NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Annual Report and Accounts

Months 1 - 3
2022/23

Contents

Performance overview 4

Statement from Simon Whitehouse Accountable Officer NHS Shropshire, Telford and Wrekin 4
Statement of purpose and activities of the CCG 5
About us 5

Our mission statement and priorities 7

Mission statement 7
Strategic priorities 7
Population challenges 8
Working with partners 8

2022/23 financial position 11

COVID-19 expenditure 11
Adoption of going concern basis 12

Performance dashboard 14
Performance analysis 20

Primary care 20
Transformation and commissioning 23
Local care and community transformation 38
Medicines optimisation 45
Finance 50
Sustainable development 53
Monitoring the quality of services 56

Engaging people and communities 63

Governance and assurance 64
Engagement activities 65
Engaging people by working with others 66
Patient Advice and Liaison Services (PALS) 67

Equality, Diversity and Human Rights Report 72
Health and Wellbeing Strategy 77

Telford and Wrekin Health and Wellbeing Strategy 77
Shropshire Joint Health and Wellbeing Strategy 77

Reducing health inequalities 79
Accountability Report 81

Corporate Governance Report 81
Members' Report 81
Statement of Accountable Officer's Responsibilities 84
Draft Head of Internal Audit (HOIA) Opinion 121

Remuneration Report 127

Remuneration Committee 127

Policy on the remuneration of senior managers 127
Salary and pension benefits 128
Pension benefits 130
Compensation on early retirement or for loss of office - Finance 131

Staff Report 135

Other employee matters 138
Employees with a disability 139
Trade union facility time 139
Health and safety 140
Statement as to disclosure to auditors 140

Parliamentary Accountability Report 141
Annual Accounts 142

Performance overview

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

This annual report covers the period from 1st April 2022 to the 30th June 2022, before we commence a new era of NHS healthcare across Shropshire, Telford and Wrekin.

Throughout the final few months of Shropshire, Telford and Wrekin Clinical Commissioning Group (CCG), our staff teams have worked tirelessly across a wide agenda. Whether it be the financial challenges in the local health and care system, the continued pressures of COVID-19, or the urgent and emergency care pathway pressures, the teams have been resilient and committed in their work. This is also of course against a backdrop of uncertainty as the CCG is closed down and we transition to the Integrated Care Board (ICB).

We have continued to be guided by our mission to ensure that everyone in Shropshire, Telford and Wrekin has the best possible health and healthcare through our planning, commissioning, and monitoring of services.

We have remained committed to our five key priorities: to reduce health inequalities; improve health outcomes; improve joint working with our local partners; to achieve financial balance; and to ensure that the health services we commission are high quality, sustainable and value for money.

Our collective commitment to establishing our Integrated Care System continues, and has gone from strength to strength, with collaboration and partnership working a top priority. We have continued to work closely with our partners across the NHS, our two local authorities, and local voluntary and community sector organisations.

It is important that we look ahead to the future and evolve with the changing needs of our population. Despite the NHS continuing to face national and local challenges, the Integrated Care Board has strong local partnerships in place and fantastic staff right across the health and care system that are working hard for the local population.

I am confident that we will continue to strive for outstanding health and care services for the people of Shropshire, Telford and Wrekin and that we will support people to start well, live well and age well.

Simon Whitehouse
Accountable Officer
NHS Shropshire, Telford and Wrekin
29th June 2023

Statement of purpose and activities of the CCG

This section of the Annual Report provides summary information on NHS Shropshire, Telford and Wrekin CCG – its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed over the period of 1st April 2022 to 30th June 2022.

About us

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group (CCG) was a statutory body established under the Health and Social Care Act 2012. It was dissolved on 30th June 2022 and replaced by NHS Shropshire, Telford and Wrekin on 1st July 2022.

It was fully authorised as a Clinical Commissioning Group on 1 April 2021, following NHS Shropshire CCG and NHS Telford and Wrekin CCG being dissolved to create a single CCG with no conditions on its operations. The principal location of the business was Halesfield 6, Telford, TF7 4BF.

The CCG was a membership organisation. During the period 1st April 2022 to 30th June 2022, there were 51 GP practices in Shropshire, Telford and Wrekin, and all were member practices of the CCG. As local GPs, we had regular contact with patients and know what health services are needed to support our local population.

