NHS
Telford and Wrekin
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS 2018/19

Healthier, happier, longer

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Chair's Foreword

Another busy year for Telford and Wrekin Clinical Commissioning Group (CCG) with lots of great work being undertaken and significant headway being made on the future fit programme.

There were almost 19,000 responses to the future fit public consultation which took place over 15 weeks last summer. Following an independent review of the responses, at the end of January members of the Joint Committee of Shropshire and Telford & Wrekin CCGs, voted unanimously to see Royal Shrewsbury Hospital become an Emergency Care site and Princess Royal Hospital a Planned Care site with both hospitals having a 24 hour urgent care centre.

Telford and Wrekin Council have made a referral to the Secretary of State and we are awaiting the outcome. In the meantime, Shrewsbury and Telford Hospital NHS Trust (SaTH), are continuing to work on the outline business case and there will be an Implementation and Oversight Group set up and led by the CCGs going forward.

In other news, we are working with our partners in primary care to understand what our new primary care networks will look like and how these will work effectively with community services and align with our plans for neighbourhood working.

As always finances have been challenging and we are faced with reducing our running costs by 20% by 2021. In order to do this we are focusing on developing a much stronger working relationship with Shropshire CCG.

In October we were pleased to announce the appointment of Sir Neil McKay as Chair of the Shropshire, Telford and Wrekin Sustainability and Transformation Partnership (STP). Since taking up his post he has being working towards developing an integrated care system and this work continues.

This year we said our goodbyes to two CCG Board members Dr Andy Inglis and Dr Jim Hudson. I would like to thank them both for all their hard work and dedication. I would especially like to thank Dr Inglis for the time and commitment he has given to the health of our population in Telford and Wrekin over many years and wish him well in his retirement.

With the departure of two Board members we see the arrival of two new clinical members so a friendly welcome to Dr Ian Chan and Mrs Rachael Bryceland. We look forward to working with you both.

Finally as always it has been a pleasure to work for and in an organisation which really is dedicated to improving the health outcomes for our local population and I look forward to seeing what we can achieve together over the coming year.

Dr Jo Leahy CCG Chair

21 May 2019

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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 contained within them are not subject to audit.

Performance Report

Performance overview by Mr David Evans, Chief Officer

This is the sixth Annual Report from Telford & Wrekin CCG in a year which has seen a considerable amount of challenges.

I am pleased to report that the CCG has met all of its statutory financial targets for 2018/19 despite growing demands on the services we commission for the population.

The CCG has seen improvements in performance in some areas of commissioned services.

Transfer of Care has seen continuing improvement and has been achieved with strong support from Telford & Wrekin Council. This enables patients to have any ongoing care delivered either at home or closer to home. It is very encouraging that the local health economy is amongst the best performing in the NHS in England.

Improvement has also been seen in percentage of patients waiting over 18 weeks for treatment. There has been continuing progress in cancer treatment and I am grateful for the continuing work between Macmillan and the CCG to improve early diagnosis and survivorship for patients with cancer.

Less encouraging has been the continuing poor performance of the four hours A&E target. Despite really strong performance on discharge there are still significant challenges to meet the national target. There has been a significant increase in the number of patients attending the A&E department at Princess Royal Hospital (PRH), much higher than expected or the CCG had planned for. We have also seen a large rise in the number of patients arriving at PRH by ambulance.

Despite the challenges ahead the CCG remains committed to improving services for the population to help them live longer and healthier lives. We have made further progress in 2018/19 but there is much work still to do.

I would like to thank our partners for their support in what the CCG strives to achieve.

I would also like to add my personal thanks to all of the teams in the CCG, including the Board, the executive team, all members of staff and our member practices. It has been an enormous privilege to have led the CCG since 2013 and I am grateful for the contribution that everyone in the CCG has made in enabling us to deliver improvements in the health of the population and the services we commission on their behalf.

Mr David Evans, Chief Accountable Officer

21 May 2019

Statement of purpose and activities of the CCG

This section of the Annual Report provides summary information on Telford and Wrekin CCG; our purpose, key risks to the achievement of the organisation objectives and how the organisation has performed over 2018/19.

About us

We are a statutory body established under the Health and Social Care Act 2012. We were fully authorised as a CCG on 1 April 2013, with no conditions on our operations. The principal location of business is at 6 Halesfield, Telford TF7 4BF.

We are a membership organisation – during 2018/19, there were 14 GP practices in Telford and Wrekin, and all are member practices of the CCG. As local GPs, they have regular contact with patients and know what health services are needed to support the local population.

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

We are 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 the local population
- We buy services such as mental health, hospital care and community services
- We monitor these services to ensure patients in Telford and Wrekin have safe and quality care.

We commission services from a range of providers, including:

- The majority of local acute services come from Shrewsbury and Telford Hospital NHS Trust (SaTH)
- Community services from Shropshire Community Health NHS Trust
- Mental health services from South Staffordshire and Shropshire NHS Foundation Trust (SSSFT)
- Out of hours primary care services from Shropshire Community Trust and 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 the local 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 the area.

Telford and Wrekin Council is another key local partner. We work closely together to commission services that cross social and health boundaries. This is done through the Better Care Fund and services where a joint strategy has been developed, for example, mental health services for children and young people. We have also begun to align services across the 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

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

- To improve commissioning of effective, safe and sustainable services, which 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

In meeting the objectives above, to exercise our functions effectively, efficiently and economically, and in accordance with generally accepted principles of good governance and as an employer of choice.

Population challenges

We serve a total population of around 173,000 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 on 24 per cent in 2010.

As a result, tackling health inequalities is a priority for us:

- 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. 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 or circulatory disease or coronary heart disease are separately considered.
- The standardised mortality ratio (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 either: cancer, circulatory disease, coronary heart disease, stroke, or 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 either: breast, colorectal or 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.
- In Telford and Wrekin, it is estimated that 17,400 adults aged 16-64 have 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.
- In Telford and Wrekin, it is estimated that 4,000 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 of emergency hospital admissions for coronary heart disease (CHD) in Telford and Wrekin is 112.8 – worse than the national ratio. Admissions for stroke in Telford and Wrekin is 136.3 – worse than the national ratio. Admissions for myocardial infarction (heart attack) in Telford and Wrekin is 116.7 – worse than the national ratio. Admissions for chronic obstructive pulmonary disease (COPD) in Telford and Wrekin is 112.1 – worse than the national ratio.

(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.

Our key programmes of work

We continue to be driven by our strongly-held view that 'quality drives efficiency' and this is reflected in the priorities we set. Since 2012/13, our ambition has been to identify priorities and work programmes that will improve outcomes, quality, performance, and efficiency.

The four key programmes to support a local, system-wide healthcare transformation in Telford and Wrekin continue to be:

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

- **streamlined care – robust pathways** – to ensure we commission sufficient capacity for planned care and improve the patient experience of appointments and treatment
- **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. The emphasis is on putting the patient at the heart of our priority programmes, and the need for these programmes to inter-link and be delivered simultaneously.

The Operational Plan being prepared for 2019/20 provides an update and details the next stages of our delivery programme. This can be found at www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2019/march-2019-2/5625-07-7-ccg-draft-operational-plan/file

Working with partners

We continue to build on the strong history of partnership working in Telford and Wrekin with a number of our partners, and this has been furthered cemented with the introduction of Strategic Transformation Plans (STP). We are leading on a number of initiatives with partners that are key to delivering STP objectives and this will continue to be a key focus for 2019/20.

Providers

2018/19 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 A&E – by making sure the NHS Constitutional 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, continue to be heavily engaged in delivering a Recovery Plan which will see improvements. This is being overseen by the A&E Delivery Board and an Urgent Care Director.

We have used both 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 partnerships have been tested, but we will continue to strive to commission in a way that balances collaboration with contractual requirements, to ensure the population receives high quality healthcare services.

Telford and Wrekin Health and Wellbeing Board (HWBB)

Our Chair, Dr Jo Leahy and Chief Officer, David Evans both sit on the HWBB. The HWBB has continued to mature. The HWBB reviewed its Strategy and associated priorities for 2016-19 and the following three priorities were identified:

- Encourage healthier lifestyles
- Improve mental wellbeing and mental health
- Strengthen communities and community-based support.

The strategy is available online at

www.telford.gov.uk/downloads/file/4005/health_and_wellbeing_strategy_2016

The impact of the strategy has been monitored by the HWBB during 2018/19, 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 us to work in partnership with the Council. Switching care from an acute setting to a community setting relies in part on the success of the BCF and we have created programme support to ensure that they have the right skills and capacity to oversee this.

In addition, we have embarked on joint working on 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 ultimately to be more integrated, so the whole person is supported – not just a disease.

Health Overview and Scrutiny Committee, Telford and Wrekin Council

Our interaction with the Joint Health Overview and Scrutiny Committee (JHOSC) has continued to be significant during 2018/19, 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 the Future Fit programme and the resulting public consultation and decision on the option for Future Fit, has also been presented to the JHOSC of Telford and Wrekin Council and Shropshire Council. Discussions at the JHOSC on Future Fit, although challenging, has helped to strengthen further working relationships as well as ensuring that commissioning decisions are being undertaken in the best interests of the local population.

NHS Shropshire CCG

We work collaboratively with our neighbours in Shropshire CCG on a number of key issues including safeguarding, Future Fit, local maternity services, midwife-led unit service review and lead commissioning arrangements with shared providers.

We continue to explore opportunities to work together, with the 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. The two CCGs generally work in partnership on procurement programmes, and are closely aligned when negotiating contracts with provider trusts. This year has also seen the CCGs embark on a joint contracting function to support commissioning processes and we are considering how we can better utilise joint working between our quality functions.

Midlands and Lancashire Commissioning Support Unit (MLCSU)

MLCSU currently provides the majority of our functions through a contract ranging from financial management to human resources and information governance. The relationship with MLCSU has continued to grow during 2018/19. We continue 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's website.

The risks for 2018/19 have been predominantly about performance against meeting NHS Constitution targets, particularly the 95 per cent four-hour access target to the emergency departments.

Future Fit is another key issue, as delay in developing this programme could lead to greater workforce challenges. This could impact on the local hospital sites' ability to provide urgent and emergency care being compromised.

In addition, we monitor the continued risk to the quality and sustainability of care delivered to its population by commissioned services. Maternity services delivered by Shrewsbury and Telford NHS

Hospital Trust (SaTH) continue to be subject to reviews and they await final 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.

Workforce challenges remain a consistent issue across all commissioned services, for example children and young people's mental health services, ophthalmology, neurology and, as above, 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.

Moving into 2019/20, there is a growing set of risks about the need to deliver a system-wide efficiency target, with the risk of not achieving the collective control target. This will consequently take a higher profile over the coming months.

The CCG has achieved all planned 'business rules' cumulative surplus of at least 1%, and the in-year 2018/19 control total of break-even. However, the final position off the CCG includes a number of significant cost pressures which may have an impact on future financial performance:

- Throughout 2018/19, we have seen major over-performance in hospital contracts. The main areas of overspend are within emergency (9% over plan excluding SaTH Clinical Decision Unit) with significant over-trade also in A&E attendances and Outpatient First Attendances. There ~~is~~ was also an activity related overspend within the contract with West Midlands Ambulance Service, with activity in 2018/19 being 10% over plan. The recurrent impact of these increases in activity continue to be discussed with provider organisations
- In 2018/19, we had a QIPP (Quality, Innovation, Productivity and Prevention) savings target of £9.3m. ~~.~~The CCG has delivered £8.7m of savings against this target, after utilisation of contingency reserves, missing the target by £0.6m (6.5 per cent). The CCG continue to focus on development and implementation of contingency QIPP schemes to address this gap and produce recurrent QIPP savings for future years
- The CCG has also experienced overspends with continuing healthcare budgets due to a small number of high cost complex cases and mental health non-contracted activity
- Within the financial position, the majority of cost pressures are ~~mostly~~ recurrent and are being offset with non-recurrent benefits such as use of contingencies and one-off benefits in areas such as prescribing. The increased recurrent pressure has therefore resulted in a deterioration of our underlying deficit compared to plan and consequently a higher QIPP requirement for 2019/20 than previously identified
- The CCG continues to look for additional recurrent solutions and all underlying recurrent pressures will continue to be monitored. The full board is focused on identifying additional cost savings and a number of specific work streams have been established to explore disinvestment opportunities. Recognising the increasing financial pressures, the CCG are in discussion with external partners to potentially deliver a full 'turnaround' review of activity and finance
- As we look forward to 2019/20 there is a greater focus on system working through the Strategic Transformation Partnership (STP). The whole system is facing significant financial pressures and in this context the role of the STP is of paramount importance as no single organisation will be able to address this gap in isolation. Providers and commissioners need to work collaboratively to identify transformational changes to the delivery of healthcare

across Shropshire to deliver efficiencies that will meet this combined challenge. The Senior Leadership Group supported by the finance directors network are developing an integrated financial plan that will provide the context to the system savings required to deliver the efficiency challenge for Shropshire, Telford and Wrekin. As outlined elsewhere in this report a key focus to manage the growth in urgent admissions is the development of out of hospital services and all partners across the patch are engaged in this programme.

Adoption of Going Concern basis

The accounts have been prepared under the directions issued in the 2018/19 Department of Health and Social Care Group Accounting Manual and the Government Financial Reporting Manual. Following discussion at the CCG Board meeting held on Tuesday 12 March 2019 the Board agree that we area 'Going Concern' and the accounts have been prepared on that basis.

Performance Summary

Integrated performance and quality dashboard 2018/19

The CCG tracks the progress of our service providers (e.g. local hospitals, community services) against a number of national outcomes indicators, and ensures that patients' rights within the NHS Constitution are maintained. Additionally, we have 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 our website.

The Performance Dashboard below, shows up to 12 months' achievements from 1 April 2018 to 31 March 2019 against patient rights defined in the NHS Constitution. The data is provided via NHS Midlands and Lancashire Commissioning Support Unit using the Aristotle tool.

Performance Dashboard 2018/19

		2018/19 target	Q1 2018/19 Apr	Q1 2018/19 May	Q1 2018/19 Jun	Q2 2018/19 Jul	Q2 2018/19 Aug	Q2 2018/19 Sep	Q3 2018/19 Oct	Q3 2018/19 Nov	Q3 2018/19 Dec	Q4 2018/19 Jan	Q4 2018/19 Feb	Q4 2018/19 Mar
NHS Constitution and supporting indicators														
Incomplete pathways under 18 wks	All providers	92%	90.7%	91.4%	91.1%	91.0%	91.2%	91.1%	92.3%	92.0%	92.0%	91.3%	91.5%	90.8%
52-week RTT	All providers	0	0	1	0	0	0	1	0	1	2	2	1	0
Referral to diagnostics within 6 wks	All providers	99%	99.5%	99.6%	99.6%	99.7%	99.5%	99.7%	99.3%	99.4%	99.5%	98.9%	99.0%	98.5%
2WW suspected cancer referral	All providers	93%	92.9%	93.4%	83.6%	80.7%	81.9%	89.2%	81.6%	85.4%	91.1%	91.2%	90.1%	90.1%
2WW urgent breast referral	All providers	93%	98.4%	98.4%	41.7%	35.0%	29.3%	86.4%	36.7%	59.6%	91.1%	93.2%	94.4%	73.4%
Diagnosis of cancer to treatment in 31 days	All providers	96%	98.7%	100%	97.0%	98.7%	98.9%	97.8%	100%	97.5%	98.5%	97.3%	97.5%	100%
Subsequent surgical treatment in 31 days	All providers	94%	100%	100%	100%	100%	88.9%	100%	100%	94.1%	94.1%	84.6%	88.2%	71.4%
Subsequent anti-cancer drugs in 31 days	All providers	98%	94.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Subsequent radiotherapy in 31 days	All providers	94%	100%	100%	100%	100%	90.0%	89.5%	97.1%	96.9%	100%	100%	100%	100%
GP referral to cancer treatment in 62 days	All providers	85%	78.0%	88.2%	77.4%	88.2%	83.7%	86.7%	75.0%	80.0%	90.9%	70.5%	55.1%	69.0%
Screening service to cancer treatment in 62 day	All providers	90%	81.8%	100%	100%	100%	100%	80.0%	100%	100%	100%	100%	100%	25.0%
Upgraded priority to cancer treatment in 62 day	All providers	n/a	85.7%	92.3%	91.3%	90.5%	87.5%	100.0%	89.3%	81.0%	76.9%	58.8%	76.2%	90.5%
% CPA followed up within 7 days of discharge	All providers	95%	92.3%			100%			97.2%			98.5%		
Trolley waits over 12 hours	SaTH	0	0	0	0	0	0	0	8	5	1	33	12	3
A&E within 4 hours	SaTH	95%	74.9%	71.8%	74.5%	74.6%	74.8%	70.4%	70.5%	68.0%	65.5%	67.9%	66.4%	72.8%
Cancelled Op's not rebooked in 28 days	SaTH	0	0			0			0			4		
Children given wheelchair within 18 weeks	quarterly	92%	75.0%			87.5%			100%			100%		
Access to IAPT within 6 weeks (finished treatments, MPFT)		75%	97.0%	98.2%	98.3%	99.5%	97.8%	99.5%	97.5%	97.7%	*not yet available*			
Access to IAPT within 18 weeks (finished treatments, MPFT)		95%	99.4%	100%	100%	100%	99.1%	99.5%	100%	100.0%	*not yet available*			
Access to Eating Disorder Treatment < 1 week (urgent)		95%	n/a			n/a			n/a			n/a		
Access to Eating Disorder Treatment < 4 weeks (routine)		95%	n/a			n/a			100%			n/a		
Patient Safety and Patient Experience														
MSA breaches	All providers	0	0	0	0	3	0	6	6	0	4	6	9	1
Delayed Transfer of Care Days (DToC)	All providers		171	117	148	264	304	159	219	202	193	213	140	198
HCAI MRSA bactaraemia	All providers	0	1	0	0	0	0	0	1	0	1	0	0	0
HCAI C-Diff	All providers	19	0	2	2	3	6	3	1	0	4	1	2	2
Never Events	All providers	0	0	1	0	1	0	1	0	0	1	0	0	1
Cancelled Operations: non clinical	SaTH	n/a	124			186			170			150		
Cancelled Operations: non clinical	RJAH	n/a	10			22			39			41		
Improvement and Assessment Framework: Better Health														
Child Obesity: % children in year 6 classified as overweight			*not yet available*											
Diabetes: % patients achieved all NICE-recommended targets			*not yet available*											
Diabetes: % new patients attending structured education			*not yet available*											
Falls: injuries from falls in over-65s per 100,000			*not yet available*											
Choice: Personal health budgets per 100,000			50			67			63					
Choice: % dying patients having 3 or more emergency admissions in			*not yet available*											
Prescribing: appropriate prescribing of antibiotics in primary care						0.93	0.92	0.92	0.92	0.91	0.91	0.90	0.89	
Prescribing: appropriate prescribing of broad spectrum antibiotics			6.5%	6.5%	6.6%	6.6%	6.5%	6.5%	6.5%	6.6%	7.0%	6.8%	6.9%	
Carers: Proportion feeling supported to manage LTC						55%								
Improvement and Assessment Framework: Better Care														
Learning disability: reliance on specialist IP care			59			57			57					
Learning disability: % LD patients having annual health check			*not yet available*											
Learning disability: % of registered population on LD registers			*not yet available*											
Dementia: diagnosis rates in practices		66.7%	63.5%	64.5%	65.2%	66.0%	65.9%	65.7%	66.3%	66.6%	66.3%	65.6%	66.1%	65.9%
Dementia: care planning and post-diagnostic support			*not yet available*											
Mental Health: IAPT recovery rate		50%	60%			58%			59%					
Mental Health: IAPT access per quarter		4.75%	5.8%			5.8%			5.1%					
Mental Health: EIP treatment in 2 weeks	rolling 3 mths	53%	33.3%	85.7%	87.5%	87.5%	100%	100%	83.3%	80.0%	75.0%	100%	100%	100%
Mental Health: SMI patients having physical health checks									24.8%			47.9%		
Mental Health: Cardio metabolic assessments in MH environments			*not yet available*											
Mental Health: delivery of investment standard														
Mental Health: quality of data submitted to NHS Digital			*not yet available*											
Care ratings: high quality hospital provision			60			60			56					
Care ratings: high quality primary care provision			64			64			64					
Care ratings: high quality adult social care provision			61			61			60					
Cancer: one-year survival for all cancers			*not yet available*											
Cancer: patient experience			*not yet available*											
Maternity: neonatal mortality			*not yet available*											
Maternity: women's experience of services			82.5%											
Maternity: choice in maternity services			54.5%											
Maternity: Mothers Smoking at time of Delivery (SaToD)		reduce	19.0%			17.7%			22.2%					
Urgent Care: Emer Adm for Urgent Care sensitive conds per 100k			1438			1496								
Urgent Care: DToC attributable to NHS per 100,000			4	3	4	6	7	4	5	5	5	5	4	
Urgent Care: pop'n use of hospital beds after Emer Adm			455			465								
Primary Care Access			57%	58%	58%	57%	57%	57%	100%	100%	100%	100%	100%	100%
Primary Care Workforce per 1000 weighted pop'n			*not yet available*											
Patient Experience of GP Services			*not yet available*											
Seven Day Services: achievement of clinical standards			*not yet available*											
Sepsis Awareness prioritisation			*not yet available*											
Improvement and Assessment Framework: Sustainability														
Financial stability: in-year performance														
Use of ERS at first referral		100%	70.9%	73.6%	95.0%	100%	100%	100%	99.6%	100%	100%			
Improvement and Assessment Framework: Leadership														
Probity and Corporate Governance			*not yet available*											
Workforce engagement: staff engagement index			*not yet available*											
Workforce engagement: workforce race equality standard			*not yet available*											
Effectiveness of working relationships in LHE			*not yet available*											
Compliance with guidance on patient/public participation			*not yet available*											
Quality of CCG leadership														
Quality Premium														
Cancer diagnosed at early stages			*not yet available*											
Patient experience of making GP appointment		>=83%									63%			
Antibiotics per STAR-PU		<1.161	0.943	0.938	0.930	0.926	0.92	0.915	0.916	0.912	0.909	0.898	0.893	
Antibiotic prescribing for UTIs: over-70s trimethoprim		2846	3248	3251	3215	3164	3112	3031	2945	2812	2747	2658	2608	
E-coli based bloodstream infections (cumulative)		95	4	9	18	28	37	46	59	66	80	89	97	
Mothers Smoking at time of Delivery (SaToD)		<=15%	18.8%			17.7%			22.2%					
CHC assessments within 28 days		80%	73%			85%			71%			83%		
CHC assessments in acute setting		<15%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
MH: access for children and young people		30%	*not yet available*											
Type 1 A&E Attendances			3708	4180	3991	4174	3883	3743	4015	3742	3931	3991	3620	4221
Numbers on RTT waiting list		10096	11141	11941	11683	11649	11073	10986	11245	10953	11200	11130	12406	12302
Planned Levels of Activity (specific acute)		Plan												
Total Elective Admissions		20,470	1637	1806	1803	1815	1764	1792	1905	1830	1474	1947	1675	2000
Non-elective FFCE activity		18,900	1728	1861	1775	1855	1883	1686	1898	1902	1929	1977	1806	2038
of which 0 LoS NEL spells		5,621	601	619	607	639	659	561	634	644	656	674	625	700
First Outpatient activity		103,096	8126	8739	8249	8132	7759	7834	8819	8797	7183	9078	8080	8635
Follow-up Outpatient Activity		97,360	7227	7619	7798	8043	7673	7533	8742	8711	6754	8725	7668	8238
New RTT Pathways		55,437	4236	5113	4408	4641	4072	4421	4899	4143	3545	4175	4622	4806
A&E attendances		50,319	4388	4900	4716	4946	4640	4505	4718	4461	4685	4838	4394	4685
of which Type 1 ED		49,445	3708	4180	3991	4174	3883	3743	4015	3742	3931	3991	3620	4221

CCG improvement and assessment framework 2018/19

In addition, the CCG itself is monitored by NHS England via monthly assurance meetings, on how well it is performing as a commissioner of services for the people of Telford and Wrekin. We are required to demonstrate its progress against five key domains. Further information about this monitoring can be found at www.england.nhs.uk/publication/ccg-improvement-and-assessment-framework-2017-18/

The outcomes of the annual meeting for 2018/19 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 www.telfordccg.nhs.uk/who-we-are/publications/performance

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

Performance Analysis

Primary care

Delegated commissioning

Since April 2017, the CCG has been responsible for the delegated commissioning of primary medical care services. The Primary Care Commissioning Committee has met regularly throughout the year, in public, to discuss and agree all aspects of the primary care work programme. We have worked closely with NHS England colleagues, lay members, Healthwatch and its non-conflicted out of area GP to support the effective commissioning of primary care medical services.

In 2018/19, delegated commissioning has meant that we were responsible for managing the investment of more than £23 million in primary care. Delegation has enabled us to take further control of the strategic planning, decision making and priority setting of all general practice-based services on behalf of Telford and Wrekin patients. Other areas of primary care – namely dentistry, eye care and community pharmacy – remain the commissioning responsibility of NHS England.

Investment and evolution – GP framework to support system reform

In January 2019, the Government launched its Long Term Plan for the NHS and released a five-year framework for General Practice 'Investment and Evolution' reform which sets the contractual priorities for primary care. This will support our local plans for delivering care closer to people's homes and will provide additional funding to support general practice resilience and workforce retention.

Key to implementing this new reform will be the funding allocated to support the establishment of Primary Care Networks (PCNs). We will be encouraging our GP practices, building on the Telford and Wrekin neighbourhood working footprint (see separate section on 'Neighbourhoods') to form into local PCNs. These PCNs will be based around a GP registered list of approximately 30,000 – 50,000 patients, encompassing general practice and other partners in community and social care. These networks will offer primary care services on a scale which is small enough for patients to get the continuous and personalised care they value, but large enough – in their partnership with others in the local health and care system – to be resilient.

Delivering the priorities of the General Practice Forward View

As part of NHS England's Forward View policy, we have worked closely this year with Strategic Transformation Plan (STP) colleagues from Shropshire CCG and the NHS England local team to deliver the key elements of the GP Forward View. This has focussed on care redesign (with a focus on GP access and neighbourhood working), workforce, infrastructure, workload and investment.

General practice access

Improving access to general practice appointments remains a key priority for us. We commissioned the national extended access service from 1 October 2018, delivering over 108 additional hours of practice appointments per week (provided by GPs, advanced nurse practitioners, urgent care practitioners, clinical pharmacists, physiotherapists and practice nurses) across Telford and Wrekin.

These pre-bookable appointments are being delivered in a mixed model of practice-based appointments and via a local Telford Hub (Monday to Friday) and by our local out of hours provider Shropdoc (weekends and bank holidays). To date, we have a high utilisation rate of all appointments and they will look to procure a permanent service from 2020 onwards. Data sharing agreements were put in place to ensure that patient records can be accessed by all providers of the service –

with the consent of patients. Each practice signposts patients to the most appropriate service and we will be introducing direct bookings by NHS 111 into extended access appointments in 2019.

In addition, we provided an additional £420,000 in transformation funding this year to support general practice resilience and patient access during the busy winter and Easter periods. The practices produced plans for the funding, which included the provision of additional urgent appointments, supporting GPs to risk-assess and work with their more vulnerable patients to keep them out of hospital and active signposting to voluntary sector services where appropriate.

All practices received an upgrade of their telephone systems in 2018 to improve telephone access for patients. All practices are now providing online booking.

Primary care infrastructure – estates

An updated information and technology and estates plan for Telford and Wrekin has been produced this year, with three separate estates priorities.

The outline business case for the Shawbirch Practice relocation was approved in June, moving now to full business case. This is for a redevelopment that will support multidisciplinary team working, improve access for patients, enable more services to move out of hospital and support service transformation.

The Ironbridge Practice signed a new lease with their landlord. This will ensure a continuation of service in the gorge and we are working closely with the practice to improve their accommodation to enable more health care professionals to work from their site.

Our largest practice, Teldoc, is reviewing its current estate. Teldoc saw a merger of six practices into one in 2017 to support practice resilience. The aim is to rationalise and improve the practice's estate portfolio, to support the increasing patient numbers and to create capacity to develop new workforce roles and training capacity to support further service transformation and improvement.

Primary care infrastructure – information and technology

All practice waiting rooms now have WiFi for their patients. The ongoing installation of the Redcentric telephony system is also contributing to improved access for patients. This new system means that we can also monitor patient demand for calls to ensure waiting times to speak are kept to a minimum – especially at peak times. We have also introduced an app-based messaging service for all practices to reduce the number of missed appointments and to support health prevention campaign messaging.

We have been working this year to introduce technology which supports online consultations and video consultations with the aim of reducing pressure on the telephone systems in 2019.

We have undertaken a procurement process for the new Health and Social Care Network (HSCN) which will see increased efficiencies within practices for their clinical systems; enable controlled data sharing (where permission has been given by patients) and enable new technological advances with increased data capacity and broadband speeds.

Primary care workforce

In partnership with Shropshire CCG, we have delivered a number of initiatives this year to support their primary care workforce programme. The table below summarises the work programme priorities delivered to date.

