0	0	0	0
Depreciation	45	45	0	42
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	44	44	0	54
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	29,633	0	29,633	29,199
Pharmaceutical services	0	0	0	0
General ophthalmic services	215	0	215	169
GPMS/APMS and PCTMS	23,232	0	23,232	23,769
Other professional fees excl. audit	35	35	0	214
Legal fees	153	88	65	0
Grants to Other bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	67	13	54	171
Change in discount rate	0	0	0	0
Provisions	(13)	0	(13)	290
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	0	0	0	130
Non cash apprenticeship training grants	0	0	0	0
Other expenditure	0	0	0	0
Total other costs	**236,381**	**2,176**	**234,205**	**230,208**
Total operating expenses	**240,321**	**3,788**	**236,533**	**233,781**

6.1 Better Payment Practice Code

Measure of compliance	2017-18 Number	2017-18 £'000	2016-17 Number	2016-17 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	10,034	55,554	8,972	49,065
Total Non-NHS Trade Invoices paid within target	9,886	54,821	8,854	48,195
Percentage of Non-NHS Trade invoices paid within target	**98.53%**	**98.68%**	**98.68%**	**98.23%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,485	151,310	2,288	151,371
Total NHS Trade Invoices Paid within target	2,439	151,080	2,231	150,739
Percentage of NHS Trade Invoices paid within target	**98.15%**	**99.85%**	**97.51%**	**99.58%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

7 Income Generation Activities

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

8. Investment revenue

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

9. Other gains and losses

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

10. Finance costs

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

11. Auditors External Liability

The Auditors External Liability is limited up to £500k

12. Operating Leases

12.1 As lessee

[Where the NHS clinical commissioning group is a lessee, include a general description of significant leasing arrangements, including:
(a) *basis on which contingent rent is determined*
(b) *terms of renewal, purchase options or escalation clauses and*
(c) *restrictions imposed by lease arrangements]*

12.1.1 Payments recognised as an Expense

	2017-18				2016-17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	572	8	**580**	0	585	6	**592**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**572**	**8**	**580**	**0**	**585**	**6**	**592**

12.1.2 Future minimum lease payments

	2017-18				2016-17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	0	8	**8**	0	0	6	**6**
Between one and five years	0	0	0	**0**	0	0	0	**0**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**8**	**8**	**0**	**0**	**6**	**6**

13 Property, plant and equipment

2017-18	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2017	99	278	39	415
Addition of assets under construction and payments on account				0
Additions purchased	0	41	0	41
Cumulative depreciation adjustment following revaluation	0	0	0	0
Cost/Valuation at 31 March 2018	**99**	**319**	**39**	**457**
Depreciation 01 April 2017	30	166	18	214
Charged during the year	7	30	7	44
Transfer (to)/from other public sector body	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0
Depreciation at 31 March 2018	**37**	**196**	**25**	**258**
Net Book Value at 31 March 2018	**62**	**123**	**13**	**198**
Purchased	62	123	13	198
Total at 31 March 2018	**62**	**123**	**13**	**198**
Asset financing:				
Owned	62	123	13	198
Total at 31 March 2018	**62**	**123**	**13**	**198**

Revaluation Reserve Balance for Property, Plant & Equipment

	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2017	0	0	0	0
	0	0	0	0
Revaluation gains	0	0	0	0
Impairments	0	0	0	0
Release to general fund	0	0	0	0
Other movements	0	0	0	0
Balance at 31 March 2018	**0**	**0**	**0**	**0**

2016-17	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2016	99	238	39	376
Addition of assets under construction and payments on account				0
Additions purchased	0	39	0	39
Cost/Valuation at 31 March 2017	**99**	**278**	**39**	**415**
Depreciation 01 April 2016	23	138	11	172
Charged during the year	7	28	7	42
Transfer (to)/from other public sector body	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0
Depreciation at 31 March 2017	**30**	**166**	**18**	**214**
Net Book Value at 31 March 2017	**69**	**112**	**21**	**201**
Purchased	69	112	21	201
Total at 31 March 2017	**69**	**112**	**21**	**201**
Asset financing:				
Owned	69	112	21	201
Total at 31 March 2017	**69**	**112**	**21**	**201**

Revaluation Reserve Balance for Property, Plant & Equipment

	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2016	0	0	0	0
Revaluation gains	0	0	0	0
Impairments	0	0	0	0
Release to general fund	0	0	0	0
Other movements	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