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

NHS Shropshire, Telford and Wrekin CCG was responsible for designing and purchasing (commissioning) healthcare in the Shropshire, Telford and Wrekin area. We:

- planned what services were needed to support the health needs of our local population
- purchased services such as mental health, hospital care and community services
- monitored these services to ensure patients in Shropshire, Telford and Wrekin had safe and quality care.

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

- The Shrewsbury and Telford Hospital NHS Trust (SaTH), who provide most of our local acute services
- community services from Shropshire Community Health NHS Trust
- specialist orthopaedic surgery and musculoskeletal medicine at The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH)
- mental health services from Midlands Partnership NHS Foundation Trust (MPFT)
- out-of-hours primary care services from Shropshire Community Health NHS Trust and Shropshire Doctors Co-operative (Shropdoc)
- ambulance services from West Midlands Ambulance Service University NHS Foundation Trust (WMAS) and RJAH.

We also worked closely with other organisations to ensure local health services were joined up. This included NHS England, which is the organisation responsible for buying GP, pharmacy, dental and specialised services in our area and across England.

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

Our other key local partners were Shropshire Council and Telford and Wrekin Council. We worked together with them to commission services that cross social and health boundaries. This was done through the respective Better Care Funds (BCF), and within services where we had developed a joint strategy, for example, mental health services for children and young people.

A governance structure chart is included on page 100 of this report.

Our mission statement and priorities

Mission statement

To ensure that everyone in Shropshire, Telford and Wrekin has the best possible health and healthcare through our planning, buying and monitoring of services.

Strategic priorities

Working with our partners, NHS services, GP members and patients, we had identified five key priorities to help us deliver our mission statement. These priorities guided our decision-making to deliver high-quality, equitable, safe and locally-driven care.

To reduce **health inequalities** by making sure services are available when and where they are needed, for everyone in Shropshire, Telford and Wrekin.

To identify and improve **health outcomes** for our local population.

To improve **joint working** with our local partners, leading the way as we become an Integrated Care System.

To achieve **financial balance** by working more efficiently.

To ensure the health services we commission are **high quality**, sustainable and value for money.

Population challenges

We served a total population of around 506,000 people across Shropshire, Telford and Wrekin, who live in a large and diverse landscape of urban and rural areas.

Our growing population included many younger people, but since people are now living longer we also had an increasing number of older residents.

Through this reporting period, we had around 88,000 people living with a long-term illness – that's 18 per cent of our population.

There were also many health inequalities within the area that we wanted to tackle, as they pose challenges and problems for local people.

In Telford and Wrekin we had a large, younger urban population, with some rural areas. Many of the people we served live in deprived areas, with more than a quarter (27 per cent) of the borough's population living in the 20 per cent most deprived areas nationally, an increase of 24 per cent since 2010.

The number of over-65s living in the county has increased significantly in comparison to the national picture and will continue to do so over the next 10 years. The average age of a Shropshire resident is 43. Like many rural areas, the number of people aged 65 and over in Shropshire is expected to continue to rise.

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

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

- Rates of obesity in adults and children are significantly worse than average, with approximately 72 per cent of adults classed as overweight
- Approximately one in four people are estimated to have a mental health disorder across our CCG and this rate increases in certain geographical locations
- The treatment and management of diabetes in primary care is significantly worse than the national average
- Smoking in pregnancy in our CCG remains higher than the England average and is one the worst rates in the country
- The prevalence of those smoking within Shropshire, Telford and Wrekin is worse than the prevalence in England as a whole
- The COVID-19 pandemic has increased existing health inequalities, both locally and nationally, in ways we are only beginning to understand.

Working with partners

We continued to build on the strong history of partnership working in Shropshire, Telford and Wrekin through the Shropshire, Telford and Wrekin Integrated Care System (ICS). We were

leading on a number of initiatives with partners that are key to the delivery of ICS objectives. This has continued to be a primary focus for us in the first quarter of 2022/23.

COVID-19

The early part of 2022 has continued to be challenging for the NHS nationally and locally due to the ongoing presence of COVID-19 and its impact on patients and staff. During April 2022 we saw higher levels of COVID-19 patients in our hospitals than at any other time during the pandemic.