Workforce priority	Programme deliverables
General Practitioners (GPs)	
GP recruitment and retention	We have been shaping our local general practice organisational development programme to support both resilience and retention. Additional funding has been secured to deliver a further year of clinical leadership based on previous successful programmes. The Royal College of GPs will be delivering a 'Be the Best You' local event. Funding has also been identified to support GP leaders of Primary Care Networks (neighbourhoods) – again with the aim of supporting local clinical retention. We have also organised GP evening courses to support personal development in partnership with Shropshire CCG.
GP fellowships	Health Education England provided funding for five newly-qualified doctors across the STP in 2018/19. The STP has secured funding from NHS England to award a number of fellowships to ST3s to help them with personal and/or service development initiatives.
Supervision training for GPs	Funding was secured from NHS England to enable GPs to attend a course at Keele University designed to improve their skills in supervising other clinicians in general practice.
GP trainees	Close working with GP Trainees, particularly medical student ST3s, is helping us to support them in their transition into employment (ideally locally in Telford and Wrekin and Shropshire practices). We are working to provide vacancy information to trainees and to ensure that they have access to relevant information to help them make career choices that include local GP roles.
Preceptorship for newly-qualified GPs	Shropshire STP secured funding from NHS England to develop preceptorship for newly-qualified GPs. We are working with trainees, GPs and GP trainers to target this support appropriately.
International GP recruitment	We have been working with NHS England to understand the current supply of international GPs and, hopefully, match them with interested practices. This year we have also worked to support trainees with Tier 2 visas and to link them up with Tier 2 sponsoring practices.
Other healthcare professionals	

Physician associates	Two physician associates (PAs) were successfully recruited in Telford this year through the NHS England scheme. A local Telford GP is the PA champion for the STP programme and will oversee mentoring of the role. This scheme, which we hope to grow in 2019/20 sees the PAs working two days a week in secondary care and three days a week in primary care (half a day of which spent on a funded training course).
Clinical pharmacists	There has been a rise in in the number of practices employing their own clinical pharmacists. As we move forward with the development of Primary Care Networks, we will see more clinical pharmacists recruited to work in Telford from July 2019. NHS England has been working with the CCG to identify a clinical pharmacy champion to actively promote the role to other local practices.
General practice nursing	This year saw us appoint two nurse facilitators to support practice nurse retention and we have seen an increase in the number of trainee places. We held a successful practice nurse event which focussed on the changing face of primary care and how nurses are the cornerstone to this change. We now have a practice nurse working group which is supporting delivery of the Ten Point Nursing Action Plan and two practice nurses have been appointed to the CCG Board. An increasing number of practices have been appointing advanced nurse practitioners with nurses attending the Wolverhampton Masters Programme. Our primary care quality lead and practice nurse facilitators have been working with the STP training hub to identify training opportunities (and related funding) for nurses and health care assistants (HCAs). This work has resulted in over 30 nurses and HCAs attending training courses over the past 12 months.
Urgent care practitioners	Some of our practices have appointed urgent care practitioners this year – we will be working with these and other practices to see how we can share best practice and understand the benefits of the role. How these roles differ from advanced nurse practitioners is also important for practices to understand.
GP trainees	Close working with GP trainees, particularly medical student ST3s, is helping us to support them in their transition into employment (ideally locally in Telford and Wrekin and Shropshire practices). We are working to provide vacancy information to trainees and to ensure that they have access to relevant information to help them make career choices that include local GP roles.
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Practice management	Three practice managers were funded to attend the National Association of Primary Care Practice Management Diploma programme, and a further three attended the Keele University Practice Management programme. Local training sessions have been provided to support practice management resilience and leadership – supporting them as they move to the next stage of leadership. This support will also help them lead the development of Primary Care Networks and to raise awareness new organisational models (e.g. Integrated Care Partnerships). Local update events have been held to support business as usual management and a collaborative Data Protection Officer role was appointed across all practices to support them navigate new data protection legislation.

To support this work programme, we have been successful in bidding for a GP workforce lead for Telford and Wrekin. Following an external recruitment process, Dr Melanie Abey was appointed to the role and will be providing clinical leadership to the development of the general practice workforce ambitions in 2018 and 2019.

Primary care workload

To support all Telford practices to manage their workload, we funded Intradoc – a document and compliance management platform designed to simplify back office processes and improve information governance. This investment has supported practice efficiency and effectiveness – reducing time spent on lengthy administration tasks and improving dissemination of information across multiple sites.

In addition, training was provided to support active signposting and care navigation, improving outcomes for patients. The training empowered staff to confidently take administrative work away from GPs and other clinicians, and raised administrative team awareness of the wider health and social care services that patients can access.

Feedback from the national GP patient survey raised concerns that reception staff were not always as responsive as they could be. Training aimed at strengthening reception staff engagement skills was provided to improve patient experience of this staff group. One practice focused work on the development of signposting with significant benefits to their practice. Their Patient Participation Group (PPG) reports significant improvement in patient experience and dramatic improvements in GP survey, Friends and Family Test feedback and a reduction in complaints.

Modelling primary care activity – developing the primary care dashboard

The Business Intelligence team have worked with primary care to develop a more detailed dashboard which shows real-time patient activity data at practice, neighbourhood and CCG level. Although the dashboard is only a starting point for discussions, it can help to identify areas of good practice and areas where targeted support may be required. The priority is to reduce the dependency on hospital where possible and this data set can highlight activity trends for accident and emergency attendance, unplanned admissions and out patient referrals. Working with clinical leads and aligning this information to innovations such as the Telford Healthy Hearts programme, it is hoped we will be able to map the impact that initiatives have on hospital activity.

We have also undertaken a primary care audit in partnership with Attain. This is to benchmark further practice information to help support practice resilience, address workforce gaps and support performance.

Recommissioning the primary care out of hours service

A major project was undertaken this year in collaboration with Shropshire CCG and the West Midlands Integrated Urgent Care team, to re-procure their out of hours service contract. The procurement was successful, and the award was made public in October 2019. Shropcom won the contract in collaboration with Shropdoc.

Patient engagement in primary care

This year saw a relaunch of the 'Take Care Telford' campaign. This involved working with practices to actively promote ways in which people can remain well during the winter and Easter periods. Our local campaign has echoed national messages of active signposting away from Accident and Emergency Departments, using stay well messages to support prevention and to signpost patients and the public on how to use secondary and primary care services appropriately.

The primary care team attended the Healthwatch Annual General Meeting, presenting ambitions for addressing primary care access which was received very positively. We have had regular meetings with Telford and Wrekin Patients First and continue to support the ongoing development of patient participation groups (PPGs), visiting several meetings over the year to focus on supporting patient priorities.

We worked with practices and patients this year to raise awareness of the importance of completing the annual GP Practice Survey, which is sent out by Mori to a sample of registered patients. Hopefully more patients and members of the public will respond to the 2019 survey – ensuring that the patient voice can be used to influence and direct positive change.

Neighbourhood Working Programme

We have been working in partnership with Telford and Wrekin Council since 2015 to deliver the Neighbourhood Working Programme. This programme involves elements of community-based developments including volunteering, health and social care services and joint working between GP practices.

During 2018, we continued to work with the Council to maximise opportunities to address individuals' personal goals and support the growth of vibrant and healthy communities which promote independence.

Included in this programme are plans to move care traditionally delivered in hospital settings within individuals own homes or in community settings.

By working together, the Neighbourhood Working Programme aims to ensure:

- Communities will be connected and empowered
- People will know about their condition, the support available within their community and will stay healthy for longer
- Clinical outcomes will be optimised for patients
- Services will be available closer to home for patients
- People will feel supported during times of crisis (both physical and mental health)
- People and their carers will be supported at the end of their lives.

The following tables briefly summarise the progress made against each of the work streams and the plans for further development during 2019.

Work Stream One: Encouraging Healthy Lifestyles	
Key successes	Future plans
Completed health checks with 2,689 people	Leading a whole system approach to reducing excess weight and obesity
1,503 people referred to the healthy lifestyle service committed to a Personal Health Plan with 61 per cent achieving their primary lifestyle goal	Implementation of the Community Blood Pressure Testing programme
11,620 onward referrals to support services and community projects provided by partner organisations to support people to achieve their lifestyle goals	Implementation of the Living with and Beyond Cancer Programme
Healthy lifestyle clinics in GP practices	Continuing development of social prescribing including strengthening links with services that provide support for social issues (unemployment, welfare and debt)
Partnership work with Midlands Partnership NHS Foundation Trust (MPFT) in relation to Psychosis Pathways	Ongoing implementation of the Making Every Contact Count training programme with a focus on our adult social care workforce

Work Stream Two: Community Resilience	
Key successes	Future plans
Includes higher rates of volunteering, establishment of new community-based groups and delivery of projects and some services by community organisations	Recruitment of additional volunteers
Commissioning a mental health hub	Implement Live Well Telford
Wellbeing Care and Support Networks	Public Health team co-production with localities to focus on building community capacity to support development of our social prescribing programme with a focus on physical activity and arts and health
Enterprising Communities	Establish links for partners to support work around ‘Compassionate Communities’ with the Hospice
Health champions and volunteering establish a virtual system to capture community assets	
Community Directory: Live Well Telford design stage	

Work Stream Three: Direct Care in Community	
Key successes	Future plans
Care Home team enabling individuals to remain in their own 'home' (reductions in unnecessary acute admissions)	Build on and expand role of Care Home team
Roll out Emergency Passports, red bag scheme and I–stumble protocols	Development of Integrated team to deliver proactive interventions for those in middle tier of risk stratification
In-reach into SaTH to return home quicker	Frailty at the Front Door
Up-skilling staff and improving care for dementia patients	High Intensity Users Intervention Admission avoidance pre front door (West Midlands Ambulance Service / Rapid Response)
Rapid Response delivering admission avoidance	Explore how existing community teams and acute resources can work together to deliver integrated acute care

Work Stream Four: Speciality Review	
Key successes	Future plans
Diabetes Increased structured education classes A GP incentive scheme was carried out to help improve achievement of the three clinical treatment targets – most practices achieved their defined goal	Diabetes Improving outcomes for foot care
Respiratory IAPT workers now part of Integrated Respiratory teams BHF Bid: Detecting undiagnosed hypertension	Respiratory Refreshed Rightcare respiratory data Plans for Pulmonary Rehab Community Diagnostic Hubs
	Cardio-Vascular Disease Telford Healthy Hearts – population-wide intervention for management of lipids; hypertension; atrial fibrillation and heart failure

Work Stream Five: Primary Care Networks	
Key successes	Future plans
Grouping of GPs into four localities	NHS Long Term Plan providing contractual changes to assist in progressing formalising governance arrangements

Worked across the seven practices in South East Telford to align the vision, share learning, improve care (e.g. alcohol/substance misuse pathways)	Strengthening links between community integrated teams and GPs to develop neighbourhood working including social care
Development of a clear vision for Newport by the two constituent practices who became an early implementer 'Primary Care Home' sites	Exploring potential of Primary Care Networks to support delivery of enhanced services around acute services
Testing of the 'super practice' model by Teldoc achieved through merging a number of local practices	

Telford Healthy Hearts

Whilst the death rate in Telford and Wrekin has improved in recent years, too many people continue to have strokes and heart attacks that could be preventable. We are working with local GPs, hospital specialists and the wider NHS to identify ways to help.

As part of this work, we identified the successes that Bradford CCG had achieved. As part of their Healthy Hearts programme, they saw a ten per cent reduction in admissions to hospital for heart attacks and strokes. This is something we aim to achieve here in Telford.

The programme looks at addressing the risk factors of high cholesterol (fatty deposits in the blood) high blood pressure, atrial fibrillation (rapid heartbeats) and heart failure.

There are three key streams of work:

Public communication and engagement

For Telford Healthy Hearts, a duality of top-down media communication and grass roots community engagement will be used, building on joint work to date with the local authority under the umbrella of the Neighbourhoods programme. This communication will raise awareness of the importance of management of risk factors and that doctors locally are adopting new ways of managing people with these risk factors. It will also include promotion of established lifestyle changes that the public can adopt.

We are working with patient groups and other stakeholders (such as Age UK, Healthwatch Telford and Wrekin and Carer Support) to develop Healthy Heart Champions whose role will be to spread the message about the programme throughout the community.

Telford Healthy Heart Champions

GP level interventions

This stream of work concerns the identification of patients who would benefit from a changed intervention to their current medications, to manage their risk factors for stroke and heart attacks. All the practices in Telford and Wrekin have agreed to work on this programme of work. There is a monthly meeting of the leads from each of the practices with input from the consultant cardiologist working at the local hospital as well as clinical input from the deputy executive for primary care and Medicines Management.

Patients whose medication will be affected by the changes agreed by this group will be informed via letters/emails as per there preferred choice of communication.

Patient education/signposting

This will be delivered both through the communication and engagement element of the work and implementation of motivational interviewing skills across general practice. The aim of this is to provide/signpost people to information about Telford Healthy Hearts. It also aims to signpost people who may receive letters about medication changes to reliable information sources and available resources in the community, to achieve behavioural changes. We have developed a section of its website to provide a single source of access to this information.

Commissioning

Procurements

During 2018/19, the commissioners undertook a series of procurement exercises to meet their statutory obligations and ensure services continued to meet the local population needs. Brief details of these procurements can be seen in the table below:

Procurement	How commissioned	Description
Termination of pregnancy service (TOPS)	Jointly with Shropshire CCG	Covers counselling services, early medical termination and surgical terminations

Optometry services	Jointly with Shropshire CCG	Covers services provided by optometrists to deliver enhanced support outside of hospitals (e.g. minor eye care service)
Community dermatology	Jointly with Shropshire CCG	Covering services provided in the community to prevent attendance at hospital

During 2019/20, we may be required to undertake procurement exercises or service reconfigurations for a number of other service areas including:

Area	How commissioned	Description
Community gynaecology	Telford only	Covers services provided in the community to prevent hospital attendances
Neurology	Jointly with Shropshire CCG	Covers services provided for patients with neurological conditions including long-term community nursing support
MSK (musculoskeletal)	Jointly with Shropshire CCG	Covers the whole MSK pathway
Cardiology	TBC	Covers community-based services for patients with suspected cardiology issues
Non-emergency patient transport	Jointly with Shropshire CCG	Covers transport for eligible patients to and from hospital and other health appointments

Planned care

As part of the NHS Constitution, patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral. In addition, there are two further waiting times indicators within the NHS Performance Framework relating to patients not waiting more than six weeks for diagnostic tests and patients not waiting more than 52 weeks for treatment.

Our performance against the standards has improved during 2018/19, with both the diagnostic testing target and the referral to treatment target being met[1].

The NHS Long Term Plan strengthens the rights detailed above. To address this, we will:

- Monitor the acute trusts waiting list to ensure at the end of March 2020 does not exceed the waiting list at the end of March 2019
- Work with providers to develop a process for identifying patients exceeding six months on the waiting list and offering them an opportunity to move to an alternative provider

[1] Data correct as at 18 January 2019

- Develop a process for identifying patients approaching 40 weeks on the waiting list to ensure no patient exceeds 52 weeks.

There was a national requirement that all planned care referrals should be sent electronically via the E-Referral System (ERs) by October 2018. This was to ensure reduction in delays for referrals sent by other means and improve the patient pathway. We successfully rolled out this project and exceeded the target by working collaboratively with both primary and secondary care. We now have 100 per cent of referrals via this route including those for two week waits for suspected cancer.

Outpatient redesign

We need to ensure that we commission planned care services that meet the needs of the local population and that patients experience of appointments and treatment improves. During 2018/19, we worked with Shropshire CCG and SaTH to look at ways to improve outpatient delivery across a variety of specialties - including cardiology, gastroenterology, oncology and urology. We plan to continue this work during 2019/20 and will be looking to undertake the following actions:

- Identify an area where non face-to-face appointments can be implemented
- Explore areas where patient-led follow ups can be implemented
- Develop process for identifying unnecessary frequent attenders and implement mitigating actions for these patients
- Align diagnostics with appointments
- Use national outpatient improvement dashboard to improve clinic utilisation
- Use the learning from the irritable bowel disease app project to roll out to other areas
- Identify technology opportunities in relation to outpatient appointments.

Cancer

As part of the NHS Constitution, patients have the right to be seen by a cancer specialist within a maximum of two weeks from GP referral, where cancer is suspected. In addition, there are a number of government pledges relating to waiting times for cancer, including a maximum of 31 day wait from decision to treat to the first definitive treatment and a maximum of 62 day wait from referral to first definitive treatment.

The CCG's performance against these indicators has been challenging during 2018/19. The CCG is committed to working towards stabilising these indicators during 2019/20.

Alongside Shropshire CCG, we have established a Telford and Shropshire Cancer Group that includes representatives from both CCGs, SaTH, Telford Council, Shropshire Council, Macmillan Cancer Support and the West Midlands Cancer Alliance. We will be utilising this group to drive forward the essential work in relation to cancer services.

The West Midlands Cancer Alliance was formed to provide leadership to improve outcomes for cancer patients. We are actively working with the Cancer Alliance to implement the four best practice pathways: Lung, Prostate, Colorectal and Upper GI. The Cancer Alliance has supported the CCGs in gaining approval for dedicated project resource to focus on implementing these pathways during 2019/20.

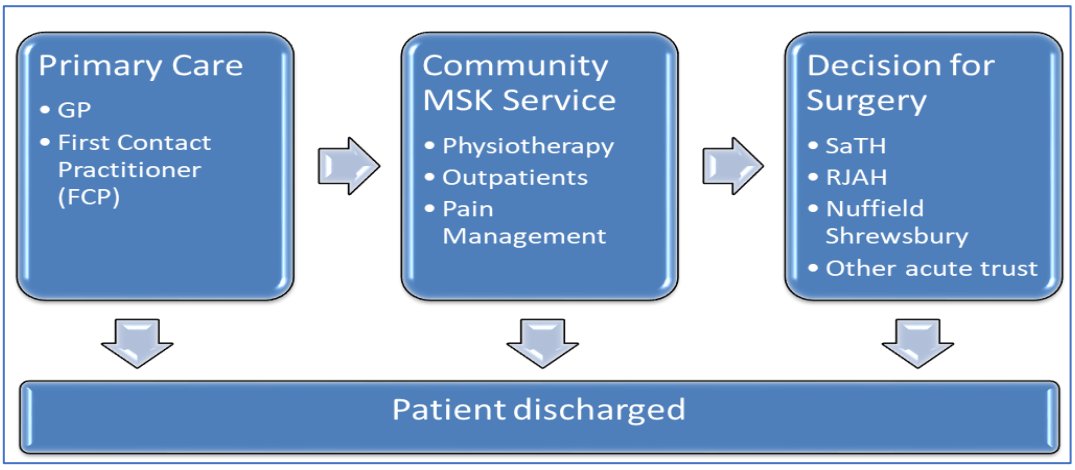
We are also supporting SaTH to deliver a programme of work around 'Living with and Beyond Cancer', focussing on supporting patients and their families to improve their outcomes. There are five main interventions covered by the programme:

1. Holistic needs assessment and care plan – implementing a questionnaire to highlight needs and signpost to support
2. Treatment summaries – aiming to guide patients and GPs post treatment including specifying signs and symptoms that would require a return to secondary care
3. Living well offer – events for patients and their families offering advice, support and signposting
4. Cancer care review – discussions between the patient and the GP or practice nurse about their cancer journey
5. Person-centred follow up – follow up plans tailored to the patients, e.g. self-care with rapid access to support if required.

MSK (musculoskeletal) redesign

It is estimated that one third of the population over 75 will have a chronic MSK problem, and one in five GP consultations are for patients with MSK problems. Due to this high demand, we have worked on improving these services over the last few years. In October 2015, we implemented a new service delivering a community-based triage, assessment and treatment service for MSK conditions. This has enabled a higher proportion of patients to have their condition managed within the community and has increased the use of conservative management.

During quarter four of 2018/19, we implemented a pilot First Contact Practitioner (FCP) scheme in Central Telford locality. This service gives patients direct access to a physiotherapist within primary care without the requirement to see a GP first. This creates a more streamlined pathway for patients.



Current MSK pathway

This pathway is an improvement on the previous position, but still contains too many handovers of responsibility between providers where patients may be lost or experience delays.

We plan to undertake further work in relation to MSK services during 2019/20, including:

- Reviewing MSK services within the community and within secondary care

- Evaluating the FCP pilot with a view to embedding FCP within the new service model
- Developing a single service model for the whole MSK pathway that incorporates FCP, community services and surgical interventions. This should streamline patient journeys and reduce unnecessary surgery.

Neurology redesign

The neurology service delivered at SaTH has been challenged for many years, primarily due to the workforce limitations. These challenges led to patients experiencing long waits to see a consultant, which in turn led to the decision to close the service to new referrals in March 2017. The provider and commissioner have been working together to try to improve the situation at SaTH and enable this local service to reopen. SaTH and the CCGs have jointly agreed that the current local service cannot be reopened, and we will commission an alternative model.

We plan to undertake the following work during 2019/20:

- Develop a new model of service delivery for neurology increasing community-based support
- Increase access to nurse-led support for people with neurological conditions
- Commission the new model of service delivery from a new provider.

Children's services

During 2018/19, we developed and implemented a Children and Young People Case Consideration Panel and decision process. This provides a clear pathway for considering children's cases with a consistent approach to reviewing and supporting individual cases. The panel meets fortnightly to review any cases received. All requests are presented on standardised templates and each case is given dedicated time for consideration. Feedback is provided to the requestor about each decision, providing an open and transparent decision process. We plan to continue utilising this panel and process during 2019/20.

During 2018/19, we have been working with the provider of Children's Community Nursing Services and Shropshire CCG to review the services. The services in place had become fragmented over time, and the group has mapped the pathways and is in the process of developing a single specification for Children's Nursing. The specification will be finalised and implemented during 2019/20. This will improve use of limited resources, ensure patient pathways are streamlined and ensure improved patient experience.

Urgent Treatment Centre

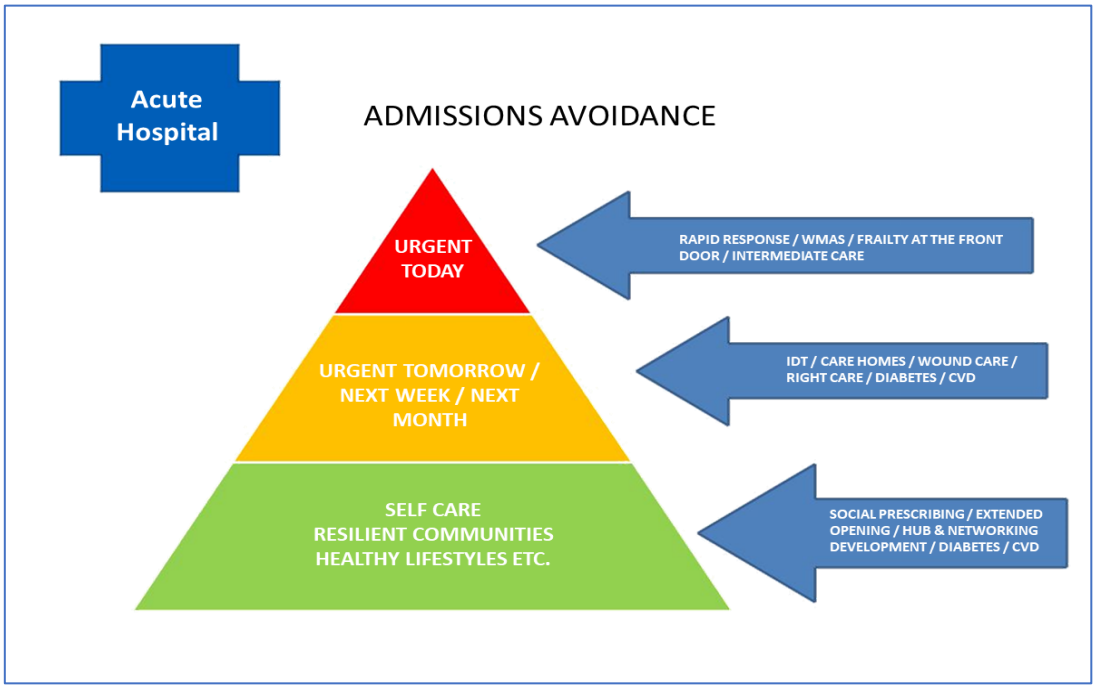
The 'Next steps on the NHS Five Year Forward View' included the requirement to roll out standardised new urgent treatment centres by December 2019, to reduce the confusion in relation to urgent care services. The Urgent Treatment Centre will be a primary care-led streaming, assessment and treatment service for adults and children with minor illnesses and minor injuries. The service will manage patients who self-present via walk-in, as well as via bookable appointments from NHS111 and the ambulance service. The CCGs are committed to ensuring that there is one Urgent Treatment Centre within Telford and Wrekin, and one within Shrewsbury by October 2019. these will be implemented before the mandated date of December 2019.

Out of hours service

NHS 111 is a statutory requirement for all CCGs to provide to their patients. During 2018/19, in collaboration with Shropshire CCG, we switched from a local out of hours telephone number to the national NHS 111 service. The changeover was smooth, and the system is working well within the West Midlands. The provider is meeting the requirements in relation to time to answer calls, and there have been no significant increases in A&E attendances or ambulance dispatches as a result of this change. We will continue to monitor this service to ensure it meets the needs of the local population.

Admissions avoidance

No one wants to have an emergency that requires them to be admitted to hospital, so we are actively working on ways to prevent this happening to its patients. The cohorts of patients being targeted by work within our CCG can broadly be split into three as illustrated in the image below:



Levels for targeted admissions avoidance

The patients at the bottom of the pyramid are able to look after themselves. If we together with our partners can get the support to this cohort right, they can be enabled to live healthy lives with low risk of admission. Work to support these patients includes social prescribing, stop smoking support, support to lose weight and community resilience. We will continue to work with the Local Authority to ensure support is in place for this cohort of patients.

The second tier of patients consists of those at risk of admission in the foreseeable future. We have improved access to primary care and will continue to do so to support this cohort of patients.

We are expanding existing nursing teams and developing newly modelled nursing teams to support these patients as well as targeted work supporting patients with diabetes, cardiovascular disease (CVD) and respiratory conditions to prevent deterioration.

The highest tier consists of patients at risk of admission today. We already commission:

- A Rapid Response team of nurses to support patients within this cohort in their own home
- Intermediate Care Services either to support patients in their own home or within a bed outside of the hospital
- A Care Home team to support improved quality in care/nursing Homes and reduce the need for non-elective admissions currently supporting six homes.

During 2019/20, we will:

- Work with the Rapid Response team to develop pathways and schemes designed to help reduce avoidable unplanned admissions
- Work with the Rapid Response team to develop closer integration with Primary Care Networks and secondary Care
- Work with West Midlands Ambulance Service to reduce the number of unnecessary conveyances by providing alternative community-based options
- Increase the scope of the Care Homes team to enable them to support more care home residents
- Develop a frailty pathway for 72 hours from the 'call for help' using £180k transformation funding secured from NHS England and outreaching from Princess Royal Hospital.

Work across the country has identified that targeting the patients who attend A&E most frequently using an approach of empathy and coaching is highly effective. We are implementing a scheme to support 'High Intensity Service Users' during 2019/20, which will see this cohort of patients supported to identify the reasons for their high usage of A&E and develop plans to support them to avoid future attendances. This direct support should begin to move these patients down the tiers from 'urgent today', through to 'urgent in the foreseeable future' and eventually into the self-care tier, where they no longer need the regular support of the high intensity service user project.

Mental health and learning disabilities

Mental health services and support across the borough continues to grow. More people are accessing services, as the stigma associated with mental health is reducing and individuals are recognising that looking after their mental health is key to a productive life.

The numbers of adults accessing talking therapies has increased in line with national guidance.

The emotional wellbeing service is on track to achieve above the national target of 19 per cent of people with depression and anxiety accessing treatment. Over 62 per cent of those who access the service recover against a national target of 50 per cent. The service is also working with the Diabetes and Respiratory team to support people with long-term conditions to reduce depression or anxiety associated with their condition.

The early intervention service for individuals with a first episode of psychosis is now above the national target of 50 per cent for seeing and commencing treatment.

The twilight service, which offers support to people in a crisis between 6pm and 2am Thursday to Sunday, was shortlisted for a national award. The service, which provides an alternative to A&E, is made up of staff from the mental health trust, the police and Branches.

Branches also support throughout the week to people who are struggling with their mental health to find activities they enjoy, employment and offer peer support six days a week.

BeeU, the emotional wellbeing service for children and young people, now provide significant numbers of children and young people with the early help they need.

On average over 100 children a month access Kooth, who offer online support as part of the service, and around 200 children a month access one of the three drop in services (including a Saturday) provided by BEAM.

Waiting times into the service have dropped this year from 1,439 to 596 with the average wait time now 62 days. Whilst this is a great improvement, we still have significant work to do in order to improve waiting times, particularly for assessment and diagnosis of autism and attention deficit hyperactivity disorder (ADHD). On average, over 500 children and young people access face-to-face sessions in this specialist element of the service, and over 150 referrals are received per month.

There has been a change to the workforce structure of the service, with an increase in the number of psychologist mental health practitioner staff who can support talking therapies.

The website www.beeu.org.uk provides information and advice for both children and young people and their families.

Key actions for mental health and learning disability services during 2019/20 include:

- Implement the Children's and Young Peoples Local Transformation Plan
- Continue to work on improving waiting times particularly for assessment and diagnosis of autism and ADHD within the BeeU service
- Implement neighbourhood models of care aligned to Primary Care Networks
- Develop an all-age intensive support team to work with individuals and families at home, reducing the need for hospital care
- Improve crisis response by enhancing the single point of access for services, strengthening the holistic out of hours crisis response offer, exploring the benefits of 'street triage', exploring how the dementia crisis service can be integrated into Primary Care Networks and exploring the use of digital solutions
- Review the mental health rehabilitation and recovery pathway for people requiring longer-term placements including specialist and community beds to ensure the services meet local needs
- Consider alternative models such as a high dependency unit for women or a complex needs team
- Implement perinatal mental health support
- Implement the suicide prevention strategy
- Develop a strategy for people with learning disabilities or autism with clear actions for improvements to the services
- Use the dementia strategy to develop local plans to identify, diagnose early and help people live well with dementia
- Ensure monitoring and delivery of the dementia diagnosis rate and the implementation of effective post diagnosis support pathways across the STP.

Digital solutions

During 2018/19, we established a task and finish group to look at telehealth and digital technology opportunities which is scheduled to continue into 2019/20. The group is in the process of undertaking a number of actions, including:

- Procuring a digital online solution for patients to remotely and securely submit information related to their health issue to their GP practice to seek advice and support

- Procuring a digital online solution for patients to remotely and securely engage with a clinician from their GP practice (video consultation)
- Implementing a pilot for atrial fibrillation self-monitoring
- Using the learning from the IBD app project to rollout to other areas to support patients to manage their own conditions
- Supporting GP practices to ensure seamless rollout of the national NHS app which provides patients with access to NHS 111, their GP record, the ability to book appointment, update data sharing preferences and register for organ donation via a computer or smartphone.

Medicines optimisation

One quarter of the UK population has a long-term condition, and one quarter of over 60s have two or more long-term conditions. Across the UK, the use of multiple medicines (known as polypharmacy) is increasing, and between 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 they improve outcomes for the person taking them) and cost-effective (that they represent good use of NHS resources). It is about ensuring that people get the right choice of medicines, at the right time and are engaged in the process by their clinical team.

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 and improve medicines safety.

Our 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 2018/19:

Prescribing budget, commissioning policies and individual funding requests

The budget allocated to primary care prescribing during 2018/19 was approximately £30 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 we have to make some difficult decisions about what will and will not be funded.

There is no duty to provide every treatment that an individual may demand – we have to prioritise the demands on our budget. Our commissioning policies are published on our website. Where a patient falls outside the criteria that funding is routinely made available, clinicians may submit an Individual Funding Request (IFR) to us if there are grounds for clinical exceptionality.

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 Charlton Medical Practice, Dawley Medical Practice, Donnington Medical Practice, Hollinswood and Priorslee Medical Practice, Linden Hall Surgery, Shawbirch Medical Practice, Sutton Hill Medical Practice and Teldoc.

The service will be made available to patients registered with Stirchley Medical Practice from April 2019. We hope to bring remaining practices on board by the end of March 2020 at the latest.