13.2 Donated assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

13.3 Government granted assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

13.4 Property revaluation

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

13.5 Compensation from third parties

Zero amount of any compensation from third parties for assets impaired, lost or given up, that is included in the Statement of Comprehensive Net Expenditure

13.6 Write downs to recoverable amount

No Assets written down to recoverable amounts or any reversals of previous write-downs in 2017/18 or 2016/17

13.7 Temporarily idle assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

13.8 Cost or valuation of fully depreciated assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

13.9 Economic lives

	2017-18 £'000
Land	0
Buildings excluding dwellings	0
Dwellings	0
Plant & machinery	15
Transport equipment	0
Information technology	5
Furniture & fittings	10

14 Intangible non-current assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

14.1 Donated assets

No assets were donated in-year

14.2 Government granted assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

14.3 Revaluation

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

14.4 Compensation from third parties

No compensation from third parties for assets impaired, lost or given up, are included in the Statement of Comprehensive Net Expenditure.

14.5 Write downs to recoverable amount

There were no assets written down to recoverable amounts or any reversals of previous write-downs in 2017/18 or 2016/17

14.6 Non-capitalised assets

The CCG has no non capitalised assets in 2017/18 or 2016/17

14.7 Temporarily idle assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

14.8 Cost or valuation of fully amortised assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

14.9 Economic lives

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

15 Investment property

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

16 Inventories

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

17 Trade and other receivables

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	1,155	0	1,265	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	0	0	0	0
NHS accrued income	329	0	831	0
Non-NHS and Other WGA receivables: Revenue	103	0	1,097	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	132	0	122	0
Non-NHS and Other WGA accrued income	89	0	100	0
Provision for the impairment of receivables	0	0	(800)	0
VAT	7	0	37	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	0	0	1	0
Total Trade & other receivables	**1,815**	**0**	**2,653**	**0**
Total current and non current	**1,815**		**2,653**	
Included above:				
Prepaid pensions contributions	0		0	

17.1 Receivables past their due date but not impaired

	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	812	48	610
By three to six months	68	0	659
By more than six months	161	0	55
Total	**1,041**	**48**	**1,324**

£691,898.74 of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2018

17.2 Provision for impairment of receivables

	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	(800)	0	(146)
Amounts written off during the year	0	800	146
Amounts recovered during the year	0	0	0
(Increase) decrease in receivables impaired	0	0	(800)
Transfer (to) from other public sector body	0	0	0
Balance at 31 March 2018	**(800)**	**800**	**(800)**

Provision for impairment of receivables are invoices to Telford and Wrekin Local Authority with regards to ALD Income

18 Other financial assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

18.1 Current

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

18.2 Non-current

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

18.3 Non-current: capital analysis

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

19 Other current assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

20 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	10	176
Net change in year	63	(166)
Balance at 31 March 2018	**73**	**10**
Made up of:		
Cash with the Government Banking Service	73	10
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**73**	**10**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**73**	**10**
Patients' money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

22 Analysis of impairments and reversals

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

22.1 Analysis of impairments and reversals: property, plant and equipment

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

22.2 Analysis of impairments and reversals: Intangible assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

22.3 Analysis of impairments and reversals: investment property

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

22.4 Analysis of impairments and reversals: inventories

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

22.5 Analysis of impairments and reversals: financial assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

22.6 Analysis of impairments and reversals: non-current assets held for sale

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

22.7 Analysis of impairments and reversals: totals

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

23 Trade and other payables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	3,061	0	864	0
NHS payables: capital	0	0	0	0
NHS accruals	2,644	0	2,802	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	2,445	0	3,088	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	11,375	0	10,236	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	49	0	46	0
VAT	0	0	0	0
Tax	46	0	45	0
Payments received on account	0	0	0	0
Other payables and accruals	548	0	946	0
Total Trade & Other Payables	**20,166**	**0**	**18,028**	**0**
Total current and non-current	**20,166**		**18,028**	

Other payables include £63k outstanding pension contributions at 31 March 2018

24 Other financial liabilities

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

25 Other liabilities

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

26 Borrowings

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

26.1 Repayment of principal falling due

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27 Private finance initiative, LIFT and other service concession arrangements

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27.1 Off-Statement of Financial Position private finance initiative and other service concession arrangements