As we moved towards the end of the period, the number of COVID -19 patients in our hospitals began to show signs of decreasing, but the requirement for stringent infection, prevention and control measures remains. We continue with our evergreen offer of COVID-19 vaccinations for all eligible residents of Shropshire, Telford and Wrekin

Locally, our ongoing approach to managing COVID-19 has continued to solidify strong partnership working on a scale that ensures we had capacity to treat COVID-19 positive patients, and also non-positive patients, in the safest way possible.

All providers, commissioners, local authority and third sector partners continue to work together to support those suffering from COVID-19, and to prevent the spread of the virus by encouraging everyone eligible to be vaccinated. We continue to ensure local people are given accurate and up-to-date advice on how to keep themselves and their families safe.

The effort has once again been unprecedented, and we would like to acknowledge all those organisations and individuals who have taken part and contributed their time, expertise, and staff to this monumental effort.

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

Until 31st March 2022 our Chair, Dr John Pepper, and Interim Accountable Officer, Mark Brandreth, sat on the Health and Wellbeing Boards (HWBBs) of both local authorities. The HWBBs also form part of the ICS governance structure to ensure that partnership working is truly at the centre of the delivery of the ICS.

Both HWBBs have a Health and Wellbeing Strategy in place.

Telford and Wrekin Health and Wellbeing Strategy

The four cross-cutting priorities where the Telford and Wrekin HWBB wants to make the fastest progress are to:

- develop, evolve and deliver the Telford and Wrekin Integrated Place Partnership Priority Programmes
- tackle health inequalities in the borough
- improve emotional and mental wellbeing
- protect people's health from infectious diseases and other threats.

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

Shropshire Health and Wellbeing Strategy

Shropshire Health and Wellbeing Strategy was refreshed in March 2022 and is available on Shropshire Council's website

The four main cross-cutting priorities for the Shropshire HWBB are to:

- Reduce health inequalities
- Joined up working
- Improving Population health
- Working with and building strong vibrant communities

Shropshire Council and Telford and Wrekin Council

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

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

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

Our interaction with the Joint Health Overview and Scrutiny Committee has continued to be significant during 2022/23. A number of service redesign projects have been discussed at the committee, as well as updates on the progress of meeting the ongoing challenges associated with COVID-19.

NHS Midlands and Lancashire Commissioning Support Unit

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

2022/23 financial position

The Shropshire, Telford and Wrekin system is part of the Recovery Support Programme – Level 4 of the NHS England and NHS Improvement (NHSEI) System Oversight Framework. The system and CCG is therefore subject to significant scrutiny around finances and financial decisions, with a specific requirement to develop an approach to recovering a deteriorating financial position.

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

All organisations agreed to:

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

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

In the three months to 30th June 2022 the CCG is reporting a breakeven position following national guidance on the transfer of CCGs to ICBs.

COVID-19 expenditure

The CCG spent £1.1m million on COVID-19-related costs in the three months to 30th June 2022.
The breakdown of this sum is as follows:

	After care and support costs (community, mental health, primary care)	COVID Medicine Delivery Unit (CMDU) service	Additional PTS costs	TOTAL
	£'000	£'000	£'000	£'000
Acute Services	8			**8**
MH Services	146			**146**
Community Health Services		102		**102**
Primary Care Services	1			**1**
Continuing Care Services	273			**273**
Other Programme Services	527		69	**596**
	955	**102**	**69**	**1,126**

This was part funded from the CCG's 'general' COVID-19 allocation, with £791k being retained within the CCG and the remainder was transferred to the three system providers: The Shrewsbury and Telford Hospital NHS Trust, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and Shropshire Community Health NHS Trust.

In addition, a specific Hospital Discharge Programme allocation of £4.6 million was received to cover the 'continuing care services'.

EU exit funding

The CCG received no funding in M1-3 of 2022/23 in respect of EU exit costs and incurred no expenditure.

Adoption of going concern basis

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

The CCG ended the three month period to 30th June 2022 in a breakeven position and a cumulative deficit position of £134m. The Shropshire, Telford and Wrekin System reported a £10.1m deficit in the three month period to 30th June 2022.

Under new government legislation passed through Parliament, the CCG ceased to exist from 30 June 2022 and a new organisation 'NHS Shropshire, Telford and Wrekin Integrated Commissioning Board (ICB)' was created on 1 July 2022.