Following the introduction of a new telephone system in February 2018, we have seen a big improvement in patient satisfaction with the service. The new system allows the analysis of calls, so for example, they can look at the times of the day or week when they get the most calls. This information then allows us to adjust staffing levels to meet the demands of the service.

In the April-November 2018 data (the latest data available at the time of writing the report), we saw prescribing costs associated with practices using the POD service decline at a much greater rate (6.47 per cent), than the costs in practices that do not currently have access to the POD (1.87 per cent).

If prescribing costs in the practices using the POD had declined at the same rate as that seen in the practices that were not using the POD, we would have spent an additional £655,000 between April-November 2018.

In addition to the financial benefits, the POD is helping to improve quality and safety for Telford and Wrekin patients. The service highlights patients who are either over or under-ordering their medicines, it 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, we started to expand the service provided by POD to care homes across Telford and will continue to grow this service during 2019/20.

Medicines optimisation in care homes

A pharmacy technician works 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 the local 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 care homes.

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

To build on this work, a care home pharmacist joined our Medicines Optimisation team in January 2018. Both the pharmacy technician and the pharmacist will work closely with the wider Care Home team and local practices to ensure that the pharmaceutical needs of residents are met. This collaborative approach will help to reduce unnecessary, unplanned and avoidable admissions to hospital, as well as ensuring that residents are not receiving sub-optimal medication regimens.

Medicines optimisation in hospitals

Our secondary care pharmaceutical adviser works closely with pharmacy teams, clinicians, contract managers and finance leads to ensure that we get the best value for money (i.e. evidence-based, cost-effective treatment) from the services commissioned from hospitals.

One significant success story is the development of an agreement to ensure quick and effective uptake of the best value biological medicine. Biological medicines are important, clinically effective medicines, which can significantly impact on a patient's disease. Six of the top ten medicines

prescribed in hospitals by spend are biological products, used to treat a range of conditions from cancer through to chronic inflammatory conditions such as rheumatoid arthritis and inflammatory bowel disease. By using the best value options, money is released to spend on other priority healthcare services for the local population.

The pharmaceutical adviser is also working closely with local 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.

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. We now routinely use RMOC advice to support local decision making and commissioning decisions.

Encouraging self-care

During 2018/19, we progressed our work on encouraging self-care. Anyone with a short-term or self-limiting condition, that can be managed with a drug/product that is available over-the-counter, is now asked to purchase the drug 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 for managing minor illnesses rather than relying on the NHS to issue prescriptions.

During 2018/19, we 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. Information on what to keep in your medicines cabinet is published on our website 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 have their care managed at home rather than being admitted to hospital. Therefore, wherever possible and safe to do so, we are securing access to medicines in the community that would previously only have been administered in hospital (e.g. intravenous antibiotics, subcutaneous fluids, intravenous diuretics). We are continuing to work closely with the Community Trust to ensure that the clinical team providing services to patients in their own homes have the required skills to administer these drugs.

Antimicrobial resistance

Antimicrobial resistance is a national and global threat to health, as no new antibiotics have been developed in the past 30 years and increasing bacterial resistance to those antibiotics in current use means infections are becoming harder to treat. It is a priority for the NHS to reduce inappropriate antibiotic use by 50 per cent by 2020/21.

Antibiotic prescribing data is monitored closely by us and all of our practices receive monthly monitoring reports which focus on the overall volume of antibiotics used and also on those antibiotics that we know are associated with the greatest risk.

Along with the wider NHS, we will support the implementation and delivery of the government's new five-year action plan on antimicrobial resistance.

Improving patient safety

We have 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 medicines related incidents to ensure that learning is cascaded through Telford and Wrekin.

Medicines in schools

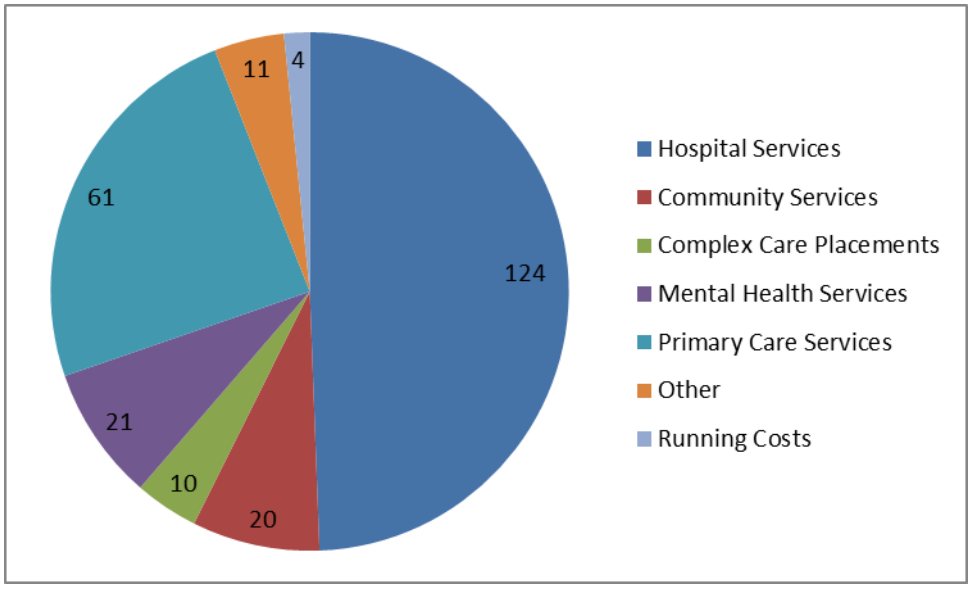
We have continued to work with schools during 2018/19. Relationships with the School Nursing team have been developed as have the relationships with the Schools team within the local authority.

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, the CCG is now encouraging schools to stock emergency adrenaline kits.

Finance

In 2018/19, the CCG received a total allocation of £247m to spend on the healthcare of its residents. The chart below shows a breakdown of our expenditure for 2018/19 by spend type:

NHS Telford and Wrekin expenditure 2018/19 (£m)



For 2019/20, based upon NHS England Business Rules, the CCG is planning to achieve a break-even position in-year and maintain its cumulative surplus although this is dependent on delivering a large efficiency programme and there are risks identified in delivery. The cumulative surplus should be at least 1%. The CCG will have a cumulative surplus of £7m by the end of 2018/19 which represents 2.8 per cent of the total allocation.

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 into the NHS.

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

In 2018/19 the CCG successfully delivered a QIPP programme of £8.7m, although this incorporates the use of contingencies to manage some areas of unidentified QIPP.

Although the CCG has achieved its control total in 2018/19, this underperformance on QIPP results in a recurrent cost pressure going forward. The 2019/20 QIPP requirement for Telford and Wrekin CCG is currently a £10.6m target and an average QIPP target of approximately £4m-£5m 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 in, 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, CCGs have an obligation to work in a way that has a positive effect on the communities for which they 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 the CCG's duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34 per cent (from a 1990 baseline) - equivalent to a 28 per cent reduction from a 2013 baseline - by 2020. We aim to meet this target by reducing our carbon emissions 28 per cent, by using 2013/14 as the baseline year.

For commissioned services here is the sustainability comparator for their providers: [Please note this is published a year in arrears]

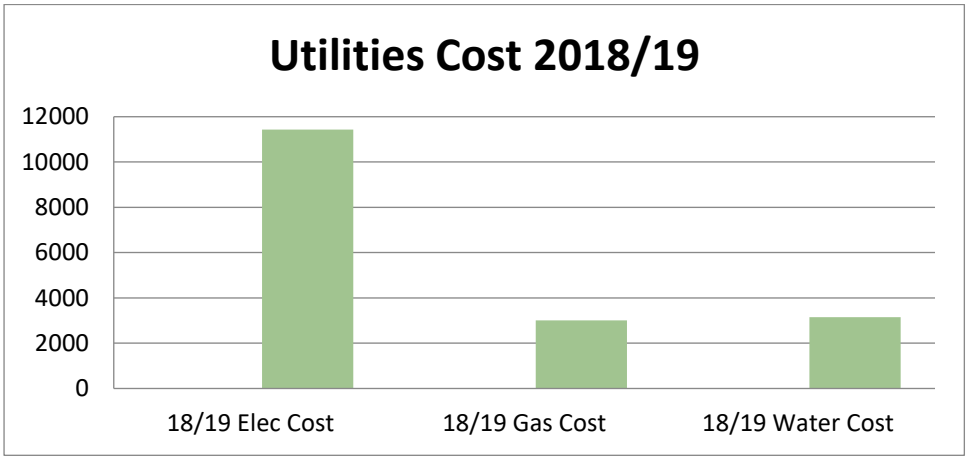
Organisation Name	SDMP	Adaptation	On track for 34% reduction	SDAT	Healthy Transport Plan	SD Reporting Score
Shropshire Community Health NHS Trust	No	No	4. No sustainable development	N/A	No	Poor

			management plan			
Shrewsbury and Telford Hospital NHS Trust	No	No	2. Target included but not on track to be met	65	No	Poor
University Hospital of North Midlands NHS Trust	No	No	1. On track to be met	N/A	No	Minimum
Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	No	No	1. On track to be met	N/A	No	Minimum
Midlands Partnership NHS Foundation Trust	N/A	N/A	N/A	N/A	No	N/A
West Midlands Ambulance Service NHS Trust	No	No	1. On track to be met	N/A	No	Minimum

More information on these measures is available at: 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.

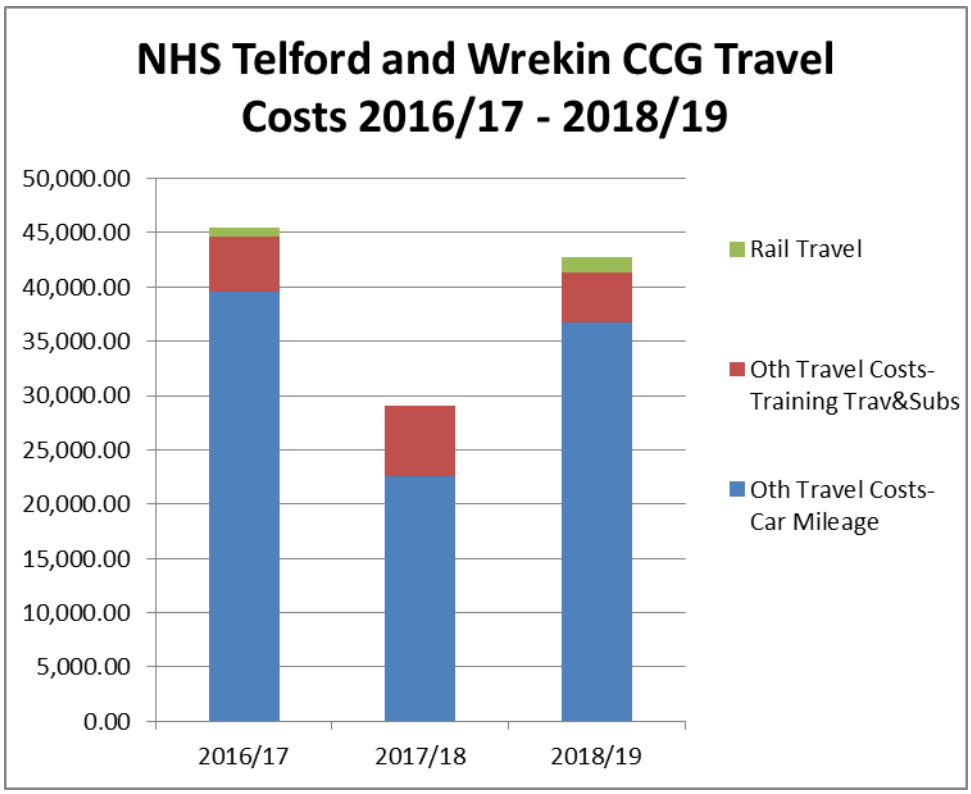
Energy



NHS Property Services are unable to provide the same information for previous financial years however we endeavour to rectify this during the forthcoming 12 months.

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. The graph below shows the expenditure incurred by the CCG on travel for the years 2016/17, 2017/18 and 2018/19.



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 www.nhs.uk/Service-Search/performance/search

Monitoring the quality of services

Our vision is to improve health services for the population of Telford and Wrekin by commissioning the highest quality services, provided near to the patient, in an integrated approach, whilst representing best value for tax payers' money.

Quality also involves working with providers to promote self-care; make early diagnoses; ensure prompt treatment and make sure that this treatment is provided in the right place at the right time, by the most appropriate person with the skills and competencies to meet the need. This could be at home, in the GP's practice, another community site, in the hospital, hospice, or the voluntary sector. The Quality team's role is to support and drive continuous improvements in all of these services, so that all patients experience person-centred care that is safe, effective and efficient.

The Quality team understands that there needs to be a significant change in the way services are commissioned and delivered. This is to ensure that those requiring NHS care are supported to have choice and control in their healthcare, effectively managing long-term conditions in partnership with health and social care professionals and having access to more community-based services that are flexible around the patient. This change is needed to develop a care system that is built around the

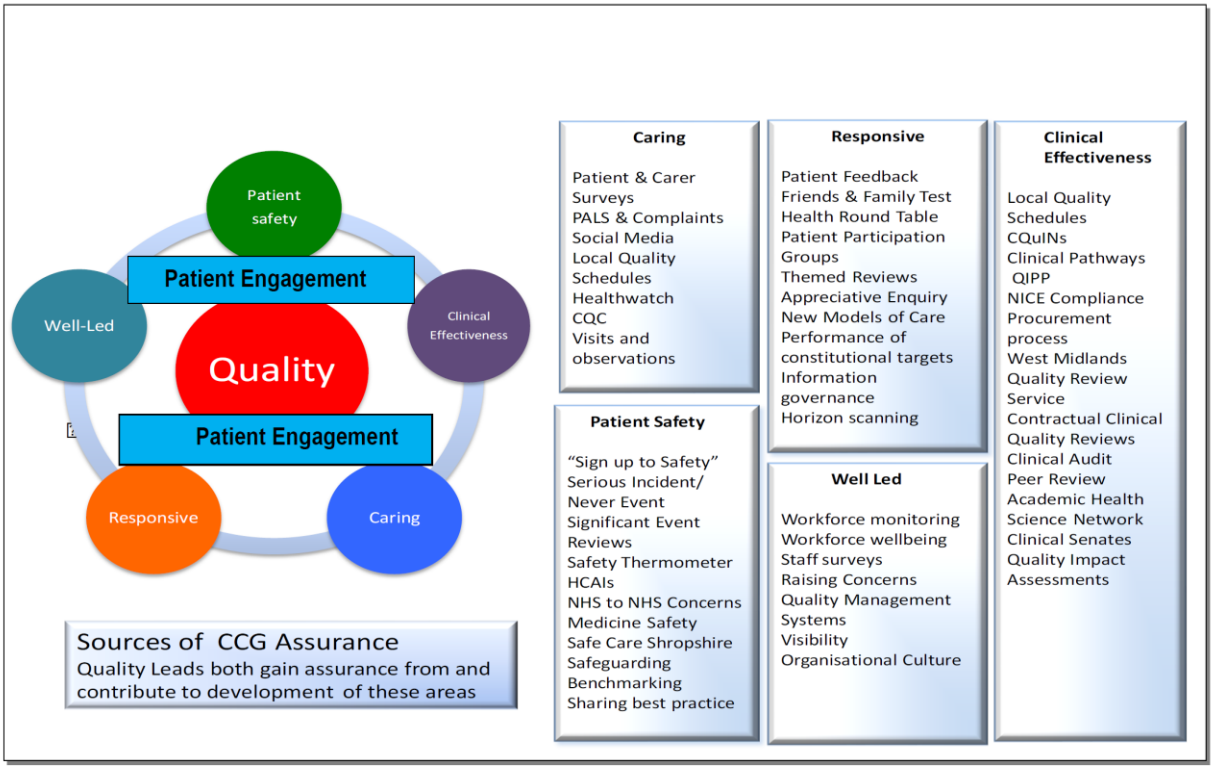
patient and their carers, which is informed by them and implemented by all local partners working together.

We are best placed to work across all providers of care to ensure that Quality Monitoring, Assurance and Improvement are linked to the commissioning cycle as well as the strategic objectives of the organisation.

Throughout 2018/19, our Quality team has monitored and sought assurances on the quality of the services provided and work in partnership with providers to take action where necessary. We have strengthened its quality assurance framework, and this has enabled us to provide greater scrutiny across the range of contracts (large and small) that we commission.

The development of the quality assurance framework maintains emphasis on the three elements of quality, as defined within the Health and Social Care Act 2012: Patient Safety, Clinical Effectiveness and Patient Experience. However, in 2016 the 'Shared View of Quality' was published (National Quality Board, 2016) and the report concurred that, although the above factors were of upmost importance to people using services, in order to provide this consistent high quality care for people, the providers and commissioners must work together, in partnership with local people and communities and must also be well-led, sustainable and equitable for all.

The updated Quality Assurance Framework includes the crucial ability to recognise and act early on any systematic deterioration in care within a provider organisation. The Quality team is committed to proactively monitoring the quality of services and taking action to respond to poor/unsatisfactory quality and patient experience. The wide range of data sources shown in the diagram below are collated and reviewed by the quality lead nurses, with senior oversight/responsibility being provided by Executive Nurse and supported by the Head of Quality / Senior Nurse.



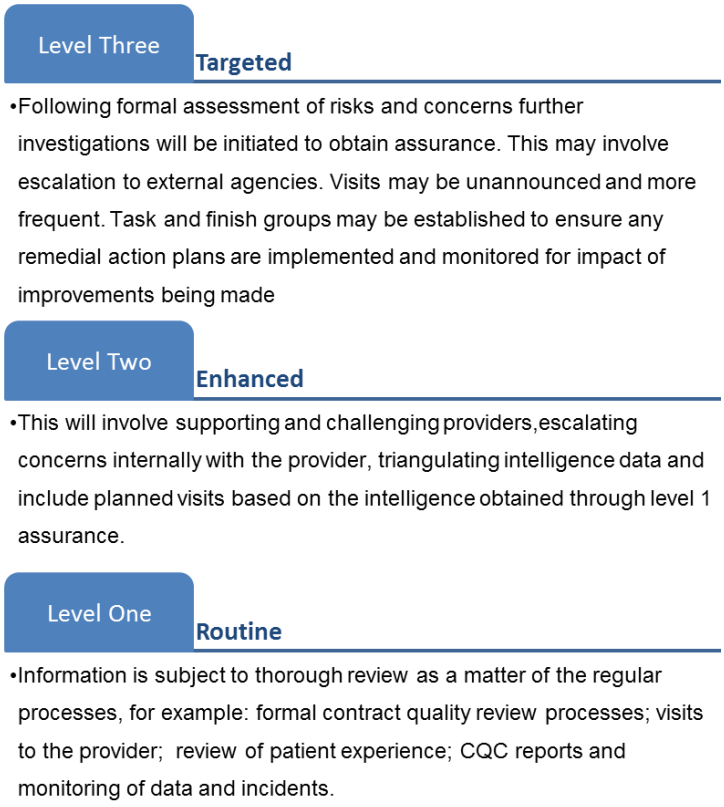
Challenge to providers is provided formally through the Clinical Quality Review Meeting (CQRM) process which provides the audit trail to evidence the discussions and subsequent action plans.

Quality leads also work with providers through joint forums such as the Safeguarding Boards; STP Forums, planned care working group, urgent care group, cancer assurance group, Enhancing Care in Care Home meetings, Local Economy intelligence sharing meetings, Quality Surveillance Groups, and work with Healthwatch and other independent sector organisations to utilise partnership collaboration to address issues of concern.

To enable the Quality team, commissioners and contracts leads to triangulate and prioritise concerns, the degree of assurance and conversely potential for risk is considered across five ascending levels of concern (listed in the table below). All of the local providers are rated, and the level of quality assurance adapted to meet the level of risks and concerns.

Five ascending levels of concern		
Level 1	No concerns / negligible concerns	**1**
Level 2	Isolated / manageable low level concern	**2**
Level 3	Persistent low / moderate level concerns	**3**
Level 4	Serious / high level concerns	**4**
Level 5	Persistent serious / extreme levels of concerns	**5**

The three levels of assurance are listed below and details the actions that the Quality Leads undertake at each level, which are then applied as required to support robust monitoring of providers.



Driving quality improvement 2018/19

Serious incidents

We have continued to review and challenge all reported serious incidents and never events, using the National 2015 Framework. The local Serious Incident Policy was updated in January 2018.

The quality leads are responsible for the review and closure of root cause analysis completed by providers and gain assurance that learning from these is adopted by providers. In 2018/19 there have been considerable challenges with a total of one 'Never Events' reported across both SaTH and Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH). We worked closely with the providers and NHS England to ensure that all appropriate measures have been addressed and a number of actions are ongoing.

A number of themes and trends were identified through serious incidents and Never Events in relation to incidents reported in the Emergency Department, theatres, unexpected deaths in the community and increase in avoidable pressure ulcers. The providers were requested to carry out a deeper dive review on these areas of concern. The results of which were shared at Clinical Quality Review Meetings (CQRM). A number of concerns relating to never events and serious incidents were also escalated to NHS England and discussed at Quality Surveillance Group.

Audit

The Commissioning Support Unit (CSU) has carried out an internal audit of our serious incident monitoring processes during January 2018. The results are still awaited.

In September 2018, the West Midlands Quality Review Service (WMQRS) carried out an external peer follow up review into the care of the critically ill and critically injured child in SaTH. The purpose of the visit was to validate the self-assessments made by the acute Trust and review the pathway for critically ill children attending the Emergency Department and children's assessment units through

to inpatient and level two high dependency unit areas. At both sites there were good working relationships with the anaesthetic services. Other areas of recognised good practice were:

- Paediatric resuscitation information, equipment and layout was consistent in all areas, which made it safer and easier for staff who were not familiar with the area to locate equipment or information quickly
- Patient pathways were clearly defined and very comprehensive
- Guidance was also in place for when the paediatric assessment unit (PAU) was open and when it was closed
- Flowcharts added as appendices within each policy which were very clear and informative.

Availability of staff with advanced paediatric resuscitation and life support training and level one Royal College of Paediatric and Child Health (RCPCH) competences was identified as a concern. The Trust have taken action to ensure this was rectified.

Workforce

We continue 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. They have worked with the STP Local Workforce Action Board (LWAB) to develop a strategic workforce strategy, which includes subgroups developing plans in workforce modelling and redesign, education, leadership and digital planning.

We are supporting different ways of working to improve skill mix within primary care through the GP Forward View workforce plan and Practice Nurse Ten Point Action Plan and in acute hospitals. For example: in the development of nurse associates, urgent care practitioners, advanced nurse practitioners and apprenticeship schemes. Trusts have also been supported to recruit from overseas to address nursing shortages. Agency usage, vacancy rates, sickness levels and appraisal uptake are all reported through CQRM and discussed with front line staff during quality assurance visits. We have raised concerns about workforce shortages and challenges at Quality Service Group and NHS England / NHS Improvement meetings.

Procurements

The Quality team has and continues to support procurement process within our CCG. During 2018/19 there have been successful procurements for out of hours GP provision, community ophthalmology and dermatology. Procurements for community gynaecology; non-emergency patient transport and urgent treatment centre are in progress.

The Quality team completes Quality Impact Assessments for each procurement; contributes to the service specification; formulates any quality questions to be asked and moderates and evaluates bidders' responses to the quality element of the new contract. The procurements of clinical services will support the highest quality care being delivered closer to home.

Infection prevention and control

Reducing and preventing healthcare associated infections is fundamental to the safety and quality of care delivered to patients and remains a high priority for us. As we continue to implement the Infection Prevention and Control Strategy, our overall vision remains that no person in Telford and Wrekin is harmed by a preventable infection.

The Infection Prevention Control (IPC) team within our CCG has changed during the course of 2018/19, but we have continued to work collaboratively with partners throughout the year with an aim to maintain the low levels of Methicillin Resistant Staphylococcus Aureus (MRSA) bloodstream

infection. Whilst we have made great strides in reducing the numbers of Clostridium difficile infections in recent years, the rate of improvement has slowed and as such has posed a significant challenge to achieve the ambitious 2017/18 target.

The Clostridium difficile and MRSA Action Plan has been regularly reviewed by the local health economy Infection Prevention and Control Group, to ensure it continues to provide a sharp 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 infection with post-infection review processes chaired by our CCG, firmly embedded within practice. Learning is identified and disseminated to mitigate against recurrence.

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 and ensuring people are cared for in a safe, clean environment and are protected from avoidable harm. We will also review the IPC function in order to ensure the best model is in place in order to monitor and achieve this aim.

Secondary care providers

The Head of Quality has continued to work closely with all providers of care, in particular the two main secondary care providers SaTH and 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 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 with the presence of CSU Contract Manager.

A monthly schedule of announced visits have taken place within SaTH and are planned for the next 12 months. CCG board members are supporting the visits. Unannounced informal visits take place on a weekly basis to obtain further assurance and the outcome of each visit is discussed with the Director and Deputy Directors of nursing. Any recommendations are also monitored through the CQRM process.

Due to increased capacity demands within SaTH A&E departments, additional quality visits have been undertaken and extra support has been provided to ensure that patients are not being ‘harmed’ due to long waiting times or staffing challenges. Care of those who have not been seen within four hours, those who have been waiting on a trolley longer than 12 hours and those assessed as ‘fit to discharge’ have been reviewed to ensure patients receive equity of care delivered with dignity and privacy whilst they await the arrangements necessary for their discharge or admission. All 12-hour trolley waits are reported and harm proformas submitted to us. Quality leads have oversight of these and have challenged SaTH as required on the level of assurances being given.

Due to increasing workforce challenges and demand pressures, an extensive review was undertaken to establish if the Trust could safely continue to run two A&E departments. Closure of one of the departments was proposed by the Trust. Through work with all partner organisations and neighbouring Trusts, pathways of care were developed to establish the level of risks of closure verses the risks of remaining open. Following interventions from NHS England, NHS Improvement, Health Education England, the two CCGs and Local Authorities, recruitment of safe staffing was achieved in order to enable both departments to remain open throughout the winter.

Following a Care Quality Commission inspection. SaTH were rated as ‘inadequate’. Service improvement plans are being closely monitored to ensure progress is being made in order that they

achieve both the short-term and long-term actions required to provide safe, effective and sustainable services.

Primary care

The Primary Care Quality Lead continues to work with commissioning managers to arrange contracting and quality visits to all practices within Telford and Wrekin. The aims of the visits are to discuss with the practice manager and GPs which areas of good practice can be shared with others and also to gain assurances regarding plans in place to address any areas which are raised as outside of local or national benchmarks. Areas discussed at the meetings include results from the Friends and Family Test, review of patient access to urgent and routine appointments, Quality Outcomes Framework (QOF) Demand Management data and new systems/initiatives to support sustainable primary care.

The Primary Care team as part of the STP general practice workforce group has been working closely to continue to support the development of new roles within general practice. This has resulted in an increase in the number of community pharmacists, funding to develop a physician associate internship programme locally and identification of practices interested in international recruitment. Next year's priorities include scoping the nursing associate apprenticeship in primary care, continued support of recruitment of new GPs and retention of GPs through exploring alternative career pathways.

We continue to support training and development and provides three Protected Learning Time (PLT) events a year. This includes separate events for practice nurses and health care support workers. Topics have included mental health, Bradford Health Hearts and wound care. This year a key driver has been to support practice nurse development as part of the NHS England Ten Point Nurse Action Plan. This is a national plan which looks at supporting the development and retention of practice nurses and supporting nurses new to the role. We are mindful of the impact of difficulties in recruiting nurses into general practice so is looking as a STP at ways of supporting recruitment and retention. The Quality Lead is co-chair of the STP Practice Nurse Development Group, which has been successful in securing funding from Health Education England to deliver training for practice nurses and health care support workers in the following areas:

- Spirometry
- Prescribing
- Long-term condition management
- Physical assessment
- Mentoring.

This supports the overall GP Forward View workforce strategy looking at new roles for nurses and health care support workers reducing the workload on doctors.

In conjunction with Primary Care Committee , we held a Practice Nurse Event with key note national speakers focusing on the changing demands for practice nursing for the future looking and looking at how national drivers can be used in a local context to develop services. Evaluations from the event were very positive and breakout session feedback will be used to support practice nurse development in the future.

The Quality Lead has driven the roll out of the National Diabetes Prevention Programme across Telford. Programmes have commenced in Hollinswood, Newport and Stirchley with more locations to be added in the future. This is a nine-month programme which supports people at risk of

developing Type 2 diabetes to make lifestyle choices to reduce their risk. Funding for the programme is from NHS England and this will continue to be funded in 2019.

The Primary Care team has also been working with Public Health England and Cancer Research UK to look at local actions which can support increased uptake in cervical screening. This ongoing work looks at sharing best practice from Telford and wider health economy.

Intermediate care services

0-25 Emotional Health and Wellbeing Service

The newly commissioned local economy-wide Emotional Health and Wellbeing Service for children and young people aged 0-25 years commenced May 2017. The Commissioners and Quality Leads have worked closely with colleagues from South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) and subsequently Midlands Partnership NHS Foundation Trust (MPFT), who are the prime provider in delivering this integrated service.

Implementing the new model and the associated change management required, whilst maintaining day to day services has been challenging for MPFT.

A task and finish group was set up to support and monitor the changes required and this continues.

Adult mental health services

As part of the quality assurance process, our Quality team monitors trends, themes and factors within the reported serious incidents. The Quality Lead undertook a themed analysis of serious incidents relating to unexpected deaths.

The review was undertaken from data contained within the Root Cause Analysis reports submitted by the provider. Additional information presented at the CQRMs where the SSSFT provided themed analysis of deaths by suicide was also considered.

The review clarified that serious incidents have remained within controls over a 24-month period. The key themes will be explored further with the Trust and reported at CQRM.

The plan is to continue to work with SSSFT / MPFT and Shropshire CCG to evolve the local elements of the NHS England Serious Incidents Framework 2015 to improve learning, and where possible, implement actions to prevent recurrence.

Joint quality assurance visits to local adult mental health services together with colleagues from SSSFT have proved to be successful and useful by both parties. The findings and observations from these visits have been positive and examples of good practice shared.

Nursing homes

The Quality Lead for Integrated Care has continued to work closely with nursing home providers to monitor care against key standards. This, together with multi-agency information sharing, identifies nursing homes and services across Telford and Wrekin that may be a cause for concern and require additional support and monitoring. The outcome of this is that a small number of homes have gone on to require closer review and scrutiny by multi-agency services under West Midlands Adult Safeguarding Policy and Procedures.

During routine quality assurance visits, most local care home providers report that they are finding the nationally recognised problems of staff recruitment and retention challenging, particularly for registered nurses. The level of financial remuneration that care homes receive is also frequently raised and again reflects the national picture. This is shared with multi-agency colleagues for

information. Despite these difficulties, nursing homes continue to be enthusiastic to work with the CCG to learn and improve standards where any weaknesses are identified.