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27.1.1 Payments committed to in respect of off-statement of financial position LIFT schemes

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27.2.1 Imputed "finance lease" obligations for on-statement of financial position private finance initiative and other service concession arrangements

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27.2.2 Imputed "finance lease" obligations for on-statement of financial position LIFT schemes

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27.3.1 In respect of private finance initiative and other service concession arrangements

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27.3.2 In respect of LIFT schemes

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27.4.1 In respect of on-statement of financial position private finance initiative and other service concession arrangements

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

27.4.2 In respect of on-statement of financial position LIFT schemes

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

28 Finance lease obligations

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

28.1 Finance leases as lessee

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

29 Finance lease receivables

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

29.1 Finance leases as lessor

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

29.2 Rental revenue

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

30 Provisions

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	219	167	232	168
Other	0	0	0	0
Total	**219**	**167**	**232**	**168**
Total current and non-current	**385**		**399**	

	Pensions Relating to Former Directors £'000	Pensions Relating to Other Staff £'000	Restructuring £'000	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2017	**0**	**0**	**0**	**0**	**399**	**0**	**399**
Arising during the year	0	0	0	0	219	0	219
Utilised during the year	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	(232)	0	(232)
Unwinding of discount	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0
Transfer (to) from other public sector body under absorption	0	0	0	0	0	0	0
Balance at 31 March 2018	**0**	**0**	**0**	**0**	**385**	**0**	**385**
Expected timing of cash flows:							
Within one year	0	0	0	0	219	0	219
Between one and five years	0	0	0	0	167	0	167
After five years	0	0	0	0	0	0	0
Balance at 31 March 2018	**0**	**0**	**0**	**0**	**385**	**0**	**385**

31 Contingencies

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

32 Commitments

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

32.1 Capital commitments

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

32.2 Other financial commitments

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

33.1.2 Interest rate risk

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

33.1.3 Credit risk

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

33.1.3 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	**Loans and Receivables 2017-18 £'000**	**Available for Sale 2017-18 £'000**	**Total 2017-18 £'000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,484	0	1,484
· Non-NHS	0	192	0	192
Cash at bank and in hand	0	73	0	73
Other financial assets	0	0	0	0
Total at 31 March 2018	**0**	**1,749**	**0**	**1,749**

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,095	0	2,095
· Non-NHS	0	1,198	0	1,198
Cash at bank and in hand	0	10	0	10
Other financial assets	0	1	0	1
Total at 31 March 2018	**0**	**3,304**	**0**	**3,304**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	**Other 2017-18 £'000**	**Total 2017-18 £'000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	5,705	5,705
· Non-NHS	0	14,368	14,368
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**20,072**	**20,072**

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,667	3,667
· Non-NHS	0	14,270	14,270
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**17,937**	**17,937**

34 Operating segments

The CCG consider that they have only one segment: Commissioning of Healthcare Services

35 Pooled budgets

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

	2017-18 £'000	2016-17 £'000
Income	0	0
Expenditure	11,495	11,200

The Better Care Fund (BCF) was implemented formally for the first time during 2015/16. The introduction of the BCF from (1/4/15) has been developed as a means of integrating working across health and social care with an aim to move care from hospitals into the community in order to improve clinical care.

The CCG and the Borough of Telford and Wrekin Local Authority have pooled budgets under Section 75 of the NHS Act 2006 and the pooled budget in Telford and Wrekin consists of a two funds held under the one Section 75 agreement. Each fund has been considered separately to determine where control of each fund lies. The CCG and the Local Authority have determined that they are the lead commissioner each for one of the funds.

The total BCF budget for Telford and Wrekin is £17.244 million with a revenue pooled fund of £15.515 million (hosted by the CCG) and a capital pooled budget of £1.73 million (hosted by the Local Authority). The fund is not comprised of new monies but existing CCG and Local Authority funds. Overall accountability for the BCF sits with Telford and Wrekin Health and Wellbeing Board in line with NHS England requirements and a detailed plan for Telford and Wrekin was developed with the involvement of key stakeholders.