This change required the CCG to review whether this creates material uncertainty regarding its going concern status.

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

- The formation of the new organisation (ICB), had been approved by NHS England (NHSE) and the services provided by the CCG transferred entirely to the new organisation together with its assets and liabilities;
- The CCG had taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt were not materially impacted. These steps included securing remote access to financial systems for all finance staff and budget holders, and working with our third party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the low value of the CCG's aged debt and its continued high achievement against the Better Payment Practice Code.
- There is a presumption that CCGs are deemed to be a going concern because there is a statutory requirement to perform the commissioning function by a public body – and this determines the requirement to apply the going concern principle – not whether the specific CCG will be doing the function in future.

Although the financial position of the CCG and the issue of a Section 30 report by the Secretary of State for Health indicates some uncertainty over the CCG's ability to continue as a going concern, the Governing Body, having made appropriate enquiries, have reasonable expectations that the CCG will have adequate resources to continue in operational existence for the foreseeable future both as a CCG and as its successor organisation, the ICB .

Further, the CCG submitted its 2022/23 financial plan covering the 3 months that the CCG was still in operation and the 9 month period for the ICB. This plan was based on the allocations notified by NHSE for the full financial year of 2022/23. The ICB has also submitted its draft plan for 2023/24 based on the allocations notified by NHSE for the full financial year 2023/24.

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

Performance dashboard

The CCG governance structure and Shadow Integrated Care Board (ICB) monitors performance achievements, trends and risks through a number of internally and externally facing governance routes.

Operational performance for 2022/23 continues to be significantly impacted by the impact of COVID-19 pandemic and ongoing emergency demand pressures. This has meant continued reductions in some areas of planned care due to required escalation of medical patients into surgical beds and the continued cessation of reporting on some key indicators e.g. audiology, delayed transfers of care etc. There are a number of key performance measures and constitutional standards that have not been met nationally, and locally within our system.

In unscheduled care the system has been very dynamic in managing patient flow to include right care first time with the single point of referral (access); the rapid implementation of the two-hour community response; and advanced care planning for our patients with long term complex needs. Ambulance handover times have been of particular concern in the first quarter of the year.

In planned care, there has been a similar approach to unscheduled care in modelling and realising transformation opportunities. The CCG has driven to maintain ‘time critical interventions’ through the use of the independent sector and dynamic management of clinical lists which has set clear priorities for 2022/23. Work continues with our service providers to identify how normal services can be further restored, and numbers of long waiters (>104wks) reduced as quickly as is possible whilst still maintaining an ability to respond to any future resurgence of COVID-19 demand.

The local health system has coped well with the ongoing levels of COVID-19 in the first quarter of 2022/23 and has endeavoured to maintain critical services as much as possible with dynamic deployment of capacity (workforce and workspace). The system is forever learning how it needs to respond to mitigate the risk to the wider healthcare environment.

The CCG Q1 performance is shown on the next page.