In line with the implementation of the care elements, described in the Framework for Enhancing Care in Care Homes, collaborative work has been undertaken to identify where and how intervention can be implemented to enable the required outcomes to be achieved. The whole Quality team is involved in this integrated approach to service redesign and different ways of working. This includes a Community Multidisciplinary team who are commissioned to proactively target and support care homes (residential and nursing) that have higher rates of admission to hospital. It is intended that this support service will evolve and where appropriate adapt and implement other schemes and initiatives that are simultaneously being trialled and developed across the country.

Community integrated district teams

The quality lead has worked closely with Shropshire Community Health NHS Trust (SCHT) colleagues to enhance the quality and outcomes of Root Cause Analysis investigations, particularly in relation to pressure ulcers. This is intended to improve the identification and correction of any weaknesses in care and service delivery that may contribute to the development of pressure ulcers.

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 the local population.

In addition to supporting all CCG Board members, including non-executives, to undertake the national safeguarding sand story training - the team were also successful in securing NHS England funding for another half day safeguarding training event for all practice staff on safeguarding adults and children.

All practices attended and there were 150 staff at the event. The agenda included:

- Birmingham Loudmouth Theatre Company ‘Safe and Sound Production’ on domestic abuse
- LeDeR (Learning Disability Mortality Review) linked to GP practice
- Holmer Lake School ‘Team Safeguarding’ Children Group
- IRIS (Identification and Referral to Improve Safety) Domestic Violence
- Looked After Children (LAC) update.

Designated Nurse for Safeguarding Children and Young People

The CCG Executive and Designated Nurse for safeguarding have contributed to the national Working Together to Safeguard Children Statutory Guidance update consultation. Our comments have been given nationally and locally to Telford and Wrekin Local Safeguarding Children’s Board (LSCB) including Child Death Overview processes. The final publication was on 4 July 2018, with LSCB given one year to implement statutory changes. Ongoing multi-agency work is in progress including Child Death Overview Panel changes.

A copy of the Working Together to Safeguard Children Statutory Guidance can be found at www.gov.uk/government/publications/working-together-to-safeguard-children--2

A news article entitled 'Members announced for new Child Safeguarding Practice Review Panel' can be found at www.gov.uk/government/news/members-announced-for-new-child-safeguarding-practice-review-panel

The Designated Nurse for Safeguarding was elected by national Designated Doctor/ Nurse colleagues as vice chair of National Network of Designated Healthcare Professionals, arranging yearly continual professional development conferences and contributing to national children and young people safeguarding developments, statutory legislation, policy and training.

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 is currently under development with additional face-to-face safeguarding level three training and the relevant CCG staff have received level three adult and children safeguarding training.

We have circulated a GP safeguarding practice audit template to medical surgeries for completion. Most responses have been received, however, further follow up is required to improve rate of returns and this is work in progress. Serious Case Review recommendations and lesson learnt continue to be implemented across agencies.

The Named General Practitioner (GP) for safeguarding is Dr Luen Wong. Dr Wong and the Designated Nurse for Safeguarding Children implemented the CCG GP forum for Telford and Wrekin GP leads on 4 July 2018. The GP forum has met up twice with key themes identified for further local developments, such as updates on safeguarding adult and children referral processes/identification of abuse/thresholds/policies/procedures, neglect issues, Mental Capacity Act (MCA), Deprivation of Liberties (DoLS) information and case reviews. A safeguarding newsletter for 2018 has been produced for circulation to GPs.

There is ongoing high media interest in Telford and Wrekin Child Sexual Exploitation (CSE) past and present multi-agency activity, requiring Executive and Designated Nurse involvement with Local Safeguarding Children Board (LSCB) partnership responses and local CSE training events. The National Independent Inquiry Child Sexual Abuse Truth Project, 'It's Time to be Heard', is in Telford and Wrekin hearing from victims and survivors.

The Local Safeguarding Children's Board (LSCB) Ofsted inspection with partner agencies was carried out in June 2016. The final report has been published by Ofsted, with Telford and Wrekin LSCB receiving a good effective rating for partnership working. The Child Death Overview Panel (CDOP) sub group across Shropshire and Telford and Wrekin was also identified as an effective good working panel across agencies to prevent child deaths locally. The Care Quality Commission (CQC) final report made 66 quality recommendations for the health and social care system, to improve safeguarding and looked after children's arrangements in Telford and Wrekin.

The majority of the CQC recommendations sit with NHS health providers to improve local service provision. We have requested that local NHS providers develop their own CQC recommendations/action plans with regular progress updates to the CCG clinical quality review meetings. These action plans have identified lead professionals to implement key actions/recommendations. The majority of recommendations have now been completed by NHS commissioners and providers including looked after children.

Shropshire Safeguarding Joint Targeted Area Inspection (JTAI) by Ofsted, HMIC, Probation and Care Quality Commission took place in November 2018. This involved LSCB members, case tracking with

front line practitioners, emergency department, community mental health services, maternity and other relevant providers of children's services. Shrewsbury and Telford NHS Hospital Trust were also inspected by the Care Quality Commission and identified as 'inadequate'. Subsequently, NHS Improvement are the lead via management oversight committee with the NHS England and we are actively monitoring the Hospital Trust improvement process on a weekly basis, to ensure recommended actions are being delivery across the health economy. Maternity recommendations including safeguarding service capacity improvements have been identified.

The CDOP continues to review local cases with a low number of reported deaths to date also for this year. A ten-year CDOP annual report has been produced and presented to both Shropshire and Telford and Wrekin LSCBs. Multi-disciplinary training on child death prevention is yearly, e.g. safer sleep, pet safety, cord blinds, etc.

Named Nurse for Safeguarding Adults

The Named Nurse Adult Safeguarding continues to work closely with the Telford and Wrekin Council and has supported the development of both effective working practices and referral processes in respect of requests from the Local Authority to local providers for assistance with statutory Section 42 Care Act (2014) enquiries and 'other' non statutory enquiries. We assist the Local Authority in either responding directly to a request for an enquiry report or alternatively, offering advice in relation to the appropriate organisation to assist in an enquiry review.

The Named Nurse Adult Safeguarding also continues to support the Telford and Wrekin Council by providing a monitoring role in respect of local provider enquiry responses. Ongoing NHS provider meetings held with the respective provider safeguarding leads and the safeguarding lead for Shropshire CCG outside of the Contract and Quality Review (CQR) processes, allows for the sharing of best practice, for response to legislation or guidance changes and also assists in identifying emerging trends and themes.

The Named Nurse inputs into the Local Provider Information Sharing meetings (formerly the CQC liaison meetings), attends the Safeguarding Adults Board meetings, and represents us at a number of subgroups - including the Partnership, Training, Learning and Development (PTLD). The Named Nurse also chairs the Safeguarding Adult Board and the Quality, Performance and Operational (QPO) subgroup meeting. The Named Nurse 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.

Over the last year the Named Nurse, on behalf of both Telford and Wrekin and Shropshire CCGs, successfully bid for monies from NHS England to facilitate a pan Shropshire Adult Safeguarding Forum for domiciliary care and residential care home providers. The forum is held on a quarterly basis and allows for the sharing of learning outcomes in respect of national and local safeguarding enquiries and reviews. Positive engagement and feedback from providers has ensured that ongoing funding for the forum will continue through 2019/20.

Over 2018, a Mental Capacity and Safeguarding Training audit was undertaken in Telford and Wrekin nursing homes. The purpose of the audit was to understand the effectiveness of training programmes around both subjects for staff within the care home sector. As a result of the audit, learning has been identified to assist the homes in identifying their individual learning outcomes to provider training organisations. Additionally, the Named Nurse has, along with the Shropshire CCG lead, worked with NHS provider organisations to audit their compliance around Mental Capacity and Best Interest Decision making. Further audits to understand the effectiveness of MCA and adult

safeguarding training within NHS provider organisations is planned over the remainder of 2018/19 and into 2019/20.

An ongoing programme of Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) training is in place. Support and training for GP practices is available through the GP safeguarding forum for Telford and Wrekin GP leads and through tailor made training for practices on request. In May 2018, the Named Nurse contributed to the GP training conference which addressed adult safeguarding topics in respect of the Learning Disability Mortality Review (LeDeR) and Domestic Abuse.

In August 2018 the Adult Safeguarding: Roles and Competencies for Health Care Staff was published. In response, the Named Nurse has adapted the CCG adult safeguarding training programme to ensure compliance by 2021. Additional support in respect of meeting Adult Safeguarding Supervision requirements has been facilitated through both group and individual safeguarding supervision arrangements.

During 2018, on our behalf the Named Nurse has completed four Independent Management Reviews, two in respect of Safeguarding Adult Reviews and two Domestic Homicide Reviews. Learning outcomes and recommendations have been identified and action plans implemented.

Designated Nurse for Looked After Children

The Designated Nurse for Looked After Children continues to work closely with Shropshire Community Health Trust, external provider trusts, Telford and Wrekin Council and external Councils to ensure that children responsible to Telford and Wrekin and children placed into the area are adequately supported ensuring timely transfer of information and access to services when required.

The Designated Nurse supports ongoing NHS provider meetings, held with the Nurse Specialist for Looked After Children and Designated Doctor for Looked After Children, as required to improve outcomes for children outside of the CCG Clinical Quality Review Meetings (CQRM) as the need necessitates. Health plans for Telford and Wrekin children who are placed at a distance are reviewed on a quarterly basis alongside the Nurse Specialist Looked After Children. This allows challenge in terms of timely intervention / quality issues. Additionally, complex case meetings take place with the Provider Nurse Specialist for Looked After Children to support understanding of the most vulnerable children in care. The Designated Nurse for Looked After Children engages in strategy meetings where required in relation to complex children, if CCG representation is required, and escalates any issues accordingly liaising with internal or external service services as required.

The Designated Nurse attends the Council-led Corporate Parenting Strategic Group and Quality Performance and Operations as sub-group of the boards; providing support with necessary work-streams and leading on the Corporate Parenting Strategic Health Action Plan, liaising with health colleagues across Shropshire to ensure actions are on track for completion.

The Designated Nurse has formulated terms of reference for the Strategic Health of Looked of Children Group which has been in place during the last year. This forum engages pan-Shropshire health and Council partners to ensure that oversight is provided to the health of looked after children. The next year will see embedding of the objectives to ensure that outcomes are visible and reported accordingly, with a focus on audit.

Training is provided to foster carers and social work staff by the Nurse Specialist for Looked After Children in line with Intercollegiate guidance. However, the Designated Nurse will attend where required to support training objectives. Additionally, the Designated Nurse has been involved in

ensuring that GPs receive training around children in care processes alongside the Designated Doctor for Looked After Children.

The Designated Nurse is a member of the Children and Young People Consideration Panel at Telford and Wrekin CCG. They provide discussion and support in terms of looked after children cases and ensuring that due consideration is provided in terms of requirements for children in care.

During the course of the year, the nurse has been engaged both regionally and nationally to assist with work-streams associated with improving outcomes for children in care. A GP resource document has been formulated to assist GPs with standardising system, process and practice for children in care when a child in care is registered at a GP practice.

The Designated Nurse for Looked After Children offers advice, support and guidance across the health economy and provides scrutiny of health outcomes for children in care. Challenges have existed during the past year in terms of administrative workforce / systems within provider services which has impacted on the provision of elements of health data. A revision of key performance indicators for provider reporting requirements has taken place during this year and is receiving review as part of the contract negotiations for 2019/20 – this is to enable more quality focused measures to be in place. The agreement to a service specification related to looked after children ensures that the overall health of children in care is monitored and reviewed.

Over the next year, the Designated Nurse will be ensuring that more close links are established with private residential settings to gain more understand of the types of establishments in place within Telford. Although there is not a specific requirement to provide quality visits to the premises, it is important to ensure that an improved knowledge is evident in terms of children placed within Telford. A greater focus on quality elements within the provider organisations is of key focus for the forthcoming year.

Engaging people and communities

As a commissioning organisation, we have a legal duty under the National Health Service Act 2006 (as amended) to involve the public in the commissioning of services for NHS patients ("the public involvement duty"). For NHS Telford and Wrekin CCG, this duty is outlined in Section 14Z2 of the Act. To fulfil the public involvement duty, the arrangements must provide for the public to be involved in (a) the planning of services (b) the development and consideration of proposals for changes, which if implemented, would have an impact on services and (c) decisions which, when implemented, would have an impact on services.

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

Governance and Assurance

Our commitment: We are committed to understanding the needs of our population and empowering patients to have more choice and control over their condition, in the development of future services and by identifying priorities. We aim to improve local health services and respond to the health needs of everyone in the area by ensuring patients and the public are at the heart of decision making.

This commitment is embedded in our CCG Constitution which sets out how it will make arrangements to secure public involvement in the planning, development and consideration of

proposals for changes and decisions affecting commissioning arrangements.
www.telfordccg.nhs.uk/who-we-are/publications/constitution/5145-nhs-tw-ccg-constitution-2/file

This is further strengthened in:

- Our mission statement: "Working with patients, Telford and Wrekin CCG aspires to have the healthiest population in England. Healthier, Happier, Longer"
- Our values: "to put patients and the public at the heart of commissioning in Telford and Wrekin allowing services to be personal and responsive to local need"
- Our aims: "improvements in patient experience".

Our Communications and Engagement Strategy (which can be found on our website www.telfordccg.nhs.uk/who-we-are/publications/strategies-and-plans/strategies/25-communciation-and-engagement-strategy-v1-3-april-2016-2/file) demonstrates how we will include patients, the public and stakeholders in our decision making to continually improve services.

It also outlines how we will adhere to our statutory responsibilities to carry out effective consultation and engagement and is aligned to our equalities work programme to ensure that we work with our whole population and groups who may be under represented.

It sets out our principles on how we will involve and engage with patients and the public and the value that we place on involvement. We have an action plan that sits with the strategy that sets out the practical actions we will undertake to deliver our strategic priorities. We have made great strides in completing the action plan and the Communications and Engagement Strategy will be refreshed in 2019.

The CCG Governance Board receives assurance on the robustness of its involvement with and relationship with the public through the established Assuring Involvement Committee (AIC), which, in line with its Terms of Reference, is made up of up to 12 volunteer members which include 11 members of the public and the Board Lay Member for Public and Patient Involvement.

The Committee is chaired by a volunteer member and meets on a monthly basis with a full agenda and discusses with the commissioners the communication and engagement plans for each proposal on new or changing services commissioned by us. The Chair of the AIC completes a report following each Committee meeting, which is then presented to the next CCG Governance Board in public for assurance purposes.

We recently ran a recruitment process for vacancies for AIC members and provided training for new members in the form of presentations and a training pack. Patients or members of the general public that would like to apply to be a member of the AIC can find details and an application on our website.

In addition, if our providers are in the process of transformation of services, this will include the engagement and involvement work that they have planned.

We have a number of sub-committees where patient involvement is key:

- Assuring Involvement Committee – patient volunteer chair
- Planning, Performance and Quality Committee – lay member Chair

- Primary Care Committee – lay member Chair
- Audit Committee – lay member Chair
- Individual Funding Committee – lay member Chair
- Remuneration Committee – two lay members attend
- Joint Commissioning Policies Advisory Committee – lay member/patient volunteer attend.

We also have a number of working groups that include patient volunteers/lay members:

- Telemedicine Working Group – patient rep
- Medical Safety Committee – patient rep.

We are also able to review patient experience and involvement as part of the regular Clinical Quality Review Meetings (CQRM), held with our providers as set out in our Quality Assurance and Improvement Framework 2018-20.

The 14 GP practices which make up the membership of our CCG, have individual PPGs (Patient Participation Groups or Practice Patient Groups) that work with their respective practices on issues affecting the local residents of that practice. Representatives from the PPGs meet monthly and give feedback to us on issues affecting patients and the public.

NHS England Patient and Public Engagement (PPE) assurance rating

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

We are very pleased to confirm the results for NHS Telford and Wrekin's review: we have achieved 11 out of a possible 15 points, giving us an overall rating of 'Green'. Out of the five categories we were assessed against, we were judged 'good' across four and 'outstanding' in one. This is welcome news and demonstrates the considerable hard work and commitment that has gone into improving our arrangements and engagement activities in the last year.

Impact of participation

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

You said, we did:

Patient feedback	Actions to address	Change
Our Engagement Team often receives calls from individual patients via our PALs service with issues they are experiencing in accessing healthcare. One example was an elderly lady who was blind and relies on a guide dog. Due to a previous negative	The Patient Engagement Lead contacted the GP practice to find out if there was an alternative for this lady, rather than going to the surgery.	The practice had a list of patients who cannot access the surgery and added this lady to the list for a home visit to receive her flu vaccination.

experience whilst crossing the road, the lady only visited the GP practice when she was very poorly. She received notification to have her flu jab, and asked that this was done at home rather than going out to the surgery.		
Via our neighbourhood work in collaboration with Telford and Wrekin Council, GP practices in our area have been delivering more holistic care centred around the practice. This allows practices with the local authority and voluntary sector to design and deliver more tailored services for particular areas. Some neighbourhood areas in conjunction with patients and their PPGs have identified that their neighbourhoods have high levels of isolation, which evidence shows leads to poorer health outcomes, so they are working with the voluntary sector and local authority to signpost people to different activities. One example was an elderly lady who had moved to Telford to be near her family but was living on her own. Although she did attend the day centre locally one day a week, she was still finding it very lonely.	We and the practice linked her into local projects that could help this lady with her isolation. One particular initiative was targeted which was a new partnership project between the Telford and Wrekin Health Champions and the Shropshire Wildlife Society called 'Feed the Birds'.	The lady has been signed up to the project and will receive a visit weekly from a volunteer. She will be provided with a bird feeder and feed, and asked to observe and record the different birds that use the feeder. Weekly visits from a Shropshire Wildlife Society member established social interaction and was an opportunity to record the information the lady had collected about the birds. As a result of this success, we sent information to all local GPs about the project.
One local GP practice identified that here was a lack of lower-level mental health support available in their area. This lack of options for local patients was also linked to inappropriate A&E attendances. As a result of this intelligence and as part of our Neighbourhoods initiative, the practice has linked in with Telford Mind. The charity now has a presence in the practice and can help support patients with mental wellbeing.	Patients do not have to be registered with the practice to attend Telford Mind support, so this is truly a neighbourhood service. The charity wanted to be able to measure their outcomes so that they can demonstrate the benefits and impact of their presence to GP practices and to us.	We have promoted the scheme across the area and is facilitating discussions for other practices to utilise the service for their own patients. A member of our Data Analyst Team has been assisting the charity to set realistic outcome measures that they can evidence the difference it has made.
Following on from our public consultation on Future Fit, part of	The patient lead found a local NHS dentist that was taking on	Working with our NHS England partners, we

which involved engagement with the local Gypsy and Traveller community, our Patient Engagement Lead has established monthly clinic visits with the community nurse for children and young people to the one site in our area. During one of these visits, a gentleman was suffering from pain from a severe toothache and was unable to find a dentist.	patients and went back to the traveller site to pass on the details to the gentleman.	were able to find a local NHS dentist. Working in partnership with Shropshire Community Trust, a monthly clinic is being held on the permanent traveller site to give advice and support.

Future Fit public consultation

During 2018, together with the neighbouring Shropshire CCG, we held a 15-week public consultation on the reconfiguration of the acute hospital services in Shropshire, Telford and Wrekin and mid Wales. This gave us the opportunity to find and talk to many different support groups, organisations and voluntary sector colleagues that are part of the nine protected characteristics – but also further demographic groups such as people of no fixed abode, gypsy and traveller families, people living with mental health issues and people recovering from addiction.

The main issues arising from the consultation were concerns over transport and access to newly-configured services. In response, the programme has set up a Travel and Transport group which has already started to develop plans to mitigate these issues. Another key area of feedback was communication of the new model and how people access these services in the future. Again, along with its acute provider, we are currently developing a structure for communications to be developed and distributed on behalf of all the partners involved.

This consultation has not only helped to contribute to the development of those proposals but has also allowed us to add stakeholders and groups that we were not aware of to engage with in the future. Our Engagement Schedule can be found on our website www.telfordccg.nhs.uk/who-we-are/publications/publications/engagement/5127-nhs-future-fit-timetable-of-public-events-may-sept-2018/file

The full consultation report which sets out how the consultation was delivered and the feedback received can be found on the Future Fit website nhsfuturefit.org/the-consultation/about-the-consultation

Signposting campaign

NHS Midlands and Lancashire Commissioning Support Unit's (MLCSU) Communications and Engagement Service were asked to develop a campaign proposal to support us to communicate changes we made to the local walk-in centre provision. At the same time, the campaign would also educate patients and the public on the options available to them to access healthcare services.

The campaign was launched and included social media advertising, outdoor advertising and printed material. The printed material was shared with our GP practices, stakeholders and voluntary and community groups.

As part of the process we met with both the Polish and Chinese communities to ask for their feedback. It was identified that leaflets in English were not picked up by these communities, however they would read any information that was printed in their language. The material for the campaign was translated and printed into Polish and Chinese and shared with the community.

A review of the campaign, carried out in April 2018, has shown that patients are now aware of NHS 111 and that their local pharmacy can also help with minor ailments.

With the introduction of the GP Extended Hours in October 2018, the leaflets have been reviewed to include information about how patients can access GP appointments during evenings, weekends and at Bank Holidays.

Gluten-free prescribing

Gluten-free (GF) foods are prescribed to people who are diagnosed with gluten sensitive enteropathies or, as it is more commonly called, coeliac disease. Many CCGs, like ours, restricted the type and quantity of GF foods available on prescription prior to national engagement and a growing number of CCGs have discontinued GF prescribing altogether.

We decided to engage with patients and the wider public on a proposal to discontinue providing gluten-free foods on prescription. This was because the decisions that we make about how to spend its budget has implications for all residents of Telford and Wrekin. Locally, this will release monies that can be invested in other local healthcare services. An Equality Impact Assessment was carried out prior to the engagement work.

Patients, carers and the wider public were given the opportunity to have their say by taking part in a survey. In addition, the engagement team visited the Bickerstaff Endoscopy Unit on a couple of occasions to speak to patients as they attended the gastroenterology clinic. During the engagement, information was sent to all GP practices.

The feedback from the engagement was analysed and presented to the Programme Management Committee (PMC) and the Performance, Planning and Quality (PPQ) Committee. In July 2018, our Governance Board was asked to consider the engagement report and support the PPQ's recommendation to disinvest in all gluten-free prescribing for people with gluten sensitive enteropathies. The Board confirmed that they had considered the engagement report and our response to the key themes that were highlighted during the engagement process. The Board endorsed the decision by the PMC and the PPQ to disinvest in all gluten-free prescribing.

To help support patients, information from the Coeliac Society around 'Shopping on a Budget' has been distributed to GP practices and the Telford Foodbank will include the information in any food parcels that are gluten-free. Read more at www.telfordccg.nhs.uk/get-involved/feedback-on-completed-involvement-activity/gluten-free-prescribing

GPFV – GP Extended Access

The General Practice Forward View (GPFV) published in April 2016 set out plans to enable CCGs to commission and fund additional capacity across England. The aim is to ensure that everyone has improved access to GP services by 2020. This includes sufficient routine appointments at evenings

and weekends to meet locally-determined demand, alongside effective access to out of hours and urgent care services.

Shropshire CCG, our CCG and the Shropshire Patient Group held a large event and extended an invitation to the Telford Patients First Group. The event was very well attended by patients, carers, GPs and CCG staff.

Presentations were given by Shropshire CCG and us on the background to the GPFV and GP Extended Access. Attendees were then given the opportunity to have table discussions on the presentation and offer feedback. They were then asked to help develop the first draft of a survey that would be made available to all patients during April and May 2018. A survey for patients, carers and the general public to complete was developed. This was sent out to all GP practices together with a poster. In addition, information was sent to our local radio station and local newspaper. Social media was used to encourage people to have their say on future access to GP appointments.

Telford Patients First Group invited the Head of Primary Care to attend their open meeting. She spoke about the GP Extended Access which should be implemented from October 2018 and did say that the Government had set a very difficult challenge for us to meet. Access for patients will be what patients need, not necessarily what the Government stipulate. The group were able to have a lively discussion and feedback on their own views and issues. It was decided to meet with the group again, once the scheme had been implemented and a period of settlement had passed.

The Assuring Involvement Committee (AIC) invited the Head of Primary Care to their October 2018 meeting to present the local scheme and the Communication Plan.

Following the implementation of the local GP Extended Access scheme, we held a focus group in February 2019 for members of the Telford Patients First Group. This was an opportunity for the group to feedback on how the scheme was implemented, and the current accessibility of appointments.

Read more at www.telfordccg.nhs.uk/news-and-updates/news/501-the-gp-extended-access-service-telford-and-wrekin-gp-practice-patients

Procurement of the Community Gynaecology Service

The current Community Gynaecology contract was awarded on 17 November 2015 for three years, with one year's extension until 31 October 2019. We now need to start a tender exercise to ensure that the service is in place for 1 November 2019. A new tender would be commissioned as a like for like service, with very few minor amendments to the service specification.

The commissioner of this service took into account comments and surveys carried out by the current provider. For 2018/19 they did not receive any comments, compliments or complaints. Anecdotal feedback from service users was very positive - they prefer to access the service in the community and the turnaround from referral through to treatment was confirmed to be very quick.

In November 2018, a 'marketplace event' was held for GPs and health professionals to discuss the clinical pathway. A number of suggestions were made which will be considered by the commissioner.

During December 2018, the commissioner and Quality Lead for Integrated Care engaged directly with service users at the current clinics. Open discussions were had with the patients and a lot of feedback was gathered. All women liked the community venues and confirmed that they should stay.

In addition, the commissioner shared the service pathway with local GPs at their Forum meeting and the GP with specialist interest in Women's Health and Sexual Health. A number of comments were made that will be considered as part of the procurement process.

The commissioner is working with the project team to develop the pathway and specification to take on comments collected as part of the engagement, which will form the final specification to go to tender around March or April 2019.

Procurement of optometry services

A joint tender process has been undertaken with Shropshire CCG to identify a new provider for the optometry service to commence from 1 April 2019.

The commissioner from this service attended the Telford Patients First Group meeting in July 2018 and talked about the services. The group were able to give feedback on the current services. In addition, the commissioner visited the local Rheumatoid Arthritis Support Group to gain views and attended a number of optometry practices to hear the views of people currently using the service and gain feedback from the professionals involved in the delivery of the service. Patient surveys were also reviewed to gather information on the services.

Procurement of termination of pregnancy service (TOPS)

We and Shropshire CCG have a joint contact with a provider to provide a Termination of Pregnancy Service (TOPS) across the county.

The initial contract was awarded on 1 December 2015 for five years. The current provider formally notified the CCGs of their intention to serve notice on the contract on 31 August 2018 due to difficulties with the current contract. In order to change the elements of the contract, the CCGs needed to start a tendering process, and the provider agreed to extend their contract to 30 November 2018.

In addition to the procurement and tendering process, the commissioner has worked collaboratively with public health and primary care to run a campaign to promote safe sex and contraception with an aim to lower the number of unplanned pregnancies.

Supported by the Family Nurse Partnership, the commissioner held an activity with young people in June 2018. They looked at written information for young people about the termination of pregnancy service, and supported the tender process.

Urgent Treatment Centre

Urgent and emergency care was identified as one of the NHS' main improvement priorities in the NHS Five Year Forward View. There is a focus on improving national A&E performance whilst making access to services clearer for patients. As part of this, the CCGs are required to commission an 'Urgent Treatment Centre' (UTC) that offers a set of nationally-mandated core services and standards by December 2019.

As the current contracts for the GP-led urgent care service (co-located in Shrewsbury and Telford and Wrekin) are coming to an end, a decision has been made by both CCGs to undertake a joint

procurement for the new UTC service. The UTC service will offer a similar but enhanced delivery model to the current service offer.

Urgent Treatment Centres will:

- Maintain the 12 hours a day, 365 days a year primary care-led service co-located in A&E
- Retain the GP-led option in A&E
- Retain the walk-in option
- Offer pre-bookable appointments through NHS 111.

The main engagement activity aimed to inform and engage with local patients who have accessed the service to capture their feedback on the new Urgent Treatment Centre proposals. It also aimed to promote and raise awareness of NHS 111 as the best number for patients to call if they have an urgent care need which cannot be met through in-hours GP services.

Part of the engagement plan included talking to local groups, whose members may have used the current GP-led urgent care service. In addition, an informal survey was available for a two-week period in the form of 'What Matters to You?'. It included simple questions to gauge interest in the option of pre-bookable appointments, any comments around the proposed opening times and any other general feedback. The survey was available in the current facilities in A&E in paper format for patients to complete, as well as an online version.

Feedback from the survey showed that most people would like to be able to book an appointment for the UTC. However, there was a disparity between the paper surveys and those completed online. Responses on the paper survey were supportive of the suggested opening times, whereas those completing them online strongly disagreed with the opening times, and instead requested 24-hour care. This could be attributed to local press coverage and a similarity in name to another service which will be part of the larger NHS Future Fit programme of work.

Procurement of non-emergency patient transport (NEPT) service

NHS-funded non-emergency patient transport services help eligible patients who have a health need, and are unable to travel by private or public transport, to get to and from healthcare services for either daily living, a non-urgent or planned journey.

This service mainly helps eligible patients who are either accessing hospital healthcare services, being transferred between health services or being returned back to their place of residence. NEPT services aim to give patients safe, timely and comfortable transport whilst ensuring they are safe and well. These services are available free of charge to eligible patients. CCGs also fund non-emergency patient transport to allow eligible escorts or carers to travel with a patient, where they have skills that cannot be provided by the ambulance staff or when required to travel with a child who is under 16.

The current NEPT service in place across Shropshire, Telford and Wrekin has been in operation for the last four years, and the contract will come to an end in October 2019. The CCGs must take action to ensure there is no gap in service.

We need to ensure the eligibility criteria for patients accessing NEPT is applied fairly ensuring our service is focussed on those patients with a genuine medical need. The proposed new universal NEPT service will be for patients accessing healthcare services at hospitals and community services.

The new service will include updated eligibility criteria, which will mean that eligibility will be checked for all patients, and will be the same at each NHS service. It will also mean that patients travel by private or public transport if they are able to do so.

During February and March 2019, engagement was carried out in Shropshire, Telford and Wrekin with a number of groups, including:

- Healthwatch Shropshire and Healthwatch Telford and Wrekin
- Telford Patients First Group
- Market Drayton Senior Citizens Group
- Donnington PPG
- Jayne Sargent Foundation cancer support group
- Chair of Carers Partnership Board, Telford
- Care and Membership Liaison Officer, Shropshire Partners in Care.

The feedback from these groups identified a number of issues. In particular there were concerns that carers would not be allowed to accompany their loved ones on their journey. Another concern was that patients who would ordinarily be able to transport themselves to an appointment, may not be able to drive themselves home following certain procedures (i.e. chemotherapy, laser eye treatment). The feedback has been considered within the specification.