The contributions by the CCG into pooled budgets in 2017/18 were:

	2017/18 £000	2016/17 £000
Carers Pooled Budget	0	0
Intermediate Care	0	0
BCF – Carers	197	195
BCF – Intermediate Care	5,735	5,666
BCF – NHS Services	5,563	5,339

Expenditure on Service Provision	Amount £000	Nature of Arrangement	How Balances are Shared	Telford and Wrekin CCG £000	Telford and Wrekin LA £000	Total £000
Telford and Wrekin LA	5,932.40	Lead Commissioning - LA	LA	5,932.40		5,932.40
Community Nursing Services	3,479.52	Sole Control by CCG	CCG	3,479.52		3,479.52
Shrewsbury and Telford Hospital	1,701.24	Sole Control by CCG	CCG	1,701.24		1,701.24
Primary Care	27.17	Sole Control by CCG	CCG	27.17		27.17
Programme Management	354.69	Sole Control by CCG	CCG	354.69		354.69
iBCF	4,019.86	Sole Control by LA			4,019.86	4,019.86
DFS and Capital	1,729.68	Sole Control by LA	LA		1,729.68	1,729.68
Total:	**17,244.56**			**11,495.02**	**5,749.54**	**17,244.56**

In addition to the payments shown above, the Local Authority planned to make additional contributions to the BCF in 2017/18 of £815k, which included a brought forward underspend from 2016/17 of £160k

36 NHS Lift investments

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

37 Related party transactions

Details of related party transactions with individuals are as follows:

2017-18	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr A Pringle Shropshire Doctors Cooperative Ltd	2813	0	8	0

2016-17	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr S Allen Trinity Healthcare	1,782	0	0	0
Dr J Hudson Dr A Inglis Shropshire Doctors Cooperative Ltd	2,310	0	5	0
Mr A Nash Acounting Logic	59	0	0	0

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- Shrewsbury and Telford Hospitals NHS Trust;
- South Staffordshire and Shropshire NHS Foundation Trust;
- Shropshire Community Health NHS Trust;
- West Midlands Ambulance NHS Foundation Trust,
- Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust,
- NHS Shropshire CCG
- Telford and Wrekin Local Authority
- Midlands and Lancashire CSU
- NHS Property Services
- NHS Business Services Authority.

From the 1st April 2015 the CCG had delegated responsilbility for Primary Care Co-Commissioning, we therefore class all of our member GP practices as related parties.

38 Events after the end of the reporting period

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

39 Losses and special payments

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

40 Third party assets

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

41 Financial performance targets

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

	2017-18 Target	2017-18 Performance	2016-17 Target	2016-17 Performance
Expenditure not to exceed income	247,279	240,320	239,609	233,820
Capital resource use does not exceed the amount specified in Directions	42	41	42	39
Revenue resource use does not exceed the amount specified in Directions	244,492	237,534	235,267	229,482
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	3,804	3,733	3,809	3,786

NHS Telford and Wrekin CCG cumulative surplus is £6.958m and the in year surplus for 2017/18 is £1.273m

2017/18 Financial Target and Performance figures have been presented to allow the reader to determine the cumulative surplus which is a small presentational difference to 2016/17

42 Impact of IFRS

Telford and Wrekin CCG does not have any to report during 2017/18 or any reported during 2016/17

43 Analysis of charitable reserves

	2017-18 £'000	2016-17 £'000
Unrestricted funds	1	2
Restricted funds	0	0
Endowment funds	0	0
Total	**1**	**2**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	3,243	3,006	237	1,307	1,225	82	1,936	1,781	155
Social security costs	318	318	0	139	139	0	179	179	0
Employer contributions to the NHS Pension Scheme	377	377	0	165	165	0	212	212	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	1	1	0	1	1	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	3,939	3,702	237	1,612	1,530	82	2,327	2,172	155
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	3,939	3,702	237	1,612	1,530	82	2,327	2,172	155
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	3,939	3,702	237	1,612	1,530	82	2,327	2,172	155

4.1.1 Employee benefits

2016-17	Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	2,952	2,686	266	1,277	1,236	41	1,675	1,450	225
Social security costs	285	285	0	141	141	0	145	145	0
Employer contributions to the NHS Pension Scheme	336	336	0	158	158	0	178	178	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	3,573	3,307	266	1,576	1,535	41	1,998	1,773	225
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	3,573	3,307	266	1,576	1,535	41	1,998	1,773	225
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	3,573	3,307	266	1,576	1,535	41	1,998	1,773	225

39 Losses and special payments

39.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	0	0	0	0
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**0**	**0**	**0**	**0**

39.2 Special payments

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	0	0	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**0**	**0**	**0**	**0**