Patient feedback and relevant data

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

The primary data source we use for population health is the Joint Strategic Needs Assessment (JSNA). The JSNA is a statutory process undertaken by Telford and Wrekin Council to inform the development of priorities across the borough for the Council, us and other partners.

The process brings together and explores a wide range of data, performance information and intelligence to identify those issues where the borough is doing well and also those which remain a challenge and where more needs to be done. This data is used our Commissioners to begin service redesign projects and to help determine what services we need for our local population. The Communications and Engagement team also consider this information when stakeholder mapping for specific engagement/consultation projects.

The JSNA is not one single document - individual parts of the JSNA can be found on Telford and Wrekin Council's facts and figures pages at www.telford.gov.uk/info/20121/facts_and_figures

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

- Complaints and PALs queries made to us and our providers which can highlight trends
- Quality and Commissioning teams also gather information from quality and contracting meetings with our providers on patient experience and quality issues
- Surveys of GP patients and other services we commission
- NHS Friends and Family Test outcomes by provider
- Information received via Healthwatch Telford and Wrekin
- CQC reports.

How we reach diverse and potentially excluded groups

Specifically, in relation to our obligations under the Equality Act, when identifying stakeholders for engagement, we will be sure to seek out the ‘seldom heard’, looking at the nine protected

characteristics plus carers, people who suffer from a mental health problem or addiction and those who are socioeconomically deprived. These nine characteristics are outlined in the Equality Act 2010. To support development of commissioning plans and decision making, it is essential that engagement and communication methods consider the needs of people with a protected characteristic and enables them to participate.

An example of how practical engagement delivery is designed to meet the needs of our diverse population, is the Future Fit consultation which not only had to engage the wider population, but also had to ensure that we engaged and involved those people who would traditionally not take part or not feel able to take part. Our schedule of who we engaged with during this consultation demonstrates the wide range of people we engaged with, from the congregation of two African churches meeting in Brookside community centre to an Age UK run centre in Newport. This schedule is available on our website www.telfordccg.nhs.uk/who-we-are/publications/publications/engagement/5127-nhs-future-fit-timetable-of-public-events-may-sept-2018/file

This example, and others that have been undertaken in year, has enabled progress to be achieved in line with our equalities objective 1, where we are improving lives of local people and patients.

Working with patient groups and the voluntary sector

Throughout the borough of Telford and Wrekin, there are myriad of patient groups and voluntary organisations supporting people. During 2018, there has been regular engagement with these groups by visiting their meetings and discussing commissioning intentions and getting feedback from those attending. Regular attendance at the meetings helps to build trust, and patients then feel that they can share their experiences with us. To find out who we have engaged with during 2018/19, visit our website www.telfordccg.nhs.uk

Some examples include:

- Working with local charity the Jayne Sargent Foundation and Breast Cancer Support Group to help develop our Cancer Strategy.
- Regular visits to the Telford Patients First Group along with commissioners to discuss changes to surveys and listening to their feedback
- Linking in with a number of mother and baby groups to talk about their experiences of using local maternity services
- Visiting the local Gurdwara following prayers to talk to the congregation about the NHS Future Fit consultation and listening to their feedback
- Establishing a monthly drop-in clinic at the local gypsy and traveller site to help the residents to access local services.

We also work very closely with Healthwatch Telford and Wrekin and other specific voluntary groups like Telford Patients First Group, Impact and Telford After Care Team (TACT) to deliver engagement activity in partnership or on behalf of us. This year, these relationships have proved very important to the successful and wide-ranging delivery of the Future Fit consultation, and we would like to thank these organisations for their valuable contribution.

How we involve patients and the public

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

- News releases
- Website
- Newspaper columns
- Radio adverts
- Website updates
- Posters and leaflets in GP practices and community venues
- Social media, for example Facebook and Twitter
- Sending event attendees reports of the outcomes
- For some projects: newsletters and direct communication
- Attending individual groups and organisations to feedback face-to-face on how their views were used and changes we have made as a result
- Individual phone calls and emails to people who have been involved
- The yearly Telford and Wrekin CCG Annual General Meeting
- Our stakeholder newsletter – if you would like to sign up to receive a copy of the stakeholder newsletter direct to your inbox, then please email twcccg.patientservices@nhs.net
- Our membership scheme – if you would like to join, please email twccg.patientservices@nhs.net or telephone 01952 580407
- The Telford Patients First Group is a voluntary group, independent of us, that aims to provide a conduit for patients to have their voices heard by NHS organisations. We have a close working relationship with this group as a key patient group in our area and a vital way in which patient feedback is both passed to us but also disseminated out to PPGs.

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

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

Patients can apply to be part of the Assuring Involvement Committee, where they are supported by an induction process so that they have an understanding of how we work and our legal obligations, followed by more formal training (for example Information Governance).

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

Our reading group has been supported and involved in checking any of our documents that will be public facing. They have been involved in a number of projects including the consultation document for gluten-free prescribing and the survey for GP Extended Access.

Learning and best practice

Our experience of delivering a public consultation for Future Fit together with our neighbouring CCG in Shropshire has been challenging in terms of time commitment and available resources required. However, in terms of the number of responses totalling 18,858 from all geographical areas, with the

largest response from people in Telford and Wrekin, it proved to be very beneficial in confirming where people's concerns lay with the proposals. Not only have we made contact with a number of groups and individuals which will help for future engagement, our engagement staff also have a more detailed understanding of the processes and delivery methods that work with different groups of people, to illicit a response that can be used to design improved engagement in the future.

Future plans

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

- Refreshing our Communications and Engagement Strategy
- Delivering public consultation on midwife-led units in our STP area
- Working with Healthwatch Telford and Wrekin to ensure that local residents are fully engaged with Telford and Wrekin's transformation of health and care services
- More integrated working with our communication and engagement colleagues across our Strategic Transformation Plan (STP) area to share knowledge and expertise
- Supporting neighbourhood initiatives to build local networks as a key enabler for our self-care and management of long-term conditions projects
- Enhancing our relationships with seldom heard groups that make up the nine protected characteristics in our area and building new ones
- Delivering engagement Forums, workshops, focus groups, commissioning intentions events our Annual General Meeting.

Patient Advice and Liaison Service (PALs)

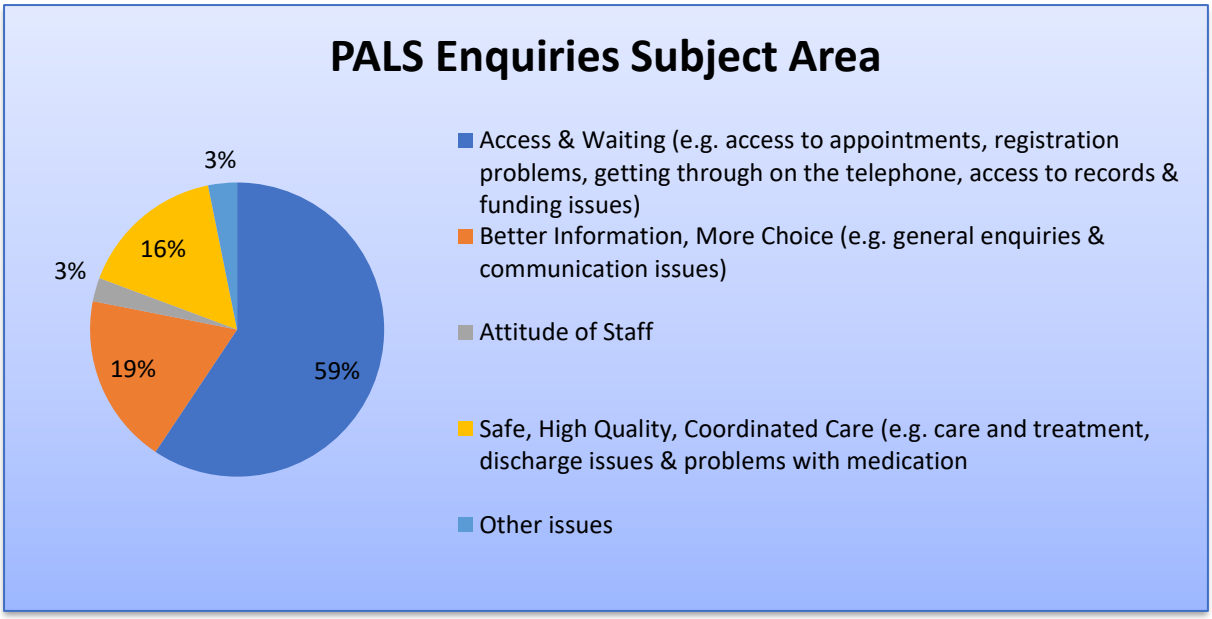
PALS is integral to Telford and Wrekin CCGs commitment to working closely with patients and staff to improve services.

All enquiries received through PALS are recorded on a database and used to improve services. 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 2018/19, 347 contacts were received through PALS, this is a significant decrease on the number of enquiries received the previous year.

The table below illustrates what PALS enquiries related to:



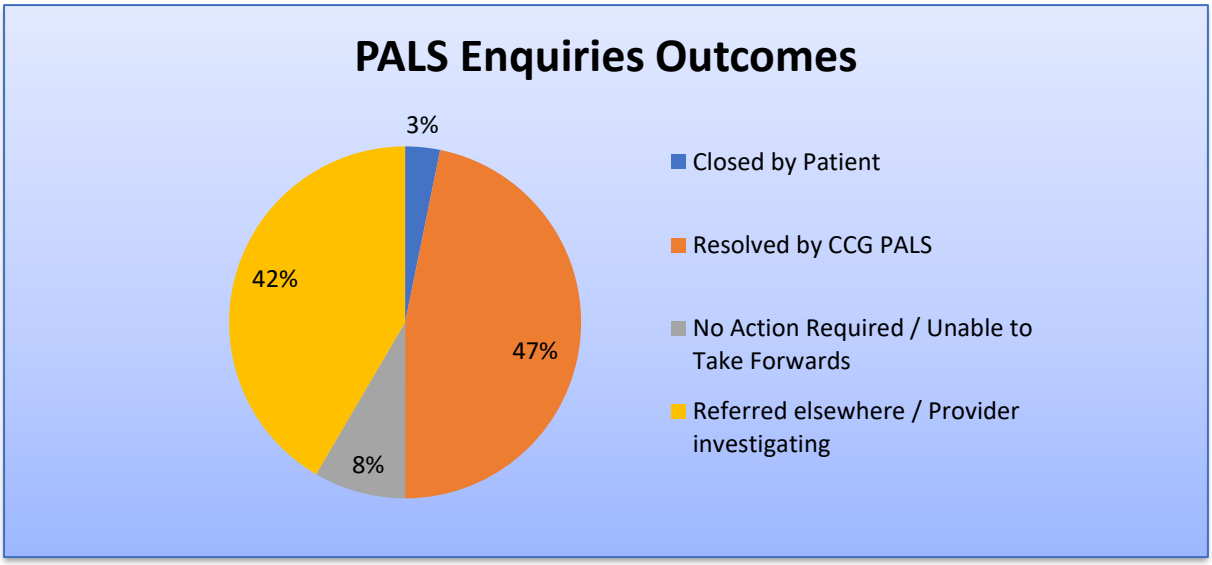
Over half the PALs queries we received raised concerns around gaining access to services.

For primary care this related to difficulties getting a timely appointment and getting through to GP practices on the telephone.

For hospital services this was about waiting times for appointments and referral issues.

From a CCG perspective, the majority of concerns were around getting through to CCG services via the telephone. There were also a number of enquiries about services that are not funded by the CCG as detailed in the Excluded and Restricted Interventions Policy.

The below table illustrates PALS enquiries outcomes:

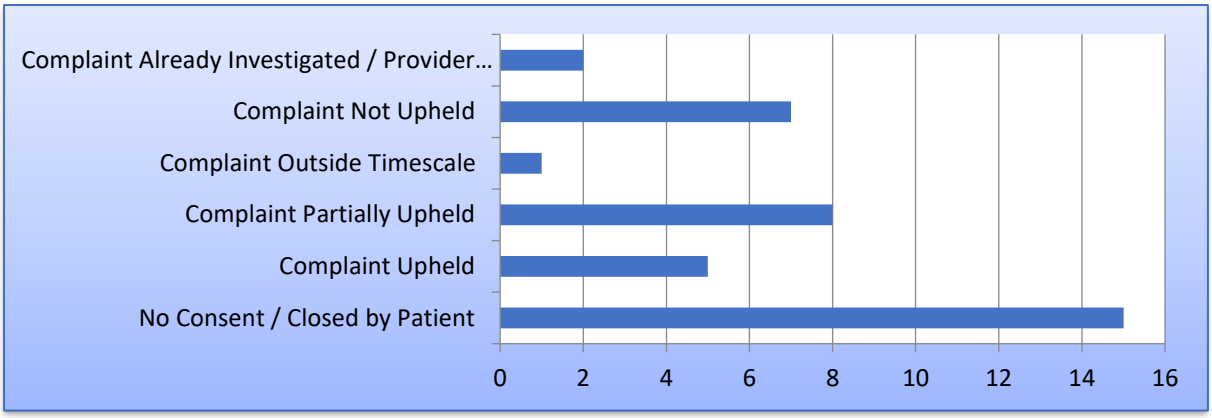


Of the 347 contacts received, 47% were resolved by the CCG PALS Service and 42% were referred to providers for the matter to be resolved directly.

Complaints

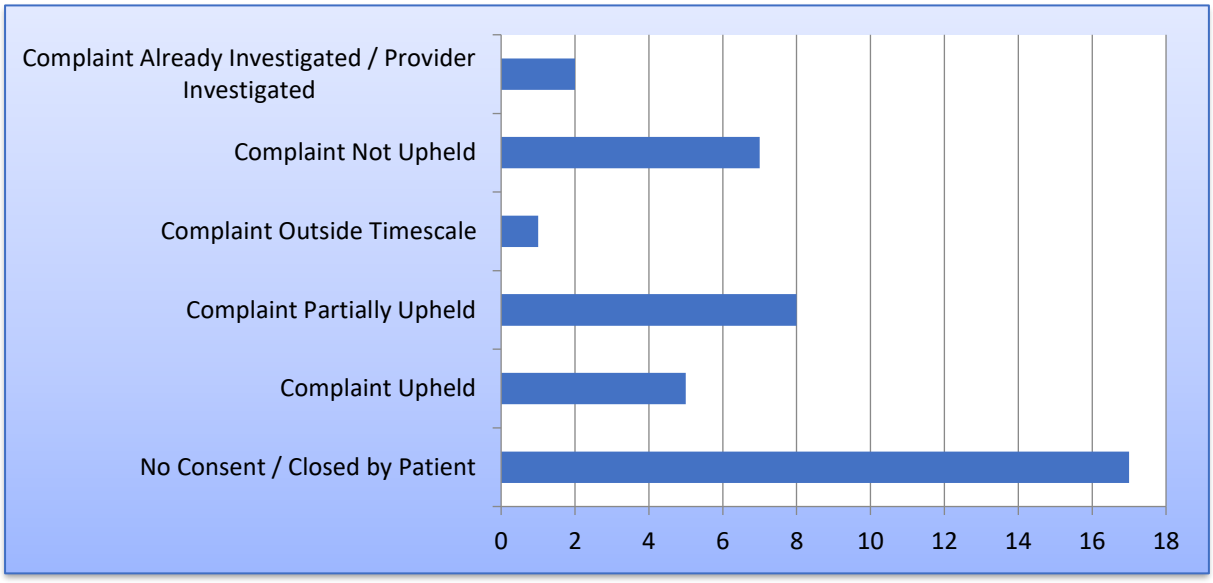
Last year (Apr 18 to Mar 19) Telford and Wrekin CCG received 67 complaints, which related to a number of providers commissioned by the CCG, this is an increase on the number of complaints received the previous year.

The table below illustrates the service areas complaints received related to:



Of the 67 complaints received, 18 cases are ongoing and 40 cases have been closed.

The table below illustrates the outcomes of the complaints where the process has been completed:



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

- Following concerns being raised about care, a service has now put a process in place for monthly reviews of patients by a senior nurse. In addition nurses are being encouraged to escalate any challenges they may have in a daily meeting. Improvements have also been made to the handover process, when a patient is transferring to another service

- The CCG demonstrated its willingness to learn from feedback by reviewing its policy and updating it to better reflect national guidelines
- Waiting times at a local service highlighted capacity issues. In order to address this, they arranged for weekly reviews of patients lists by senior management and for a higher level of scrutiny. Patients who were on the waiting list for 12 weeks are now reviewed by the Clinical Director to monitor any deterioration and expedite the referral as required. In addition, the Consultant is providing additional clinics, whilst the service tries to increase their workforce
- Concerns were raised around issues with prescribing of a specific medication, as part of the outcome to the concerns the CCG agreed to share learning with all GP Practices via a newsletter to help prevent further problems occurring in future.

MP Letters

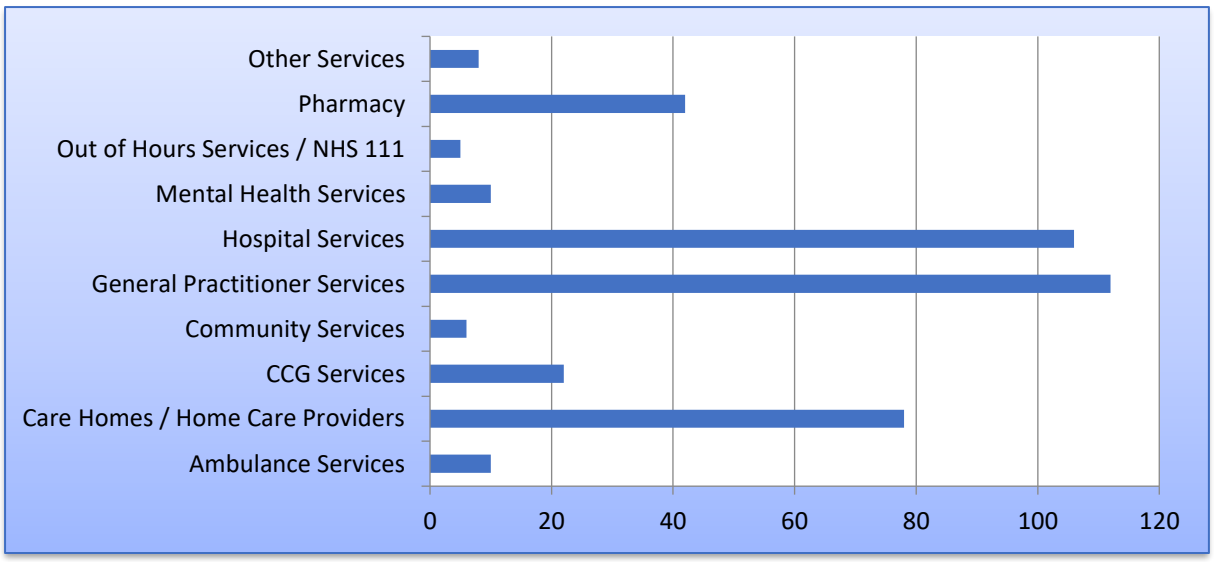
During 2018/19, Telford and Wrekin CCG received 16 MP letters/emails which related to the care that constituent were receiving; nine of these related to care provided by commissioned services, three were around CCG commissioning decisions and four related to services not commissioned by Telford and Wrekin CCG. The majority of concerns that were raised related to access to services.

NHS to NHS Concerns

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

During 2018-19, Telford and Wrekin CCG received 399 N2N concerns, 297 of these were medication issues which are managed separately by the Medicines Management Team.

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



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

- A meeting was arranged between two local providers in relation to how they can work better together to support local patients who opt to have a termination of a pregnancy

- A service highlighted delays in referrals reaching them. This highlighted an issue within the referral assessment service. The service made changes to their process to prevent delays in future
- Following a service receiving mismatching information on a referral, which related to more than one system being used, the providers are working together to combine the two data feeds which should lessen the risk of mismatched patient information in the future.

Equality report

We are 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:

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

EDS2 can also be applied to people from other disadvantaged groups who may experience difficulties in accessing NHS services. This includes: 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. For more information on the scoring mechanisms, visit www.england.nhs.uk/about/equality/equality-hub/eds/

The results of our assessment can be found on the Equality and Diversity page of the CCG's website: www.telfordccg.nhs.uk/who-we-are/equality-and-diversity

We have rated ourselves 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 utilise some key processes to help them understand in more detail how different groups access healthcare:

A key source of information is the Joint Strategic Needs Assessment (JSNA) for the resident population of the CCG, which analyses the health needs of the population of the area. The JSNA informs and guides commissioning of health, wellbeing and social care services to improve health and wellbeing and reduce inequalities. The JSNA informs Joint Health and Wellbeing Strategy. The JSNA and the Joint Health and Wellbeing Strategy is available at: http://www.telford.gov.uk/info/20121/facts_and_figures/424/joint_strategic_needs_assessment_jsna

The most recent 2015 Telford and Wrekin population profiles are available by ward at: www.telford.gov.uk/factsandfigures

We utilise the standard NHS contract which places a requirement on providers to ensure that they consider the needs of individuals in the delivery of their services, including disability access and equity of access. These are monitored as part of the Contract Monitoring process. To improve our 'developing' rating, we intend to work more with providers on the recording and reporting of protected characteristics.

We have made targeted efforts 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. These include:

NHS Future Fit: During 2018 along with Shropshire CCG, we ran a 15-week consultation called NHS Future Fit. It concerned the reconfiguration of the acute hospital services in Telford and Wrekin, Shropshire and Mid Wales. This gave us the opportunity to find and talk to many different support groups, organisations and voluntary sector colleagues that are part of the nine protected characteristics, but also further demographics (such as: people of no fixed abode, gypsy and traveller families, people living with mental health issues and people recovering from addictions).

As part of the NHS Future Fit consultation, an Equality Impact Assessment was carried out. This highlighted that for some patients, changes to service delivery could have a significant impact on their ability to attend hospital due to transport and travel needs. A separate transport and travel group was established to look at this area in more depth, to ensure an equal access to services when changes are implemented.

More information about the NHS Future Fit consultation is available within the Future Fit consultation findings report nhsfuturefit.org/key-documents/consultation-findings/587-future-fit-consultation-findings-report/file

For more detail about who we engaged with in Telford and Wrekin, view their matrix www.telfordccg.nhs.uk/who-we-are/publications/publications/engagement/5127-nhs-future-fit-timetable-of-public-events-may-sept-2018/file

NHS Future Fit Equality Impact Assessment nhsfuturefit.org/key-documents/impact-assessment/2018-2/649-equality-impact-assessment-v26/file

Women and Children's Quality Impact Assessment nhsfuturefit.org/key-documents/impact-assessment/2018-2/644-women-children-s-quality-impact-assessment/file

Engagement and decision-making processes are designed so that those groups or individuals who would be most impacted by a proposed change, are prioritised within engagement and involvement activity. This ensures a particular group of patients is not missed – for example, during the NHS Future Fit consultation a midway review was undertaken, which analysed whether further targeted work was required to ensure representativeness nhsfuturefit.org/key-documents/about-the-future-fit-programme/midpoint-review

The report highlighted a need to focus on a more diverse community (including race and religion) and engage more with pregnant women, young mums and parents. We did this by linking into the locally-run 'Bumps and Babes' and 'Mums and Toddlers' groups and visiting the meetings. In addition, we contacted the leaders of faith groups for the Gurdwara, Mosque and Hindu Temple. We went along and had face-to-face meetings with the congregation at the end of their religious services.

Local maternity services: As part of ensuring they are hearing the local population's views of their needs, we have been engaging with women who are pregnant or recently given birth and partners. This is as part of redesigning future services for the midwife-led units (MLU) and the local maternity services (LMS) as a whole. To allow new mothers to attend, we facilitated meetings where young children could come along and play, whilst their mothers and partners took part in discussions. With the help of our local authority and community health trust partners, we also identified a number of 'Mums and Toddlers' groups in specific areas where transport was an issue and visited the groups to talk with the members. As part of the LMS, a Shropshire, Telford and Wrekin Maternity Voices Partnership has been created by using social media (Facebook) to enable a wider group of women, partners and families to get involved. In addition, a number of face-to-face groups have also been established locally.

As well as these two major pieces of work, other examples of how we have targeted either particular groups or assisted individuals include:

Through the Patient Advice and Liaison Service: A visually impaired patient was reluctant to attend the GP practice for a flu jab, due to past negative experience of crossing the road to the surgery. A call was made to the GP practice who were more than happy to visit the patient at home and give them their vaccination.

Patients who experience an urgent change in their health conditions may be required to go into hospital. The Telford Integrated Community Assessment Team (TICAT), which is made up of professionals from adult social care and based at the Princess Royal Hospital, works with other professionals in the hospital. TICAT will talk with the patient and their carer, to assess the needs of the patient, so that they can be supported either at home or discharged to an Intermediate Care Team (ICT) bed. The ICT bed could be in a residential or nursing care home as a 'step down' from hospital care. The primary place for patients to be supported should be in their normal place of residence. Fact sheets have been developed, with input from families, for patients to help them understand the process. Feedback about this service from the patients is discussed at the Local Authority 'Making it real' Board.

Nationally there has been a decline in the number of women attending for cervical screening ('smear tests'). The CCG has started to work with the local authority community team and public health to engage with women in those areas, where there is a particularly low uptake, to try to establish what

the barriers are for attending and how women can be encouraged to take up the invitation to screening.

Working with the community nurses, the CCG will be holding monthly open clinics and advice sessions at the local gypsy and traveller sites. Many mums have indicated that they would like their children vaccinated against the flu and the HPV, so working with the community nurses, they will be offered the chance to have the vaccinations at the community centre on the traveller site.

We to record equality monitoring data as part of our complaints function. From this monitoring of the complaints data, it can be seen that the majority of complainants are White British and heterosexual, which would require us to explore why other groups are not utilising the complaint process. We met with a local Asian women's group and Down Syndrome Support Group in order to try to understand boundaries to making a complaint. Further work will be done with the nine protected characteristics during 2018/19.

We continue to ensure we reinforce the Accessible Information Standard, via a staff policy to help ensure that those people suffering from a visual or sensory impairment are able to specify how the CCG will communicate with them about their medical treatment. See 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 their aim to make strong links with those groups that make up the nine protected characteristics and other groups like people suffering from mental health problems, substance misuse, etc.

As commissioners of services, the we have contracts with the organisations who 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. We require all provider contracts to contain equality and diversity clauses, notably as per Service Condition 13 of the NHS Contract. This applies to all of the nine protected characteristics. Compliance with this service condition is monitored as part of routine quality monitoring of each contract. That is, they must not discriminate on grounds of protected characteristics, must provide assistance and make reasonable adjustments where service users, carers and legal guardians do not speak English, or where they have communication difficulties. They must also provide a plan to show compliance with the legislation.

Examples of good practice from the providers we have worked with are:

- The dementia passport, butterfly scheme, carers' passport and learning disabilities patient passport - to allow patients and carers to access the hospital to support the person being cared for outside normal visiting hours. They also have a stay with me (John's campaign) for carers.
- A local speech and language therapy service has developed tray liners for meal trays that identify that a patient has a food allergy.
- Pink boxes have been introduced at a local hospital for patients to put their hearing aids in, to help prevent loss during an inpatient stay.
- Staff at local hospitals are being offered sign language training to assist with communication with hearing impaired patients. In addition, signers are available in clinic if advance notice is provided.
- A local gynaecology service has provided a side ward specifically for male to female transgender patients.

- One trust has patients from protected characteristic groups visit patient areas and talk to team leaders, in order to create more awareness of specific protected characteristics and how best to support these patients (e.g. disability groups, patients from the Polish community, LGBT group).
- Community hospital wards have made adaptations to be dementia-friendly environments and for certain physical disabilities.

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

- Improving lives of local people and patients
- Inclusive leadership and representative and supported workforce.

Workforce Race Equality Standard (WRES) requires us to ensure employees from black and minority ethnic (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 10.7 per cent in the Telford and Wrekin population. See the population and household characteristics report published by Telford and Wrekin Council in June 2017 http://www.telford.gov.uk/downloads/file/4218/chapter_2_population_and_household_characteristics

Telford and Wrekin CCG percentage of staff by pay band and ethnicity as at 31.03.2018

Pay Band	BME	Unknown / Not Stated	White	Average Total
Apprentice				
Band 2	33.33%	0.00%	66.67%	100.00%
Band 3	8.70%	4.35%	86.96%	100.00%
Band 4	0.00%	11.11%	88.89%	100.00%
Band 5	0.00%	0.00%	100.00%	100.00%
Band 6	10.00%	0.00%	90.00%	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%	
Band 8 - Range D	0.00%	0.00%	100.00%	100.00%
VSM	12.00%	8.00%	80.00%	100.00%
Grand Total	**9.35%**	**3.74%**	**86.92%**	100.00%

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

Based upon analysis of our WRES data, we have identified three key actions:

- Request and collation of ethnicity data of its Governance Board members
- Ensure that forthcoming local staff survey has ethnicity data requested.

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

The remaining action which will be addressed in the first quarter of 2019/20 is:

- 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 Equality and Diversity Policy. This ensures that no potential or actual employee receives less favourable treatment on the grounds of age, disability, sex, sexual orientation, race colour, nationality, religion or belief, national or ethnic origins, gender reassignment, pregnancy or maternity, marriage or civil partnership, or trade union membership.

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

We remain committed to ensuring that staff receive up-to-date and relevant equalities and inclusion training, which is described in the Equality and Inclusion report above. This is further supported by our Equalities and Diversity Policy, which sets out the 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." We have embraced this in our own strapline: "Healthier, Happier, Longer."

During 2018/19, progress continued to address the three priorities in the Health and Wellbeing Strategy:

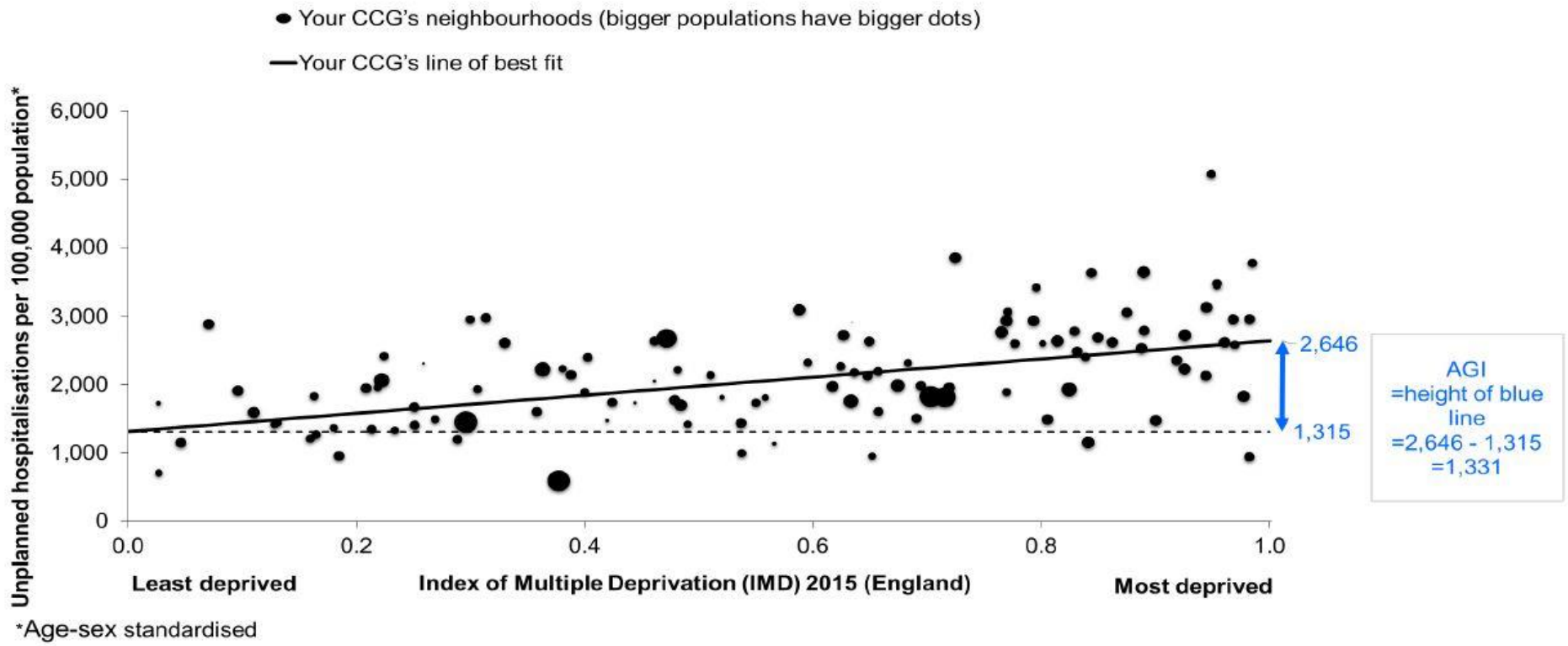
- Encourage healthier lifestyles
- Improve mental wellbeing and mental health
- Strengthen communities and community-based support.

There has been considerable progress on all three priorities during 2018/19, and on the CCG's joint work with the council on neighbourhood development.

Reducing health inequalities

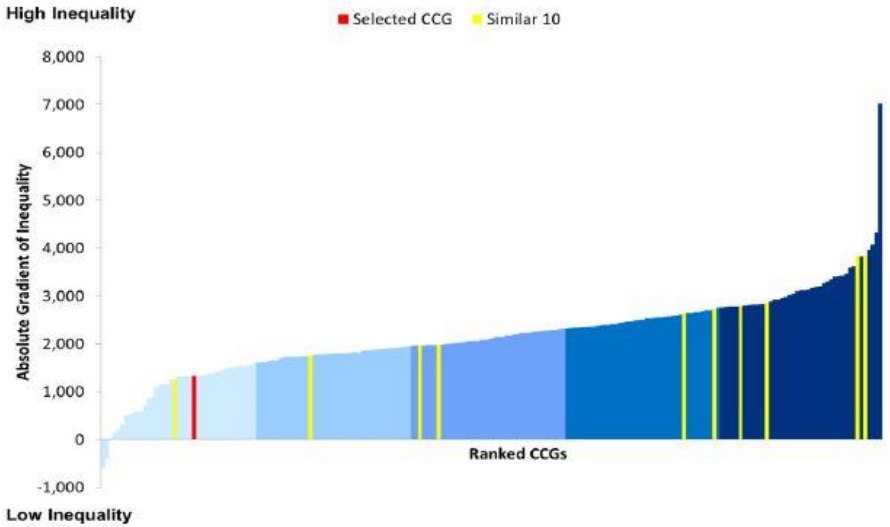
Emerging analysis from Rightcare demonstrates that we are reducing inequalities as shown is the following graphs. For areas with high inequalities between their most advantaged and disadvantaged communities, there are large differences in admissions to hospital for ambulatory care sensitive conditions. These graphs show that over time, the gap in admissions between populations in Telford and Wrekin has been reducing and that there has been an acceleration in the more recent trend.

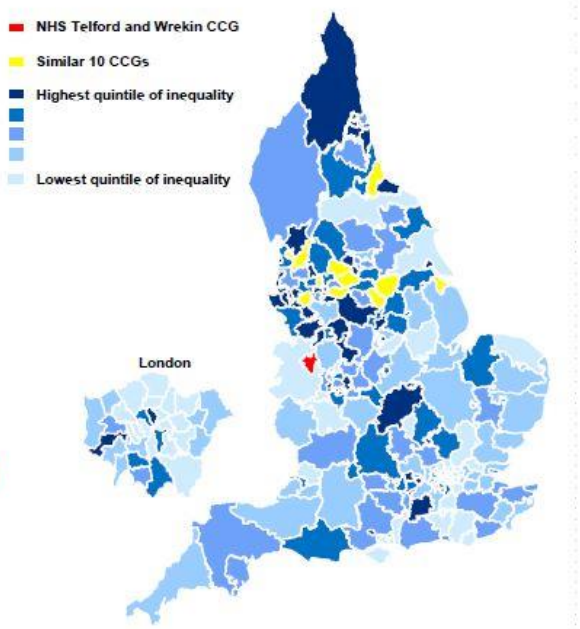
The graph below shows the Absolute Gradient of Inequality (AGI) for the CCG. The steeper the gradient of the line of best fit, the greater the height of the blue line, the greater the AGI and so the greater the inequality. The graph shows neighbourhoods, which are also known as Lower Super Output Areas (LSOAs).



Sources: Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.
Note: Numbers less than 6 have been suppressed when plotting neighbourhoods but have been included in overall calculations.

The graph below shows the Inequality in Telford and Wrekin CCG compared with their Similar Ten and other CCGs in England. Each ranked bar on the chart represents the level of inequality in a CCG. The red bar is Telford and Wrekin CCG, and the yellow bars are the Similar Ten CCGs. These CCGs are also shown in the table below alongside their Absolute Gradient of Inequality (AGI) value, ranked from lowest (1) to highest (11) inequality. The CCGs in the highest quintile have the highest levels of inequality. The heatmap shows the geographical variation in levels of inequality across the country. The darkness of shades shows the CCGs' inequality, with the darkest quintile having the highest inequality.*

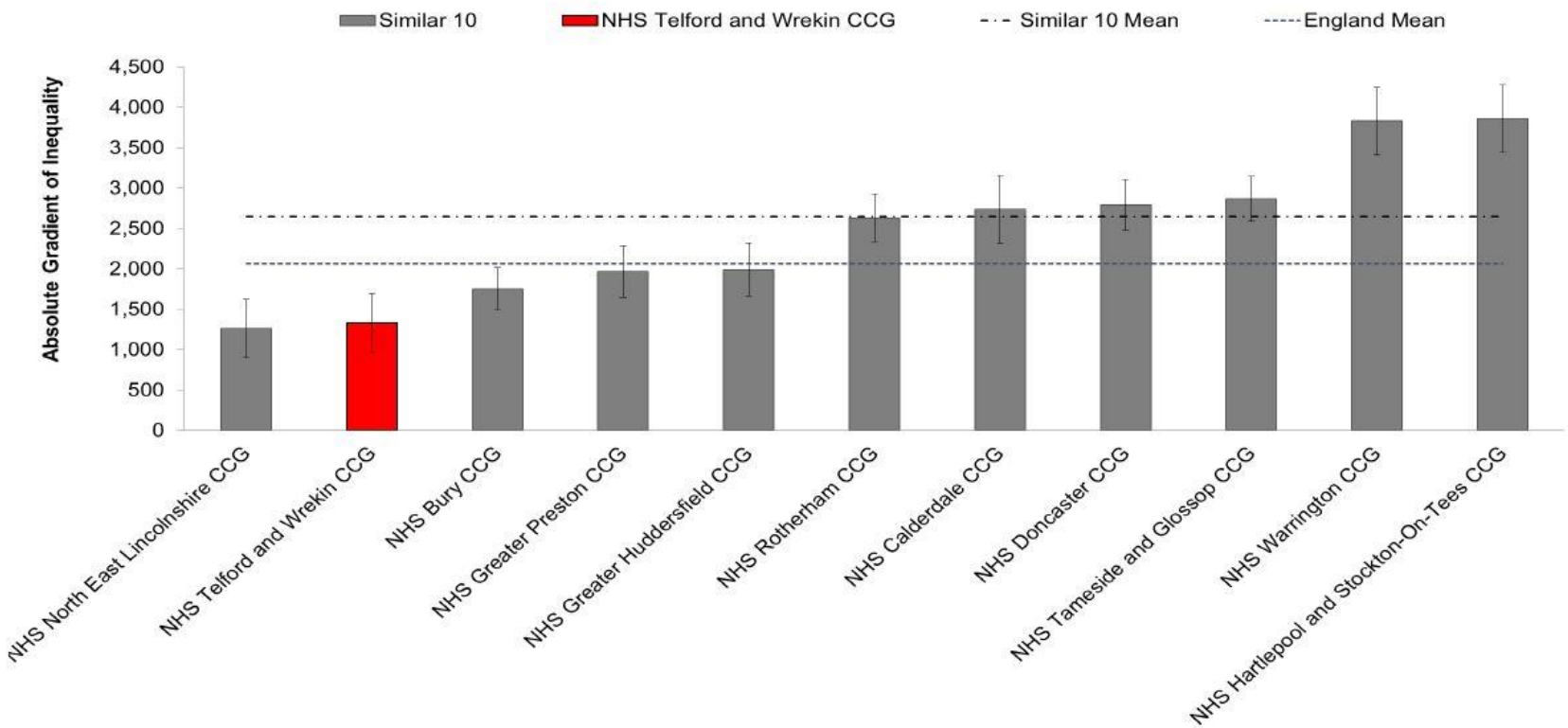




Rank	CCG Name	AGI
1	NHS North East Lincolnshire CCG	1,261
2	NHS Telford and Wrekin CCG	1,331
3	NHS Bury CCG	1,751
4	NHS Greater Preston CCG	1,968
5	NHS Greater Huddersfield CCG	1,990
6	NHS Rotherham CCG	2,633
7	NHS Calderdale CCG	2,737
8	NHS Doncaster CCG	2,790
9	NHS Tameside and Glossop CCG	2,869
10	NHS Warrington CCG	3,829
11	NHS Hartlepool and Stockton-On-Tees CCG	3,861

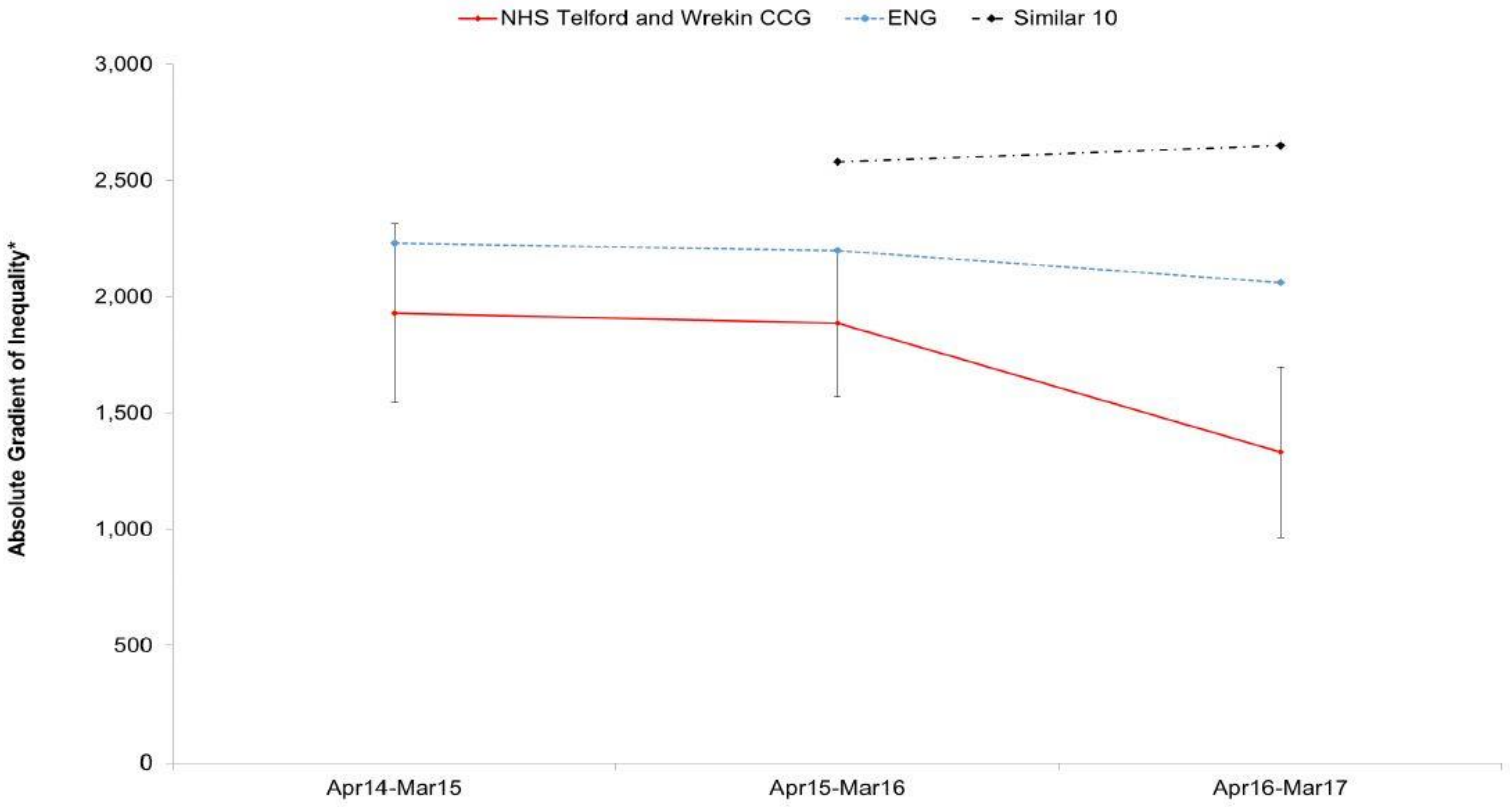
Sources: Unplanned hospitalisations: SUS 2016/17, NHS Digital, population data - CCG registered population, October 2016, NHS Digital
Notes: * Difference in age sex standardised rates of unplanned hospitalisation per 100,000 population between the most and least deprived neighbourhoods in England if England had the same inequality as the CCG. See NHS England CCG Improvement and Assessment Framework Technical Annex for more details.

The graph below shows Inequality in Telford and Wrekin CCG compared with their Similar Ten. The current levels of Inequality for the CCG and its Similar Ten CCGs are shown by the bars on the ranked chart. The 95 per cent confidence interval error bars illustrate the uncertainty in the measure of equality. Horizontal lines represent the mean of the Similar Ten as well as England. CCGs that are below the Similar Ten Mean have less inequality than it's Similar Ten CCGs.



Sources: Unplanned hospitalisations - Secondary User Service (SUS) 2016/17, NHS Digital, population data - CCG registered population, October 2016, NHS Digital.

The graph below shows the Time Series for the CCG's Inequality compared with their Similar Ten and England. The current and previous levels of inequality for the CCG are shown by the solid line on the line chart. The 95 per cent confidence interval error bar illustrates the uncertainty in the measure of inequality. The England average, and the average of the Similar Ten are also shown as benchmarks.



Sources: Unplanned hospitalisations - Secondary User Service (SUS) 2016/17, 2015/16, and 2014/15 (where available), NHS Digital, population data - CCG registered population, October 2016, NHS Digital.
Note: * Difference in age sex standardised rates of unplanned hospitalisation per 100,000 population between the most and least deprived neighbourhoods in England if England had the same inequality as the CCG.

Accountability Report

Corporate Governance Report

Members Report

The CCG is a membership organisation composed of the 14 GP practices located within the geographical area of Telford and Wrekin. 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.

The member practices are outlined below:

Practice Name	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, Shropshire, 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, Shropshire, 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. Itis made up of a number of different clinical and non-clinical professionals, lay members, and patient representatives.

CCG Governance Board composition during 2018/19:

CCG Governance Board Member	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)	GP/Primary Care Health Professional Member
Dr Martin Allen (voting)	Secondary Doctor Member
Mrs Tracy Slater (voting)	Secondary Nurse Member
Mr Geoff Braden (voting)	Lay Member – Governance
Mr Neil Maybury (voting)	Lay Member – Patient and Public Involvement (PPI)
Mr Peter Eastaugh (voting)	Lay Member – Primary Care
Mr David Evans (voting)	Chief Officer
Mr Jon Cooke (voting)	Chief Finance Officer
Mrs Christine Morris (voting)	Executive Lead Quality, Nursing and Safety
Mrs Liz Noakes (non-voting)	Statutory Director of Public Health
Mrs Fran Beck (non-voting)	Executive Lead Commissioning
Miss Alison Smith (non-voting)	Executive Lead Governance and Engagement
Mr Patrick Spreadbury (non-voting)	Chair of the Assuring Involvement Committee – observer
Mr Clive Jones (non-voting)	Local Authority Member – observer

Committee(s) including Audit Committee

So that the CCG Governance Board can provide strategic direction to the CCG and to assure itself of the CCG's internal control infrastructure, we have 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 is:

- Mr Geoff Braden: Committee Chair and Lay Member - Governance
- Mr Neil Maybury: Lay Member - Patient and Public Involvement
- Mrs Carolyn Fenton-West: GP/Primary Care Health Professional Board member
- Dr Adam Pringle: GP/Primary Care Health Professional Board 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.

Register of Interests

Conflicts of interest, declared by Telford and Wrekin CCG's Governance Board members and other committees where membership is different, can be found on the our website 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

Telford and Wrekin CCG fully support the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year 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 Clinical Commissioning Group 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 CCG Accountable Officer Appointment Letter.

I also confirm that:

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

Governance Statement

Introduction and context

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

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

As at 1 April 2018, the Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The Clinical Commissioning Group includes 14 practices across Telford and Wrekin area, and has a head count of 104 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 Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial

propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group as set out in this governance statement.

Governance arrangements and effectiveness

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

NHS Telford and Wrekin Clinical Commissioning Group is a clinically-led membership organisation made up of general practices with 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 Clinical Commissioning Group 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 using the following link:

www.telfordccg.nhs.uk/who-we-are/publications/constitution/5547-nhs-tw-ccg-constitution/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 Clinical Commissioning Group Practice Forum meetings. The group has reserved some decisions to itself to make through the mechanism of Practice Forum which is outlined in the Scheme of Reservation and Delegation that forms part of the Constitution.

The Practice Forum met 10 times during the year. Practice Forum members and attendance are listed below:

	Names of Practice Forum members	Meetings attended during 2018/19
Charlton Medical Practice	Dr D Sharp	4
Charlton Medical Practice	Deseny Lucas	2
Court Street	Dr Teresa McDonnell	8
Court Street	Maria Humphries	10
Dawley Medical Practice	Dr H Bufton/Dr Adeleke	2/7
Dawley Medical Practice	Jude Williams	4
Donnington Med. Practice	Dr J Hudson (Chair)	10
Donnington Med. Practice	Angela Crompton	6
Hollinswood / Priorslee MP	Dr R Mishra	7
Hollinswood / Priorslee MP	Mala Mishra	2
Ironbridge Med. Practice	Dr M Garland/D Mehta	1/8
Ironbridge Med. Practice	Christine Parker	10
Linden Hall, Newport	Dr S Waldendorf	8
Linden Hall, Newport	Karen Sloan	6
Shawbirch Med. Practice	Dr C Freeman / Dr P Coventry / Dr C Garrington / Dr P Davies / Hazel Heinink	3/3/1/1/1
Shawbirch Med.Practice	Ruth Waldendorf	4
Stirchley Med. Practice	Dr M Innes	7

Stirchley Med. Practice	Tracie Craddock	10
Sutton Hill	Dr A Inglis	8
Sutton Hill	Hollie Sheldon/Tracy Oliver	8
Teldoc	Dr I Chan	7
Teldoc	Wayne Cooper/Nakash Lewis	1/3
Wellington Med. Practice	Dr D Ebenezer	6
Wellington Med. Practice	Tania Burrows	1
Wellington Road, Newport	Dr A Egleston	6
Wellington Road, Newport	Lynn Kupiec	7
Woodside Med. Practice	Dr M Awty	6
Woodside Med. Practice	Kirsty Arkinstall	5

As set out in the Constitution the Clinical Commissioning Group has delegated the majority of its decision making to the Clinical Commissioning Group 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/Primary Healthcare Professional 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 12 times during the year. The names of members and their attendance are listed below:

Names of Governance Board members	Board Role	Meetings attended during 2018/19
Dr Jo Leahy (voting)	GP Chair	11
Dr Jim Hudson (voting)	GP/Healthcare Professional Member	8
Dr Andy Inglis (voting)	GP/Healthcare Professional Member	9
Mrs Carolyn Fenton West (voting)	GP/Healthcare Professional Member	9
Dr Adam Pringle (voting)	GP/Healthcare Professional Member	9
Dr Martin Allen (voting)	Secondary Doctor Member	6
Mrs Tracy Slater (voting)	Secondary Nurse Member	11
Mr Geoff Braden (voting)	Lay Member – Governance	6

Mr Neil Maybury (voting)	Lay Member – Patient Public Involvement	10
Mr Peter Eastaugh (voting)	Lay Member – Primary Care	11
Mr David Evans (voting)	Chief Officer	10
Mr Jon Cooke (voting)	Chief Finance Officer	10
Mrs Christine Morris (voting)	Executive Lead Quality, Nursing and Safety	8
Mrs Liz Noakes (non-voting)	Statutory Director of Public Health	8
Mrs Fran Beck (non voting)	Executive Lead Commissioning	7
Miss Alison Smith (non voting)	Executive Lead Governance and Engagement	7
Mr Patrick Spreadbury (non-voting)	Chair of the Assuring Involvement Committee - observer	8
Mr Clive Jones (non-voting)	Local Authority Member - observer	7

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 risk management and quality governance controls. The committee met nine times during the year.

Names of Audit Committee members	Meetings attended during 2018/19
Mr Geoff Braden (Chair)	6
Mr Neil Maybury	8
Mrs Carolyn Fenton West	9
Dr Adam Pringle	6

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

- Assurance gained from and further development of the Board Assurance Framework (BAF) and Executive Risk Register
- Assurance gained from overseeing the development and recommendation of corporate and human resource policies
- Assurance gained from overseeing the continued development and self certification of the CCG against the Information Governance (IG) toolkit
- Assurance on quality process for triangulating information to monitor provider quality and ensuring high standards of safeguarding.
- Assurance on the CCGs 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 the CSU
- Assurance gained from Internal / External Audit reports
- Assurance on Quality Systems employed by the CCG
- Assurance on processes in place to manage conflicts of interest, gifts, hospitality and sponsorship and procurement decisions taken.

The Audit Committee undertakes an annual self-assessment of its own effectiveness to help inform its own programme of work and the annual report it presents to the CCG Governance Board annually.

Remuneration Committee recommends to the Board appropriate salaries, payments and terms and conditions of employment. It met four times during 2018/19.

Names of Remuneration Committee Members	Meetings attended during 2018/19
Mr Geoff Braden (Chair)	3
Dr Jo Leahy	4
Mr Neil Maybury	3
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 Very Senior Managers (VSM) and policy development

Planning, Performance and Quality Committee (PPQ) oversees and provides assurance on performance and quality of commissioned services. The committee met 10 times during the year.

Names of PPQ members	Meetings attended during 2018/19
Mr Neil Maybury (Chair)	7
Dr Andy Inglis	8
Dr Jim Hudson	8
Mrs Tracy Slater	7
Mrs Carolyn Fenton West	9
Dr Adam Pringle	1
Substitutes:	
Mr Geoff Braden (for Mr Neil Maybury)	1
Dr Adam Pringle (for Mr Neil Maybury)	1
Mr Peter Eastaugh (for Mr Neil Maybury)	1
Dr Jo Leahy (for Dr Jim Hudson)	1

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

- Assurance on financial performance including medium-term financial strategy
- Assurance on preparation for planning and contracting for 2019/20.
- Assurance on infection control and serious incidents via annual reports for 2017/18
- Oversight of policy development; elective caesareans – excluded and restricted procedures policy, procurement strategy, excluded and restricted policy and medicines management policies.
- Assurance on quality, innovation, productivity and prevention (QIPP) delivery
- Assurance on quality and performance outcomes.
- Assurance on safeguarding and continuing health care

- Assurance on patient involvement via the quarterly patients services report.
- Reporting by exception on Shrewsbury and Telford Hospital A&E / cancer under-performance
- Assurance on specific procurement projects: out of hours, primary care streaming, optometry services, wound dressings service, dermatology service, community gynaecology service.
- Assurance on particular services by exception: Emotional Health and Wellbeing Service 0 - 25, Local Maternity Services, Neurology services, co-ordinating commissioners update on West Midlands Ambulance Service (WMAS), Urgent Treatment Centre, Shrewsbury and Telford Hospital NHS Trust (SaTH) quality oversight, admission avoidance project, telemedicine working group, learning disability review programme, notification processes for looked after children, cessation of prescribing gluten free foods.

Individual Funding Committee (IFC) approves commissioning decisions for individual funding requests on behalf of the group. The committee met 10 times between 1 April 2018 and 31 March 2019.

Names of Individual Funding Committee members	Meetings attended during 2018/19
Mr Neil Maybury (Chair)	10
Dr Jim Hudson	8
Mrs Helen Onions	8
Mrs Jacqui Seaton	6
Mr Mike Grogan	4
Dr Adam Pringle (Substitute for Dr Hudson)	3
Dr Jo Leahy (Substitute for Dr Hudson on one case due to conflict of interest)	1
Mrs Fran Beck	0
Mrs Chris Morris	0

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

An analysis of activity between 1 April 2018 and 31 March 2019 shows the number of cases taken to the IFC for consideration was 26. From this the number of cases approved by IFC was 12.

The IFC has had no reviews (appeals) held to date during 2018/19.

The Assuring Involvement Committee

Assuring Involvement Committee is composed of a number of volunteer members of the public who submitted expressions of interest via an advertisement to become committee members. The role of the committee is to ensure that the CCG involves patients and the public in its decision making and strategic service design. The committee met 10 times during the period 1 April 2018 and 31 March 2019.

Names of Assuring Involvement Committee members	Meetings attended during 2018/19
Mr Patrick Spreadbury (Chair)	10
Mrs Christine Choudhary (Vice Chair)	9
Mrs Beverley Ashton	9
Mrs Valerie Dawson	10
Mr Neil Maybury (Lay Member PPI)	5

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

1. Scrutinising involvement, engagement or consultation plans for:

- Gluten-free prescribing
- GP extended access service
- Local maternity services
- NHS Future Fit
- Ophthalmology service
- Neighbourhood working
- Dermatology service
- Midwife-led units
- Gynaecology service
- Winter communications plan 2018/19
- Non-emergency patient transport Service (NEPTs)
- Telford Healthy Hearts campaign
- Urgent treatment centre

2. Receiving regular reporting on:

- Patients services quarterly report
- Progress against the CCG's Communications and Engagement Strategy Action Plan

3. Receiving update reports on previous engagement / involvement activities:

- Development of the Sustainability Transformation Partnership (STP) Cancer Strategy
- Cancer one-stop shop
- Cancer screening
- Admissions avoidance project.

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 2018/19 as the personal health budget support plans produced contained no identifiable risks as determined by the complex care clinicians. As such, none were escalated to the Personal Health Budgets Risk and Scrutiny Committee.

Programme Management Sub-committee oversees the delivery of the CCG's own quality, innovation, productivity and prevention (QIPP) targets and the development of new QIPP schemes for consideration. The sub-committee met 11 times during the year.

Names of Programme Management Subcommittee members	Meetings attended during 2018/19
Dr Jim Hudson	10
Mr David Evans	4
Mr Jon Cooke	8
Mrs Fran Beck	9
Mrs Chris Morris	3

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

- Performance monitoring delivery of 2018/19 QIPP targets
- Considering QIPP plans for 2018/19 for recommendation to the Planning, Performance and Quality Committee and Board.

Medicines Safety Sub-committee oversees the effective reporting and learning from medication safety incidents. The Sub-committee has met 4 times between 1 April 2018 and 3t March 2019.

Names of Medicines Safety Committee members	Meetings attended during 2018/19
Dr Aidan Egleston (GP)	1
Jacqui Seaton (Head of Medicines Management and Medicines Safety Officer)	1
Mike Grogan (Pharmaceutical Adviser)	4
Linda Geddes (Pharmaceutical Adviser)	3
Patsy Clifton (Nurse Prescriber, Wellington Medical Practice)	3
Patrick Spreadbury (Patient Representative)	4
Sharon Smith (Patient Engagement Lead)	3
Kathy George (Adult Safeguarding Lead)	2

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

- The committee receives details of all Medicines Safety Incident Reports received by the CCG and ensure that learning is cascaded across the CCG
- Since the formation of the CCG's Medicines Safety Committee and the continued inclusion of Medication Safety Incidents in the Prescribing Incentive Scheme, progress has been made in detection, reporting and learning from patient safety incidents
- The Medicines Safety Committee oversees the publication of a monthly Medicines Safety Newsletter which is distributed to GP practices including locum GPs, care homes, community pharmacies, and practice nurses
- The committee also highlights locally those medicines alerts that have been cascaded by Medicines and Healthcare products Regulatory Agency (MHRA) central alerting system to ensure that national issues are brought to the attention of local health and care professionals.

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. The committee met five times during the year.

Names of Clinical Pathways Committee members	Meetings attended during 2018/19
Dr Andy Inglis (chair)	4
Dr Jim Hudson	1

Dr Adam Pringle (Substitute for Dr Hudson)	2
Ms Helen Onions	0
Mrs Chris Morris	2
Mrs Laura Clare	3
Mrs Jacqui Seaton	0
Mrs Angie Parkes	4
Mrs Vicki Pike (substitute for Mrs Angie Parkes)	1
Mr Mike Grogan (substitute for Mrs Jacqui Seaton)	5
Mr Hitesh Patel (substitute for Mrs Jacqui Seaton)	1
Ms Ann-Marie McShane (substitute for Ms Onions)	5

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

During 2018/19 the Clinical Pathways Committee approved, under delegation from CCG Governance Board, six clinical pathways which included:

- Temporal arteritis
- Familial hypercholesterolemia
- Sub-cutaneous fluids
- Inflammatory bowel disease / irritable bowel syndrome
- Abnormal liver function tests
- Headache pathway.

Primary Care Commissioning Committee oversees the commissioning of primary care under delegated decision making authority from NHS England. It was a new Committee introduced in April 2015 following amendments to the CCG Constitution. The committee met seven times during the year.

Names of Primary Care Commissioning Committee members	Meetings attended during 2018/19
Mr Peter Eastaugh (voting)	7
Dr Andy Watts (voting)	3 out of possible 4
From 1 August 2018	6
Mr David Evans (voting)	5
Mr Jon Cooke (voting)	5
Mrs Christine Morris (voting)	4
Mrs Fran Beck (voting)	6
Miss Alison Smith (voting)	6
Dr Adam Pringle (non-voting)	6
Mrs Carolyn Fenton-West (non-voting)	4

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

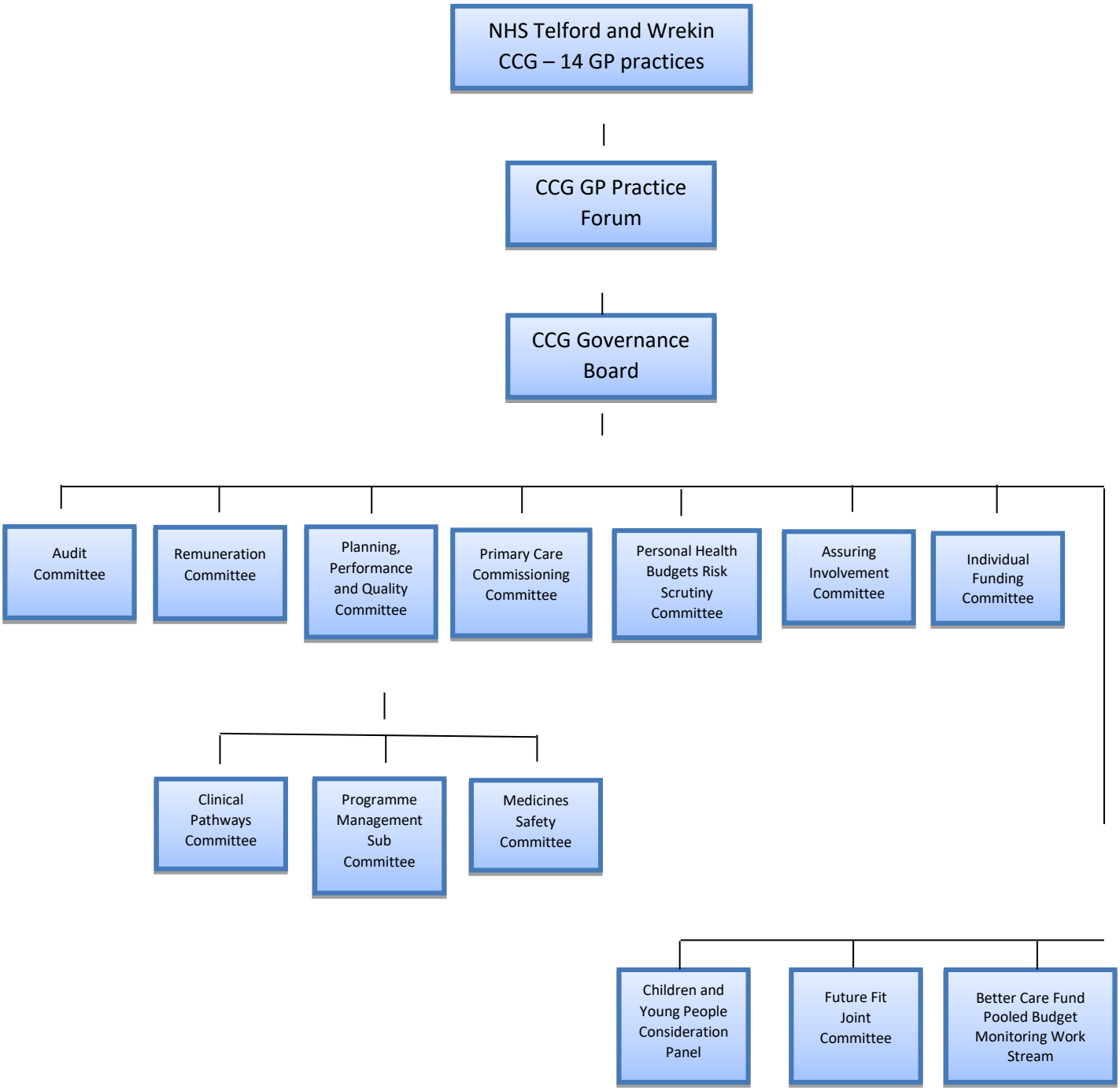
- The committee has continued to oversee development of the governance processes to support robust decision making; established clear expectations regarding declarations of interest, quarterly assurance reports completed and submitted to NHS England and a risk register for primary care commissioning

- Primary care performance reporting: 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 2018/19:
    - GP Forward View Workforce Plan
    - Practice resilience support for specific practices
    - Development and agreement of an memorandum of understanding with NHS England regarding the operational finance ledger
    - Primary care fraud risk assessment
    - Good practice examples of neighbourhood initiatives by GP practices
    - Extended GP access service
    - Physician associate internship programme
    - Local response to Primary Care Network guidance
    - Take Care Telford marketing campaign
    - Winter planning for primary care
    - Quality Outcomes Framework
    - Practice merger applications
    - Plans to enable direct booking from 111 to general practice
    - NHS Long Term Plan – Primary Care Strategy.

Children and Young People Consideration Panel approves commissioning decisions for individual funding requests for children and young people on behalf of the group. The panel was created on 13 February 2019 following a period of shadow working. The panel met once between this date and the end of the financial year.

Names of Children and Young People Consideration Panel members	Meetings attended during 2018/19
Vicki Pike (Chair)	1
Helen Bayley	1
Catherine Smith	1
Yvonne Chetwood	0
By invitation:	
Frances Sutherland	0
Maria Hadley	1

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



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. 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 2018/19. The outcomes of these 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 two Organisational Development partners to help identify where the Board can improve its effectiveness. This has included looking at the skills base of the Board as a collective and providing development around communication from the Board to the public. The CCG Governance Board also receives regular reporting from committees via Chair reports and for those committees with delegated decision making an annual report that seeks to summarise that committee's effectiveness in discharging its duties.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the Clinical Commissioning Group 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 the principles of the code. There is just one exception: 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 Clinical Commissioning Group 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 2013 Harris Review, the Clinical Commissioning Group 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 Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

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 to provide assurance on its direction and control across the whole organisation in a co-ordinated 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 wherever possible will prevent risk arising, by the application of policies and procedures for staff and contractors to follow, the CCG Constitution, standing orders and prime financial policies, the use of technical support external to the CCG e.g. legal advice, Information Governance advice, HR advice, and 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, and to manage them efficiently, effectively and economically.

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

The risk appetite was determined and approved by the board and the strategy outlines the processes for maintaining and monitoring the Board Assurance Framework and the 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 an 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 seek quality and innovation towards best practice in patient-centred care.

Risk management is embedded in the activity of the Clinical Commissioning Group and can be demonstrated through:

- completion of equality impact assessments for reviewed or new policies
- incident and serious incident reporting is encouraged by the CCG and evident through the Datix reporting system.
- IG, raising concerns and fraud awareness / training has been provided to senior managers and staff
- training for staff and Board members is mandated for particular areas: Health and Safety, IG, safeguarding, safer recruitment, fire safety, business continuity / emergency planning, Integrated Single Finance System (ISFE) finance system and newly introduced; conflicts of interest
- Intelligence gathering through quality and performance contracting processes with providers
- Complaints and Patient Advice and Liaison Service (PALs) enquiries
- NHS-to-NHS Concerns reporting via 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. The following processes are used to identify risks:

- retrospectively following the occurrence of an adverse incident
- proactively by identifying of 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.

Our capacity to handle risk is as follows:

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 effectively. Each Executive Lead, or members of their respective teams, will inform the Executive Risk Register. Both 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.

A summary of the major risks identified, during 2018/19, in the Board Assurance Framework is set out below and the actions being taken to mitigate the risks. The major risks to the CCG have been reviewed and revised where necessary every quarter and then presented to Audit Committee and the CCG Governance Board. However, one emerging risk is the requirement for each CCG to save 20 per cent from its administration costs by the end of financial year 2019/20 to ensure full year effect by the beginning of financial year 2020/21. The CCG is currently working through options as to how this can be achieved and will be working on an action plan to present to the Governance Board.

Description of major risks added to the Board Assurance Framework during 2018/19	Existing controls:	Further actions:
Risk is that the organisation is distracted from addressing the health inequalities needs of the population as identified by the Joint Strategic Needs Assessment (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 Right Care approach regarding diabetes to PPQ (Aug 2017) and also STP Board • Board meetings have gone to bi-monthly to allow greater strategic discussion and oversight. • More detailed modelling and analysis was completed at the end of October for the Future Fit DMBC. • Realignment of portfolios has created a dedicated Deputy Exec role to focus on Neighbourhood Development and Rightcare to ensure delivery of CCG priorities. • T&W Council leading on improving Healthy Lifestyles - report to Board Autumn 2018. • NHS Improvement Oversight meeting Safe Today process in place	• Greater focus on reporting on CCG priorities to PPQ and CCG Board - via performance reports • Neighbourhood development now a greater priority for the Future Fit Programme Board given the mutual dependencies of the hospital reconfiguration and diversion of activity into the community - both self-help and interdisciplinary working. This is being strengthened with revisions to the STP Board and work programme • CCG and Telford and Wrekin Council are creating a joint team to increase pace of change for Neighbourhood development in line with creation of Primary Care Networks. New team will focus on risk stratification / identification / better care of patients with high risk of diagnosis / diagnosis through improved primary care activities • Realign enhanced payments to focus on CCG / RightCare priorities • Telford Health Hearts initiative - work programme now being implemented.

2. Risk that Shrewsbury and Telford Hospital NHS Trust (SaTH) is unable to provide good quality sustainable services	• • Contract mechanisms - CQRM, SPF • Escalation processes embedded in the contract governance processes. • NHSE Assurance meetings • Joint Commissioning Board with SCCG Activity and finance meetings • Workforce remains a considerable issue but the scale of this is now more visible to the CCG due to the commissioning scrutiny processes. • Cancer Assurance Board • Executive team - reporting weekly • Regulators - NHSI/E and CQC • SaTH now have agreed business continuity plan for PRH A&E overnight closure if required. • Plans in place within the Trust to manage these risks however these may change at short notice leading to required changes to services.	• Planned care working group continues to provide focus on fragile services within SaTH elective care • The CCGs are working jointly on plans to commission different service models to ensure sustainability and good quality care • Monthly Board visits arranged to departments in SaTH for oversight • Weekly unplanned visits to SaTH and daily safe today process in place.
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 CFO July 2017. • STP Director appointed and PMO resource in place	• STP Finance Workstream undertaking ongoing review of activity modelling. • Further CCG financial assurance will be required at the point of decision on Future fit following consultation • Shropshire Community Trust resilience - solutions are being reviewed • Strategic Leadership Group is now meeting monthly

	• Prevention and self management now forms part of neighbourhoods • NHS England assured by Future Fit process to date. • Independent STP Chair appointed	• Independent STP Chair is undertaking a review of STP structure/governance/vision
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 NHSE STP scrutinised by NHSI	• Monitor of key objectives including finance - regular updates to Board. • Although initial review of disinvestment opportunities has been completed, and work is continuing, at this stage there is no single project plan or programme of actions to deliver • Plan to be developed to address the 20% savings target for 2012
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 - West Midlands Quality Review Service (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	• Escalating when we have gaps in assurance using escalation processes to seek further assurances • SaTH remain on enhanced rating at QSG • Scrutinise SaTH CQC Action Plan CCG to undergo a review of its quality oversight processes.

	• Infection controls and systems • Safeguarding Board for Adults and Children • Safeguarding leads across all commissioner areas • CQC Report SaTH November 2018 • Quality Service Group (QSG)NHS England • NHS Improvement Oversight meeting for SaTH.	
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 Accountable Officer on STP • Leadership Programme • Executive to Executive meeting with Shropshire CCG held in February 2018 Leadership courses • Clinical leadership - Paen (Professional Education, Development and Support) • Succession planning • Partnership working • Board 2 Board with SaTH • Regular Executive to Executive meetings with Shropshire CCG now planned. STP OD support arranged and two more in 2018 facilitated by the King's Fund • Internal OD support for Board has been ongoing • 360 degree survey results presented to Board and discussion at Board away day. Action plan in place.	• OD work with Telford and Wrekin CCG Board to consider further collaborative working with NHS and social care partners • Three newly-elected GP / Primary Care health Professionals Board members.

9. Risk that a number of financial pressures are emerging together with over activity at SaTH which may impact on the financial performance of the CCG	• Regular review through Executive meetings and PPQ • Dedicated working group to develop disinvestment opportunities • Monthly reporting to include underlying financial position • Robust financial monitoring and budget management • Restricted access to uncommitted resource.	• ongoing contract challenge • further development of disinvestment opportunities: ○ development of full action plans for each of the areas identified for potential disinvestment including named leads, timescales, measurable milestones etc ○ review of non-tariff services (Block and Variable) for additional areas of challenge ○ wider clinical review of all commissioned services ○ undertake Impact Assessments of potential disinvestments ○ ensure the work with the local authority on reviewing Better Care Fund is progressed ○ a full assessment of stroke reviews in SaTH needs to be completed and if appropriate, alternative arrangements identified ○ a multi-disciplinary team to be established to consider the best route for primary care to deliver savings whether this is through efficiencies, cessation of services or diverted activity ○ a full review with SaTH of the block element of the contract • Consider external support to develop "turnaround" programme with focus on non-elective admission avoidance.
10. Risk of CCG not meeting its four-hour waiting time target for Emergency Department (ED) and continues to worsen	• Dedicated Urgent Care Director with strong Emergency Care Intensive Support links	• Urgent Care Director refocusing the Recovery Plan Focus on seven-day working across the system

	• ED Delivery Board and ED Delivery Group include all partners ensuring a system wide approach to mitigating the risk • CCG provides significant resource to managing flow on a daily basis to ensure complex patients are discharged within 48 hours and on the most appropriate pathway • The ED Board has approved a Recovery Plan which the ED Group monitors • Regulators are heavily involved in supporting / challenging SaTH and our system • Practices have improved urgent care and extended hours access • CCG has commissioned a streaming service to divert patients with minor injuries / illnesses from the ED • Demand and capacity modelling better than in previous years in Winter Plan • Emergency Care Improvement Programme • Support via Urgent Care Director.	• Maintain excellent working relationships with Telford and Wrekin Council albeit with more to do to improve capacity gaps in community care • CCG-led initiatives to improve streaming model, and divert avoidable admissions with collaborative work between WMAS and Shropshire Community
11. Risk that the implementation of the new 0-25 Emotional Wellbeing service model for children and young people is delayed.	• Dedicated contract monitoring of the 0-25 service • Joint Recovery Action Plan based on recommendations from a recent Intensive • Support Team review has been agreed and is being implemented.	• Wider cultural changes are needed across the system in schools, primary care etc. to ensure partners make appropriate contributions to the support of children and young people with emotional/behavioural challenges.
12. Risk that the CCG is distracted from delivering its organisational objectives due to the need to reduce administration costs by 20 per cent by the end of 2019/20.	• Change management policy	• Discussions with Board, membership and partners to identify opportunities • Board requested further information on impact of 20 per cent on CCG and more detail on options and how we can retain Telford "voice".

The CCG's continuing major risks during 2018/19 can be summarised as:

Risk that SaTH is unable to provide good quality sustainable services

The Trust has had a history of challenges: workforce provision, A&E performance and maternity services. The CCG have jointly escalated concerns to NHS England QSG with NHS Shropshire CCG. In addition, the Trust was evaluated as "inadequate" by the CQC in 2018. An NHS Improvement Oversight Committee oversees the Trust improvement plan following the CQC visit 2018 and the Chair and Executive Nurse sit on this. The full action plan responding to the CQC inspection is awaited.

The CCG has continued with underperformance on Constitutional targets for Accident and Emergency four-hour waiting time, referral-to-treatment (RTT) and cancer targets for 62 days and two weeks.

Nationally-mandated GP Streaming Service has been introduced to help manage activity through A&E. The CCG and Trust have been focussing on improving flow out of hospital including access to equipment at weekends and improving pre-midday discharges. The CCG has been continuing to support the acute daily capacity hub in order to facilitate capacity flow and taking part in a daily local health economy conference call which has helped to maintain a very low delayed transfers of care (DTOC) rate for Telford and Wrekin patients working closely with our local authority. In addition, the CCG has focussed on admissions avoidance including the use of the care home team, *5 via 111 and raid response / WMAS integrated working scheme.

The Trust also made an emergency decision at the end of 2018 with regard to closure of A&E unit at Princess Royal Hospital overnight due to lack of consultant cover as a direct result of workforce recruitment issues. The Trust were able to avoid implementing this decision due to recruiting sufficient middle grade doctors to fill the rota, however workforce issues continue to be fragile.

RTT has historically been a challenge but recent figures show that the target of 92 per cent has been met at the end of November 2018.

In terms of cancer waiting times, exception reporting takes place at 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. Pathways are under review for certain specialities, and SaTH is developing action plans for five key areas. However, there continues to be issues around capacity, patient choice and radiology and a remedial action plan has now been shared with commissioners.

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 continue, although this has been lessened to some extent by the recent decision made by both CCGs though a joint committee to support option 1 of the Future Fit proposal. This decision will allow the implementation phase and progress towards outline business case and full business case stage that will require more detailed modelling of the proposals. This provides more assurance on the viability of these proposals and also the interoperability of other transformation projects like neighbourhoods with it.

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 2018/19. 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 and then onto the Acute Trust. Further escalation has been made to QSG to address significant concerns relating to patient safety and experience as well as oversight of progress against action plans resulting from a risk review process in 2017/18. Action plans for service improvement across all requisite areas are in place and monitored through CQRM and corporate assurance processes through PPQ to Board.

The CQRMs are in place for providers and one for all SaTH service areas. There is a specific CQRM for SaTH maternity at this time, given the national scrutiny in this area. Outputs from these are shared in the PPQ reports which then go to the Governance Board for attention.

All serious incidents are reviewed in accordance with our policy and aligned to the national process. The CCG's process has recently been reviewed by internal auditors, which received significant assurance. In addition the CCG, together with NHS Shropshire CCG, have recently had a peer review by West Midlands Quality Review Team and outcomes are awaited.

Risk of failure to manage a growing underlying financial position for 2019/20

During Month 10, the CCG has continued to see over performance in the acute sector, mental health, non-contracted activity and continuing healthcare. And although these pressures can be managed by non-recurrent benefits for 2018/19, it creates an increasing underlying deficit to the CCG for 2019/20. The CCG continues to focus on development and implementation of contingency QIPP schemes to address this gap and produce recurrent QIPP savings for future years.

It is likely that these risks will not change substantially and will remain on the Board Assurance Framework for 2019/20.

Other sources of assurance

Internal Control Framework

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

The 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 Board and its committees/sub committees
- Equality Delivery System
- Safeguarding annual report
- Emergency and Business Continuity Planning/core standards
- External regulator reports on providers i.e. recent CQC report on Shrewsbury and Telford Hospital NHS Trust.

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 had permission of the individual to publish the information on the register – administrator will check permission given when submitted.
- Two declarations had not been signed by the respective line manager – administrator will check signature when submitted.
- Five declarations and not been renewed within 12 months – CCG will conduct quarterly checks.

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

Data Quality

The Board relies on the data quality elements in its contracts with providers, that requires them to quality assure their data prior to submission. The CCG also uses Midlands and Lancashire Commissioning Support Unit (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 is the national UNIFY system and SUS data which is verified via the contracting process with providers.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. Telford and Wrekin CCG are compliant with the standards set out in the IG Toolkit for 2018/19.

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

There are processes in place for incident reporting and investigation of serious incidents. We have had 13 of level 0 IG breaches during the year around the same process, and an independent investigation has taken place to establish the root cause and mitigations and this report is currently awaited. We have developed an Information Asset Register which enables the CCG to identify high-

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

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

During 2019/20, the CCG will continue to move towards having a fully embedded information risk culture throughout the organisation and retaining its IG compliance.

Business Critical Models

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

Third party assurances

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

Control Issues

There are no significant control issues that have materialised during 2018/19 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 Committee (PPQ) 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 in addition receives summary financial reporting at each meeting. The current rating for Quality of Leadership indicator of the CCG Improvement and Assessment Framework was last rated by NHS England for 2016/17 as amber/green rating. The updated rating for 2018/19 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 MLCSU. Outcomes from these internal audit reviews are detailed in the Head of Internal Audit Opinion.

Delegation of functions

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

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

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

The CCG, in accordance with its Constitution, reviews its Scheme of 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 who provide the services of an Accredited Counter Fraud Specialist, contracted to undertake counter fraud work proportionate to the CCG's identified risks.

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

The 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 Counter Fraud Authority quality assurance recommendations.

The CCG is committed to ensuring NHS resources are appropriately protected from fraud, bribery and corruption and follows the national NHS counter fraud strategy and the series of standards for commissioners of NHS services. As an NHS commissioner the CCG ensures that NHS funds and resources are safeguarded against those minded to commit fraud, bribery or corruption. Failure to do so may impact on a commissioners ability to invest in provider services, as NHS funds and resources would be wrongfully diverted from patient care.

In order to reduce economic crime against the NHS, it is necessary to take a multi-faceted approach that is both proactive and reactive. The CCG's Local Counter Fraud Specialist (LCFS) follows the four key principles, in accordance with the NHS counter fraud strategy. These are designed to minimise the incidence of economic crime against the NHS and to deal effectively with those who commit crime. The four key principles are:

Strategic Governance - this sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation. The Chief Finance Officer is the nominated individual at the CCG to oversee and provide strategic management and support for all anti-fraud, bribery and corruption work within the organisation. An accredited counter fraud specialist is contracted via CW Audit to undertake counter fraud work proportionate to identified risks. The counter fraud specialist attends the Audit and Governance Committee on a regular basis to provide updates on the work plan, highlight any relevant guidance and to give assurance of any investigations.

Inform and involve those who work for, or use the NHS, about economic crime and how to tackle it. NHS staff and the public should be informed and involved to increase everyone's understanding of the impact of economic crime against the NHS. This takes place through communications and promotion such as face to face counter fraud presentations, public awareness campaigns and media management. The LCFS provides counter fraud material to CCG staff, including new starters. Working relationships with stakeholders are strengthened and maintained through active engagement.

Prevent and deter economic crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit economic crime. Successes are publicised internally during counter fraud presentations and using other media opportunities so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing economic crime by robust systems, which will be put in place in line with policy, standards and guidance.

Hold to account those who have committed economic crime against the NHS. The CCG's LCFS is a professionally accredited investigator and is qualified to the required standards. Once allegations of suspected economic crime are received by the CCG, the LCFS must ensure that investigations are undertaken to satisfy national legislation. The CCG encourages the prosecution of offenders, and where appropriate refers offenders to their professional bodies for disciplinary sanction. Economic crimes must be detected and investigated, suspects prosecuted where appropriate, and other methods of redress sought where possible. Where necessary and appropriate, economic crime, investigation and prosecution will take place locally wherever possible. Nevertheless the LCFS also works in partnership with the police and other crime prevention agencies to take investigations forward to criminal prosecution.

During 2018/19 the NHS Counter Fraud Authority undertook a quality inspection of the CCG which comprised an assessment of compliance against two of the NHS Counter Fraud Authority Standards, these being; Strategic Governance and Inform and Involve, which consisted of 13 standards in all. The CCG was assessed as compliant with 11 standards and partially compliant with two standards. An action plan was agreed to address the two partially compliant standards rated as amber, which have now been completed during 2018/19.

Head of Internal Audit Opinion

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

The Head of Internal Audit concluded 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 initial assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the current 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 2018/19 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 2018/19 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	• Complaints • Budget Setting and QIPP • Financial Systems • Conflict of Interest • GP Forum • Provider Serious Incidents • Financial Reporting • Primary Care Commissioning (Commissioning and Procurement) DRAFT
Moderate Assurance	• Contract Monitoring • RightCare

The following non-assurance assignments have also been completed:

- Board Assurance Framework (BAF) – interim and final review; a 'Level A' position statement was given.
- Data Security and Protection Toolkit; an 'Action Required' position statement was given.

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

Moderate Assurance

Contract Monitoring: As lead commissioner for Midlands Partnership NHS Foundation Trust (MPFT), Telford and Wrekin CCG had implemented a governance structure to monitor delivery of the contract. A Strategic Commissioning Board (SCB) existed at an executive level, which included membership from Shropshire CCG, Telford and Wrekin CCG and the Trust. At a more operational management level, the separate contracts with MPFT for adult services and for the 0-25 emotional health and wellbeing (EHWB) service had been monitored through an Adults Activity, Finance and Performance Group, an Adults Clinical Quality Review Meeting (CQRM) and a 0-25 EHWB Contract Review / CQRM Group. We confirmed that meetings were held regularly at an operational level and that both Telford and Wrekin CCG and Shropshire CCG were represented at all meetings, although there was a lack of consistent senior input from Shropshire CCG at the 0-25 CQRM.

Opportunities existed to strengthen the operation of processes in practice in a number of areas. The SCB only met twice during the period examined, and did not have Terms of Reference in place until November 2018. Although a Contract Performance Notice (CPN) had been in place for the 0-25 EHWB service since November 2017 and the plan had been monitored at CQRM, sufficient improvements in services had not been made and further issues have emerged. Alongside the contract process, two task and finish action plan meetings were held chaired by the Executive Nurse, Lead for Quality and Safety and a detailed prepared Project Plan with clear trajectories had been developed.

The review also considered that improvements could be made in demonstrating that the monitoring process is more closely aligned to contract documentation requirements. Whilst Terms of Reference of monitoring groups referred to quarterly reviews of Data Quality and Service Development Improvement Plans (DQIP and SDIP), our review of minutes suggest that this was not taking place and more generally there was opportunities to more clearly demonstrate a relationship between matters being considered at meetings, stated duties in Terms of Reference and contract requirements.

RightCare: The CCG have been proactive by becoming engaged in the RightCare programmes, seeking to use information on variations to support decisions. Future programmes could be enhanced through improved project management.

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.

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

In year the CCG has made excellent progress ensuring actions are completed on a timely basis. As at 31 March 2019 there were no high risk actions outstanding.

Reliance on third party assurances

Midlands and Lancashire (M&L) Commissioning Support Unit (CSU) report on Internal Controls Type II Finance and Payroll Service Auditor Report for the period 1 April 2018 to 31 March 2019 was received and reviewed. The report provides Reasonable Assurance overall, with qualified opinion assigned to three control objectives. These objectives and the reason for the qualification were reviewed. Following this review, we can confirm that there are no issues or concerns we wish to highlight within this 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 Clinical Commissioning Group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the 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
- 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 the 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 and the Planning, Performance and Quality and Remuneration Committees.

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 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 serves to 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.

Mr David Evans

Accountable Officer

XX May 2019

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 2018/19, pay for Board members was mainly on nationally determined pay rates.

No 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 2018/19.

Remuneration report tables – pension and salary

These tables are subject to audit by the CCG's external auditor.

Salaries and allowances:

2018/19									
	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	01/04/18 to 31/03/19	95-100	0	0	0	0	95-100
	David Evans	Chief Officer	01/04/18 to 31/03/19	110-115	0	0	0	0	110-115
	Fran Beck	Executive Lead Commissioning	01/04/18 to 31/03/19	90-95	0	0	0	5.0-7.5	95-100
	Christine Morris	Executive Lead Quality Nursing and Safety	01/04/18 to 31/03/19	95-100	0	0	0	20.0-22.5	115-120
	Alison Smith	Executive Lead Corporate Governance and Performance	01/04/18 to 31/03/19	90-95	0	0	0	15.0-17.5	105-110
	Dr Martin Allen	Board Secondary Care Clinician	01/04/18 to 31/03/19	5-10	0	0	0	0	5-10
	Mr Geoff Braden	Board Lay Member Governance	01/04/18 to 31/03/19	5-10	0	0	0	0	5-10
	Dr James Hudson	Board GP Member	01/04/18 to 31/03/19	35-40	0	0	0	0	35-40
	Dr Andy Inglis	Board GP Member	01/04/18 to 31/03/19	35-40	0	0	0	0	35-40
	Dr Jo Leahy	Chair	01/04/18 to 31/03/19	90-95	0	0	0	0	90-95
	Tracey Slater	Board Secondary Care Nurse	01/04/18 to 31/03/19	10-15	0	0	0	0	10-15
	Peter Easthaugh	Board Lay Member - Primary Care	01/04/18 to 31/03/19	5-10	0	0	0	0	5-10
	Carolyn Fenton-West	GP/Primary Care Health	01/04/18 to 31/03/19	35-40	0	0	0	0	35-40
	Neil Maybury	Board Lay Member - PPI	01/04/18 to 31/03/19	5-10	0	0	0	0	5-10
	Dr Adam Pringle	Board GP Member	01/04/18 to 31/03/19	35-40	0	0	0	0	35-40

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	20.0-22.5	110-115
	David Evans	Chief Officer	01/04/17 to 31/03/18	110-115	0	0	0	15.0-17.5	125-130
	Fran Beck	Executive Lead Commissioning	01/04/17 to 31/03/18	85-90	0	0	0	22.5-25.0	110-115
	Christine Morris	Executive Lead Quality Nursing and Safety	01/04/17 to 31/03/18	95-100	0	0	0	65.0-67.5	160-165
	Alison Smith	Executive Lead Corporate Governance and Performance	01/04/17 to 31/03/18	85-90	0	0	0	27.5-30.0	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	5.0-7.5	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	(17.5)-(20.0)	60-65
	Tracey Slater	Board Secondary Care Nurse	01/04/17 to 31/03/18	10-15	0	0	0	22.5-25.0	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	62.5-65.0	100-105
	Shalienda Allen	Board GP Member	01/04/17 to 07/04/17	0-5	0	0	0	5.0-7.5	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	187.5-190	215-220

Pension benefits as at 31 March 2019

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

2018/19								
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 2019 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2018 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2019 £'000	Employers contribution to stakeholder pension
Jon Cooke - Chief Finance Officer	(2.5)-(5.0)	(17.5)-(20.0)	30-35	80-85	596	0	594	0
David Evans - Chief Officer	0.0-2.5	0.0-2.5	40-45	120-125	0	0	0	0
Fran Beck - Executive Lead Commissioning	0.0-2.5	0.0-2.5	40-45	125-130	0	0	0	0
Christine Morris - Executive Lead Quality Nursing and Safety	0.0-2.5	0.0-2.5	35-40	105-110	691	112	803	0
Alison Smith - Executive Lead Corporate Governance and Performance	0.0-2.5	0	30-35	0	326	81	407	0
Carolyn Fenton-West - GP Primary Care	0.0-2.5	(0.0)-(2.5)	15-20	45-50	325	48	372	0
Dr Adam Pringle - GP Board Member	(2.5)-(5.0)	(2.5)-(5.0)	5-10	20-25	183	0	167	0

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	0	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	0	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

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

We do not have any to report during 2018/19.

Payment to past members

We do not have any to report during 2018/19.

Pay multiples

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

We are required to disclose the relationship between the remuneration of the highest-paid director in our 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 2018/19 was £130,357 (2017/18, £130,357). This was 3.47 times (2017/18, 3.66) the median remuneration of the workforce, which was £37,570 (2017/18, £35,577).

In 2018/19, 0 (2017/18, 0) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £17,652 to £139,360 (2017/18 £16,104 - £139,360)

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 average headcount of 112 staff during 2018/19. This is equivalent to 88.65 WTE.

Number of senior managers

Staff composition – gender of Board, senior managers, very senior managers (VSM) and other staff:

Gender analysis of CCG workforce (based on staffing at 31.03.2019 - Extracted from ESR 18.04.2019)

	Headcount by Gender			
Staff Grouping	**Female**	**Male**	**Unknown***	**Grand total**
governing body	6	9	3	**18**
other senior management	10	5	0	**15**
All other employees	71	14	0	**85**
Grand total	**87**	**28**	**3**	**118**

	% by Gender		
Staff Grouping	**Female**	**Male**	**Unknown**
All other	33.3%	50.0%	16.7%
Governing body	66.7%	33.3%	0.0%
Other senior management	83.5%	16.5%	0.0%
Grand Total	**73.73%**	**23.73%**	**2.54%**

*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
- Patrick Spreadbury

Staff composition by pay band

Pay band analysis of CCG workforce (based on staffing at 31.03.2019 - Extracted from ESR 18.04.2019)

Sum of Headcount	**Sum of Headcount**
Band 2	3
Band 3	23
Band 4	9

Band 5	6
Band 6	12
Band 7	11
Band 8 - Range A	10
Band 8 - Range B	12
Band 8 – Range C	4
Band 8 - Range D	**2**
Medical	**14**
VSM	**9**
Gov Body (off payroll)	**3**
Grand Total	**118**

*Gov 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 2018/19 was whole time equivalent (WTE) days available of 31,834.63 and WTE days lost to sickness absence of 1,207.12, and average working days lost per employee was 13.94 which was managed through the Absence Management Policy.

Employee consultation

Telford and Wrekin CCG 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 the regional Joint Staff Consultative Committee (JSCC) – which provides a forum for Trade Union staff representatives to meet and contribute to service change and development. We also hold quarterly staff forum meetings for representatives from each team to discuss key issues and provide feedback as well as raising issues. The Chief Officer holds drop-in sessions for staff to discuss issues and we also hold regular CCG team briefings with both the Chief Officer and Chair.

We have continued to engage proactively in 2018/19 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 access to a table tennis table for staff to use in the rest area at break times.

Employees with a disability

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

The CCG's commitment to people with disabilities includes:

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

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 per cent, b) 1-50 per cent, c) 51-99 per cent or d) 100 per cent of their working hours on facility time?

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

We spent £195k on consultancy services in 2018/19.

Off payroll engagements

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

The table below shows the existing arrangements as of 31 March 2019:

Table 1: Off-payroll engagements longer than six months

For all off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	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 1 April 2018 and 31 March 2019, 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 2018 and 31 March 2019	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 1 April 2018 and 31 March 2019.

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 and severance payments

We do not have any to report during 2018/19.

Healthy and Safety

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

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 as a result of a trip over a chair positioned by a doorway, which was subsequently moved.

Fraud

We adhere to the standards set by NHS Protect, in order to combat economic crime within the NHS. We comply 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.

We employ the services of assurance provider CW Audit Services to provide its local counter fraud specialists. We do not tolerate economic crime and have an Anti-Fraud Bribery and Corruption Response Policy in place, which is designed to make all staff aware of their responsibilities should they suspect offences being committed. When economic crime is suspected it is fully investigated in line with legislation, with appropriate action taken, which can result in criminal, disciplinary and civil sanctions being applied. This work is monitored by the Audit Committee as a standing agenda item at each meeting.

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 2018. All required actions have been taken to ensure the CCG can work with partners in Telford and Wrekin in the event of emergency situations.

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 our use of resources (Value for Money conclusion).

Statement as to disclosure to auditors

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

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

Parliamentary Accountability and Audit Report

Telford and Wrekin CCG are 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 121. An audit certificate and report are also included in this Annual Report at page x.

Annual Accounts

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 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	-	(2,308)
Other operating income	2	(1,688)	(478)
Total operating income		**(1,688)**	**(2,786)**
Staff costs	4	4,390	3,940
Purchase of goods and services	5	244,451	236,069
Depreciation and impairment charges	5	52	45
Provision expense	5	(386)	(13)
Other Operating Expenditure	5	287	280
Total operating expenditure		**248,793**	**240,320**
Net Operating Expenditure		**247,106**	**237,534**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**247,106**	**237,534**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**247,106**	**237,534**
Comprehensive Expenditure for the year		**247,106**	**237,534**

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	13	187	197
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		187	197
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	2,397	1,815
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	117	73
Total current assets		**2,514**	1,888
Non-current assets held for sale	21	-	-
Total current assets		**2,514**	1,888
Total assets		**2,701**	2,086
Current liabilities			
Trade and other payables	23	(15,222)	(20,166)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	(219)
Total current liabilities		**(15,222)**	(20,385)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,521)**	(18,299)
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	(168)
Total non-current liabilities		**-**	(168)
Assets less Liabilities		**(12,521)**	(18,467)
Financed by Taxpayers' Equity			
General fund		(12,521)	(18,467)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(12,521)**	(18,467)

The notes on pages 5 to 26 form part of this statement

The financial statements on pages 5 to 26 were approved by the Governing Body on 21st May 2019 and signed on its behalf by:

Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(18,467)	0	0	**(18,467)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Impact of applying IFRS 9 to Opening Balances	0			**0**
Impact of applying IFRS 15 to Opening Balances	0			**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(18,467)**	**0**	**0**	**(18,467)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(247,106)			**(247,106)**
Net gain/(loss) on revaluation of property, plant and equipment		0		**0**
Net gain/(loss) on revaluation of intangible assets		0		**0**
Net gain/(loss) on revaluation of financial assets		0		**0**
Total revaluations against revaluation reserve	**0**	**0**		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			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 Year	**(247,106)**	**0**	**0**	**(247,106)**
Net funding	253,052	0	0	**253,052**
Balance at 31 March 2019	**(12,521)**	**0**	**0**	**(12,521)**

	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 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 2018	**(15,564)**	**0**	**0**	**(15,564)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating costs for the financial year	(237,534)			(237,534)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**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 Year	**(237,534)**	**0**	**0**	**(237,534)**
Net funding	234,631	0	0	234,631
Balance at 31 March 2018	**(18,467)**	**0**	**0**	**(18,467)**

Statement of Cash Flows for the year ended
31 March 2019

	Note	**2018-19** **£'000**	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(247,106)	(237,534)
Depreciation and amortisation	5	52	45
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		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	(582)	838
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(4,944)	2,138
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	(386)	(13)
Net Cash Inflow (Outflow) from Operating Activities		**(252,966)**	(234,527)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(42)	(41)
(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
Non-cash movements arising on application of new accounting standards		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		**(42)**	(41)
Net Cash Inflow (Outflow) before Financing		**(253,008)**	(234,568)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		253,052	234,631
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
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**253,052**	234,631
Net increase (decrease) in cash & cash equivalents	20	**44**	63
Cash & Cash Equivalents at the Beginning of the Financial Year		**73**	10
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		**117**	73

External Audit Opinion and Report

Independent auditor's report to the members of the Governing Body of NHS Telford and Wrekin Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Telford and Wrekin Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2019 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 2018-19; 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.

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office 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 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 2018-19 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 issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

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

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 79 to 80, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis

set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

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

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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 2019.

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(1)(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 2019, 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 Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of 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.

M C Stocks

Mark C Stocks, Key Audit Partner for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham 24 May 2019

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	-	(2,308)
Other operating income	2	(1,688)	(478)
Total operating income		**(1,688)**	**(2,786)**
Staff costs	4	4,390	3,940
Purchase of goods and services	5	244,451	236,069
Depreciation and impairment charges	5	52	45
Provision expense	5	(386)	(13)
Other Operating Expenditure	5	287	280
Total operating expenditure		**248,793**	**240,320**
Net Operating Expenditure		**247,106**	**237,534**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**247,106**	**237,534**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**247,106**	**237,534**
Comprehensive Expenditure for the year		**247,106**	**237,534**

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	13	187	197
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		187	197
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	2,397	1,815
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	117	73
Total current assets		**2,514**	1,888
Non-current assets held for sale	21	-	-
Total current assets		**2,514**	1,888
Total assets		**2,701**	2,086
Current liabilities			
Trade and other payables	23	(15,222)	(20,166)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	(219)
Total current liabilities		**(15,222)**	(20,385)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,521)**	(18,299)
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	(168)
Total non-current liabilities		**-**	(168)
Assets less Liabilities		**(12,521)**	(18,467)
Financed by Taxpayers' Equity			
General fund		(12,521)	(18,467)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(12,521)**	(18,467)

The notes on pages x to xx form part of this statement

The financial statements on pages 5 to 26 were approved by the Governing Body on 21st May 2019 and signed on its behalf by:

Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(18,467)	0	0	**(18,467)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Impact of applying IFRS 9 to Opening Balances	0			**0**
Impact of applying IFRS 15 to Opening Balances	0			**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(18,467)**	**0**	**0**	**(18,467)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(247,106)			**(247,106)**
Net gain/(loss) on revaluation of property, plant and equipment		0		**0**
Net gain/(loss) on revaluation of intangible assets		0		**0**
Net gain/(loss) on revaluation of financial assets		0		**0**
Total revaluations against revaluation reserve	**0**	**0**		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			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 Year	**(247,106)**	**0**	**0**	**(247,106)**
Net funding	253,052	0	0	**253,052**
Balance at 31 March 2019	**(12,521)**	**0**	**0**	**(12,521)**

	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 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 2018	**(15,564)**	**0**	**0**	**(15,564)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating costs for the financial year	(237,534)			(237,534)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**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 Year	**(237,534)**	**0**	**0**	**(237,534)**
Net funding	234,631	0	0	234,631
Balance at 31 March 2018	**(18,467)**	**0**	**0**	**(18,467)**

Statement of Cash Flows for the year ended
31 March 2019

	Note	**2018-19** **£'000**	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(247,106)	(237,534)
Depreciation and amortisation	5	52	45
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		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	(582)	838
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(4,944)	2,138
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	(386)	(13)
Net Cash Inflow (Outflow) from Operating Activities	**(252,966)**		(234,527)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(42)	(41)
(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
Non-cash movements arising on application of new accounting standards		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		**(42)**	(41)
Net Cash Inflow (Outflow) before Financing		**(253,008)**	(234,568)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		253,052	234,631
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
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**253,052**	234,631
Net increase (decrease) in cash & cash equivalents	20	**44**	63
Cash & Cash Equivalents at the Beginning of the Financial Year		**73**	10
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		**117**	73

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 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
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**

The clinical commissioning group has entered into two pooled budget arrangement with Telford and Wrekin Local Authority [in accordance with section 75 of the NHS Act 2006]. Under the arrangements, funds are pooled for the Better Care Fund and the Transforming Care Programme and note 35 to the accounts provides details of the income and expenditure.

The TCP pool is hosted by the Local Authority and the BCF pool is jointly hosted. 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

1.4 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.
In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

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

The main sources of revenue for the CCG are around prescribing income
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non- cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.
The CCG has assessed all revenue and there is no change to the accounts under IFRS 15.

1.5 **Employee Benefits**

1.5.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5.2 **Retirement Benefit Costs**

Notes to the financial statements

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.
Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.6 **Other Expenses**

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

1.7 **Property, Plant & Equipment**

1.7.1 **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.

1.7.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8 **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 property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 **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. The only leases that NHS Telford and Wrekin CCG hold are with NHS Property Services

1.10 **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.

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

Notes to the financial statements

1.12 **Provisions**

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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

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

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

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

1.15 **Contingent liabilities and contingent assets**

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

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

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

1.16 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

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

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

1.16.2 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

Notes to the financial statements

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.
The CCG has assessed its trade receivables and the value of impairment is not material

1.17 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.17.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.17.3 **Other Financial Liabilities**

Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 **Critical accounting judgements in applying accounting policies**

The following are judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
There are no critical judgements made

1.20.2 **Sources of estimation uncertainty**

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

An accrual for £4,483K has been included within the accounts for prescribing based upon assessment by the CCG managementof expenditure to date, local knowledge and forecasts provided byt NHS Prescription Services. An accrual of £4,661k was included in the CCG accounts for 2017/18

1.21 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

The CCG is not expecting these standards to impact on the acounts from an initial review, however the CCG will explore this to ensure that this is the case and act accordingly.

1.23 **Primary Care Co-Commissioning**

On 01/04/15, NHS England issued the delegation agreement to NHS 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 responsibilites. In accounting fo this expenditure, the CCG has worked closely with NHS England colleagues to assure integrity to the accouting records.

2 Other Operating Revenue

	2018-19 Total £'000	2017-18 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	9
Non-patient care services to other bodies	-	2,298
Patient transport services	-	-
Prescription fees and charges	-	-
Dental fees and charges	-	-
Income generation	-	-
Other Contract income	-	-
Recoveries in respect of employee benefits	-	-
Total Income from sale of goods and services	**-**	**2,308**
Other operating income		
Rental revenue from finance leases	-	-
Rental revenue from operating leases	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-
Receipt of donations (capital/cash)	-	-
Receipt of Government grants for capital acquisitions	-	-
Continuing Health Care risk pool contributions	-	-
Non cash apprenticeship training grants revenue	-	-
Other non contract revenue	**1,688**	478
Total Other operating income	**1,688**	**478**
Total Operating Income	**1,688**	**2,786**

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

As per NHSE remapping of income Telford and Wrekin CCG does not have any to report in 2018/19

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2018/19	Total		2018-19
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,425**	**135**	**3,560**
Social security costs	**361**	**-**	**361**
Employer Contributions to NHS Pension scheme	**465**	**-**	**465**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**4**	**-**	**4**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	4,255	135	4,390
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	4,255	135	4,390
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,255	135	4,390

4.1.1 Employee benefits 2017/18	Total		2017-18
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,006**	**238**	**3,244**
Social security costs	**318**	**-**	**318**
Employer Contributions to NHS Pension scheme	**377**	**-**	**377**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**1**	**-**	**1**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	3,702	238	3,940
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	3,702	238	3,940
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	3,702	238	3,940

4.1.2 Recoveries in respect of employee benefits

Telford and Wrekin CCG does not have any to report during 2018/19 or any reported during 2017/18

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**88.58**	**2.48**	**91.06**	**72.70**	**3.79**	**76.49**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	2018-19	2018-19
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18		

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used

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

4.4.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	2,114	2,189
Services from foundation trusts	34,234	31,576
Services from other NHS trusts	122,809	119,185
Provider Sustainability Fund (Sustainability Transformation Fund 1718)	-	-
Services from Other WGA bodies	1	0
Purchase of healthcare from non-NHS bodies	29,439	26,647
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	27,645	29,633
Pharmaceutical services	-	-
General Ophthalmic services	274	215
GPMS/APMS and PCTMS	23,877	23,232
Supplies and services – clinical	932	934
Supplies and services – general	744	615
Consultancy services	195	278
Establishment	773	647
Transport	1	0
Premises	577	619
Audit fees	44	44
Other non statutory audit expenditure		
· Other services	10	-
Other professional fees	554	35
Legal fees	23	153
Education, training and conferences	205	67
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Total Purchase of goods and services	**244,451**	**236,069**
Depreciation and impairment charges		
Depreciation	52	45
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets		
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**52**	**45**
Provision expense		
Change in discount rate	-	-
Provisions	(386)	(13)
Total Provision expense	**(386)**	**(13)**
Other Operating Expenditure		
Chair and Non Executive Members	287	280
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	-	-
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Non cash apprenticeship training grants	-	-
Other expenditure	0	0
Total Other Operating Expenditure	**287**	**280**
The notes on pages 5 to 31 form part of this statement		
Total operating expenditure	**244,404**	**236,381**

Other Non Statutory audit expenditure - other services relates to Mental Health Investment Standard Audit

Internal audit and counter fraud services are provided by CW Audit who are part of a Foundation Trust. The cost of these services was £33k in 2018/19, (included within other professional services).

External Audit Fees are inclusive of VAT. The auditor's liability for external audit work carried out for the financial year 2018/19 is limited to £1 million.

6.1 Better Payment Practice Code

Measure of compliance	2018-19 Number	2018-19 £'000	2017-18 Number	2017-18 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	11,807	73,046	10,034	55,554
Total Non-NHS Trade Invoices paid within target	11,642	71,353	9,886	54,821
Percentage of Non-NHS Trade invoices paid within target	**98.60%**	**97.68%**	**98.53%**	**98.68%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,649	163,257	2,485	151,310
Total NHS Trade Invoices Paid within target	2,614	162,681	2,439	151,080
Percentage of NHS Trade Invoices paid within target	**98.68%**	**99.65%**	**98.15%**	**99.85%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

7 Income Generation Activities

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

8. Investment revenue

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

9. Other gains and losses

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

10.1 Finance costs

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

11. Net gain/(loss) on transfer by absorption

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

12. Operating Leases

12.1 As lessee

NHS Telford and Wrekin CCG only have leases with NHS Property Services

12.1.1 Payments recognised as an Expense

	2018-19				2017-18		
Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense							
Minimum lease payments	-	543	6	**549**	-	572	8	**580**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**543**	**6**	**549**	**-**	**572**	**8**	**580**

12.1.2 Future minimum lease payments

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

13 Property, plant and equipment

2018-19	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2018	99	319	39	457
Addition of assets under construction and payments on account	0	0	0	0
Additions purchased	-	42	-	42
Cumulative depreciation adjustment following revaluation	-	-	-	-
Cost/Valuation at 31 March 2019	**99**	**361**	**39**	**499**
Depreciation 01 April 2018	37	196	25	258
Charged during the year	8	38	7	53
Transfer (to)/from other public sector body	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-
Depreciation at 31 March 2019	**45**	**234**	**32**	**311**
Net Book Value at 31 March 2019	**54**	**127**	**7**	**188**
Purchased	54	127	6	187
Total at 31 March 2019	**54**	**127**	**6**	**187**
Asset financing:				
Owned	54	127	6	187
Total at 31 March 2019	**54**	**127**	**6**	**187**

Revaluation Reserve Balance for Property, Plant & Equipment

	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2018	-	-	-	-
Revaluation gains	-	-	-	-
Impairments	-	-	-	-
Release to general fund	-	-	-	-
Other movements	-	-	-	-
Balance at 31 March 2019	**-**	**-**	**-**	**-**

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	0	0	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 £'000	techno	Furniture & fittings £'000	Total £'000
Balance at 01 April 2017	0	0	0 0	0 0	0
	0	0	0 0	0 0	0
Revaluation gains	0	0	0 0	0 0	0
Impairments	0	0	0 0	0 0	0
Release to general fund	0	0	0 0	0 0	0
Other movements	0	0	0 0	0 0	0
Balance at 31 March 2018	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 in 2018/19 or any reported during 2017/18

13.2 Donated assets

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

13.3 Government granted assets

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

13.4 Property revaluation

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

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 2018/19 or 2017/18

13.7 Temporarily idle assets

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

13.8 Cost or valuation of fully depreciated assets

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	5	15
Transport equipment	0	0
Information technology	2	5
Furniture & fittings	5	10

14 Intangible non-current assets

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

15 Investment property

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

16 Inventories

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

17.1 Trade and other receivables

	Current 2018-19 £'000	Current 2017-18 £'000
NHS receivables: Revenue	1,806	1,155
NHS receivables: Capital	-	-
NHS prepayments	-	-
NHS accrued income	61	329
NHS Contract Receivable not yet invoiced/non-invoice	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-
NHS Contract Assets	-	-
Non-NHS and Other WGA receivables: Revenue	301	103
Non-NHS and Other WGA receivables: Capital	-	-
Non-NHS and Other WGA prepayments	114	132
Non-NHS and Other WGA accrued income	57	89
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-
Non-NHS Contract Assets	-	-
Expected credit loss allowance-receivables	-	-
VAT	43	7
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-
Interest receivables	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
Other receivables and accruals	15	0
Total Trade & other receivables	**2,397**	**1,815**
Total current and non current	**2,397**	**1,815**
Included above:		
Prepaid pensions contributions	-	-

17.2 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	00-Jan-00 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	00-Jan-00 Non DHSC Group Bodies £'000
By up to three months	326	227	812	48
By three to six months	35	60	68	-
By more than six months	209	-	161	-
Total	**570**	**287**	**1,041**	**48**

17.3 Impact of Application of IFRS 9 on financial assets at 1 April 2018

	Trade and other receivables - NHSE bodies £000s	Trade and other receivables - other DHSC group bodies £000s	Trade and other receivables - external £000s	Other financial assets £000s	Total £000s
Classification under IAS 39 as at 31st March 2018					
Financial Assets held at FVTPL	-	-	-	-	-
Financial Assets held at Amortised cost	73	1,484	-	192	**1,749**
Financial assets held at FVOCI	-	-	-	-	-
Total at 31st March 2018	**73**	**1,484**	**-**	**192**	**1,749**
Classification under IFRS 9 as at 1st April 2018					
Financial Assts designated to FVTPL	-	-	-	-	-
Financial Assets mandated to FVTPL	-	-	-	-	-
Financial Liabilities measured at amortised cost	-	-	-	-	-
Financial Assets measured at FVOCI	-	-	-	-	-
Total at 1st April 2018	-	-	-	-	-
Changes due to change in measurement attribute	73	1,484	-	192	**1,749**
Other changes	-	-	-	-	-
Change in carrying amount	73	1,484	-	192	**1,749**

NHS Telford and Wrekin have assessed the impact of IFRS 15 and found there to be no impact on the financial accounts 2018/19

18 Other financial assets

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

19 Other current assets

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

20 Cash and cash equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	73	10
Net change in year	44	63
Balance at 31 March 2019	**117**	**73**
Made up of:		
Cash with the Government Banking Service	117	72
Cash with Commercial banks	- 0	- 0
Cash in hand	-	-
Current investments	**117**	**73**
Cash and cash equivalents as in statement of financial position		
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2019	**117**	**73**

21 Non-current assets held for sale

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

22 Analysis of impairments and reversals

Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

23 Trade and other payables	Current 2018-19 £'000	Current 2017-18 £'000
Interest payable	-	-
NHS payables: Revenue	524	3,061
NHS payables: Capital	-	-
NHS accruals	2,383	2,642
NHS deferred income	-	-
NHS Contract Liabilities	-	-
Non-NHS and Other WGA payables: Revenue	2,029	2,445
Non-NHS and Other WGA payables: Capital	-	-
Non-NHS and Other WGA accruals	9,800	11,375
Non-NHS and Other WGA deferred income	-	-
Non-NHS Contract Liabilities	-	-
Social security costs	55	49
VAT	-	-
Tax	46	46
Payments received on account	-	-
Other payables and accruals	385	548
Total Trade & Other Payables	**15,222**	**20,166**
Total current and non-current	**15,222**	**20,166**

Other payables include £209k outstanding pension contributions at 31 March 2019

23.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	Trade and other payables - other DHSC group bodies	Trade and other payables - external	Other borrowings (including finance lease obligations)	Other financial liabilities	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at FVTPL	-	-	-	-	-	**-**
Financial Assets held at Amortised cost	5,704	-	14,368	-	-	**20,072**
Total at 31st March 2018	**5,704**	**-**	**14,368**	**-**	**-**	**20,072**
Classification under IFRS 9 as at 1st April 2018						
Financial Liabilities designated to FVTPL	-	-	-	-	-	**-**
Financial Liabilities mandated to FVTPL	-	-	-	-	-	**-**
Financial Liabilities measured at amortised cost	-	-	-	-	-	**-**
Financial Assets measured at FVOCI	-	-	-	-	-	**-**
Total at 1st April 2018	**-**	**-**	**-**	**-**	**-**	**-**
Changes due to change in measurement attribute	5,704	-	14,368	-	-	**20,072**
Other changes	-	-	-	-	-	**-**
Change in carrying amount	5,704	-	14,368	-	-	**20,072**

24 Other financial liabilities
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

25 Other liabilities
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

26 Borrowings
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

27 Private finance initiative, LIFT and other service concession arrangements
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

28 Finance lease obligations
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

29 Finance lease receivables
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

30 Provisions

	Current 2018-19 £'000	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
Pensions relating to former directors		-	-	-
Pensions relating to other staff		-	-	-
Restructuring		-	-	-
Redundancy		-	-	-
Agenda for change		-	-	-
Equal pay		-	-	-
Legal claims		-	-	-
Continuing care		-	219	168
Other		-	-	-
Total		**-**	**219**	**168**
Total current and non-current		**-**	**386**	

Pensions Relating to Former Directors

	£'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2018		**-**	**-**	**-**	**-**	**-**	**-**	**386**	**-**	**386**
Arising during the year		-	-	-	-	-	-	-	-	**-**
Utilised during the year		-	-	-	-	-	-	-	-	**-**
Reversed unused		-	-	-	-	-	-	(386)	-	**(386)**
Unwinding of discount		-	-	-	-	-	-	-	-	**-**
Change in discount rate		-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body		-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption		-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2019		**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Expected timing of cash flows:										
Within one year		-	-	-	-	-	-	-	-	**-**
Between one and five years		-	-	-	-	-	-	-	-	**-**
After five years		-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2019		**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

31 Contingencies
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

32 Commitments
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

32.1 Capital commitments
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

32.2 Other financial commitments
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

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 in 2018/19 or any reported during 2017/18

33.1.2 Interest rate risk
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

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.

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

33.1.5 Financial Instruments
As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

33 Financial instruments cont'd

33.2 Financial assets

Financial Assets measured at amortised cost	2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	1,181		1,181
Trade and other receivables with other DHSC group bodies	743		743
Trade and other receivables with external bodies	301		301
Other financial assets	15		15
Cash and cash equivalents	117		117
Total at 31 March 2019	**2,356**	**-**	**2,356**

33.3 Financial liabilities

Financial Liabilities measured at amortised cost	2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	218		**218**
Trade and other payables with other DHSC group bodies	7,513		**7,513**
Trade and other payables with external bodies	7,005		**7,005**
Other financial liabilities	385		**385**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2019	**15,121**	**-**	**15,121**

34 Operating segments
NHS Telford and Wrekin CCG consider that they have only one segment: Commissioning of Healthcare Services

35 Joint arrangements - interests in joint operations
CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

35.1 Interests in joint operations

			Amounts recognised in Entities books ONLY				Amounts recognised in Entities books ONLY			
			2018-19				2017-18			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Better Care Fund Section 75 Arrangement	Telford and Wrekin CCG and Telford and Wrekin LA	The Better Care Fund promoting integrated working	0	0	0	11,901	0	0	0	11,495
Transforming Care Programme Section 75 Arrangement	Telford and Wrekin CCG and Telford and Wrekin LA	The Transforming Care Programme for people with a learning disability	0	0	0	1,360	0	0	0	80

Revenue Pooled Fund	CCG Pays £	Accounting Treatment £
Rehabilitation and Reablement	698,384	CCG pays full amount to LA.
Domiciliary Care	614,850	CCG pays full amount to LA.
Rehabilitation and Reablement Bed Usage	1,064,542	CCG pays full amount to LA.
Rehabilitation and Reablement Bed Usage - Others	28,493	CCG retains to pay others.
Assistive Technologies	547,976	CCG pays full amount to LA.
Preventative Services	1,806,110	CCG pays full amount to LA.
Preventative Services - Others		CCG retains to pay others.
Others		CCG retains to pay others.
Carers	204,467	CCG pays full amount to LA.
Management Charges	58,489	CCG pays full amount to LA.
Rehabilitation and Reablement Bed Usage		CCG retains to pay others.
Shropshire Community Health Trust	3,545,639	CCG pays to SCHT via contract.
Shrewsbury and Telford Hospital	1,782,406	CCG pays to SaTH via contract.
Programme Management	177,118	CCG retains to pay staff.
Maintaining Eligibility	910,607	CCG pays full amount to LA.
Care Act Implementation	461,988	CCG pays full amount to LA.
Total:	**11,901,069**	

The CCG is party to the Telford and Wrekin Better Care Fund Pooled Budget established under Section 75 of the NHS Act 2006. The other party to the Section 75 Agreement is Telford and Wrekin Local Authority.

The CCG's total contribution to the Fund in 2018/19 was £11.901 million. The partners determine the nature of the programmes of work making up the Fund and in particular whether joint control is in operation for each programme for the purposes of IFRS 11.

In 2018/19 the CCG contributed £6.367 million to programmes on community based provision where the Council acted as Lead Commissioner. The CCG accounted for its share of expenditure on these schemes. The contributions to fund these programmes were fully expensed in the year.

In 2018/19 the CCG contributed £5.534 million to programmes on community based provision where the CCG retained sole control. The CCG accounted for its share of expenditure on these schemes. The contributions to fund these programmes were fully expensed in the year.

36 NHS Lift investments
NHS Telford and Wrekin CCG consider that they have only one segment: Commissioning of Healthcare Services

37 Related party transactions

Details of related party transactions with individuals are as follows:

2018-19	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Dr A Pringle Shropshire Doctors Cooperative Ltd	1486	0	4	0
Dr J Leahy Luminessence	0	0	1	0

2017-18	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Dr A Pringle Shropshire Doctors Cooperative Ltd	2813	0	8	0

Note to related party transactions

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significa nt number of material

- 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 in 2018/19 or any reported during 2017/18

39 Losses and special payments
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

40 Third party assets
Telford and Wrekin CCG does not have any to report in 2018/19 or any reported during 2017/18

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:

	2018-19 Target		**2018-19 Performance**	**2017-18 Target**	**2017-18 Performance**
Expenditure not to exceed income	255,802		248,835	247,279	240,321
Capital resource use does not exceed the amount specified in Directions		42	42	42	41
Revenue resource use does not exceed the amount specified in Directions		254,072	247,106	244,492	237,534
Capital resource use on specified matter(s) does not exceed the amount specified in Directions		-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions		-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions		3,807	3,792	3,804	3,733

42 Analysis of charitable reserves

	2018-19 £'000	**2017-18** £'000
Unrestricted funds	0	1
Restricted funds	-	-
Endowment funds	-	-
Total	**0**	**1**