NHS Constitution and related indicators – 2022/23

KPI	Q2		Q3				Q4			Q1		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
EB3: 18ww RTT: incomplete waits	62.8 %	62.4 %	60.4 %	60.3 %	61.7 %	59.7 %	51.5 %	59.3 %	60.0 %	59.8 %	61.3 %	59.8 %
EB3: 18ww RTT: incomplete waits beyond 52 weeks	3984	3930	3844	3816	3701	3760	3832	3729	4083	4493	4375	4385
EB4: Diagnostic waits	21.8 %	29.2 %	33.4 %	32.3 %	33.2 %	38.7 %	37.9 %	34.2 %	38.7 %	39.2 %	35.6 %	38.1 %
EB6: CWT - 2-week cancer waits	82.8 %	87.4 %	86.7 %	83.9 %	74.6 %	76.1 %	69.5 %	76.7 %	75.9 %	71.4 %	77.8 %	76.5 %
EB7: 2-week breast waits	35.4 %	82.8 %	90.3 %	63.8 %	17.2 %	6.8%	10.1 %	13.8 %	17.8 %	21.1 %	28.9 %	32.5 %
EB8: CWT - 31 days to cancer treatment	96.3 %	94.1 %	93.6 %	93.8 %	94.1 %	97.1 %	80.7 %	91.5 %	91.3 %	91.0 %	86.8 %	91.5 %
EB9: CWT - 31 days to treatment (surgery)	80.3 %	87.2 %	92.6 %	74.4 %	76.0 %	86.7 %	72.0 %	85.7 %	63.3 %	76.5 %	77.6 %	76.6 %
EB10: CWT - 31 days to treatment (drugs)	99.0 %	100%	98.8 %	98.5 %	100%	100%	83.2 %	94.4 %	90.6 %	86.7 %	91.7 %	90.0 %
EB11: CWT - 31 days to treatment (radiotherapy)	97.2 %	96.2 %	97.2 %	96.3 %	92.9 %	100%	90.5 %	81.5 %	69.9 %	82.2 %	82.1 %	87.1 %
EB12: CWT - 62 days from referral to treatment	**64.9 %**	**64.2 %**	**60.3 %**	**63.0 %**	**62.3 %**	**61.1 %**	**46.9 %**	**44.9 %**	**63.6 %**	53.3 %	47.3 %	53.6 %
EB13: CWT - 62 days to treatment after referral	**85.7 %**	**64.7 %**	**62.5 %**	**72.7 %**	**59.3 %**	**84.2 %**	**34.5 %**	**34.5 %**	**69.2 %**	58.3 %	38.1 %	72.2 %

from screening												
EB13: CWT - 62 days to treatment after consultant upgrade	77%	75%	79%	70%	73%	78%	78%	72%	69%	79%	78%	77%
EB13: CWT - 28 day diagnosis	72.0 %	70.2 %	66.1 %				**47.8 %**	**63.7 %**	**56.6 %**	**60.9 %**	**64.6 %**	**63.3 %**
EB13: A&E 4-hr waits for treatment / decision / discharge (SaTH)	**62.4 %**	**60.7 %**	**58.4 %**	**57.7 %**	**57.0 %**	**58.2 %**	**55.9 %**	**55.8 %**	**54.3 %**	**57.9 %**	**58.5 %**	**54.3 %**
EB13: A&E 12-hour waits for admission (SaTH)	**97**	**69**	**131**	**132**	**302**	**322**	**497**	**336**	**307**	**538**	**176**	**392**
EAS1: Dementia diagnosis rates	62.6 %	62.2 %	61.9 %	61.6 %	61.5 %	60.5 %	60.0 %	60.4 %	60.0 %	**60.0 %**	**59.5 %**	**59.4 %**
EA3: IAPT rollout YTD - based on MPFT reports	3038	3753	4565	5327	6160	6817	7597	8403	9145	**673**	**1430**	**2133**
EAS2: IAPT recovery rate	**51.0%**			**44.0%**			**50.5%**			**52.5%**	**60.0%**	**55.2%**
EH1-A1: IAPT completion where RTT was within 6 weeks	**95.0%**			**95.0%**			**99.6%**			**96%**	**97%**	**95%**
EH1-AS2: IAPT completion where RTT was within 18 weeks	**100%**			**100%**			**93.9%**			**100%**	**100%**	**100%**
EH10: Routine Eating Disorders - seen within 4 weeks	96.3%			88.9%			78.4%			61.3%		

EH11: Urgent Eating Disorders - seen within 1 week	68.8%			62.5%			58.3%		62.5%
EH13: SMI patients have Annual Health Checks (rolling year)	26.1%			29.4%			39.5%		TBC
EK1a: IP care in LD/autism (CCG responsible)	7	6	8	8	7	9	9	10	11	8
EK1b: IP care in LD/autism (NHSE responsible)	11	13	12	12	12	11	11	11	11	10
EK3: LD patients having Annual Health Checks (cumulative)	333			746			1560		230
EO1: Wheelchair waits (children) within 18 weeks				90.9%			90.0%		88.9%

Standard	Performance
Referral to Treatment (RTT) for non-urgent consultant-led services: Incomplete patients to start treatment within a maximum of 18 weeks from referral	At the end of June 2022, we remained stable around the 60% mark, in line with the performance at the end of the previous year. Performance was impacted particularly at SaTH by the impact of COVID-19 and emergency pressures leading to the loss of capacity for elective care, and at RJAH due to COVID related staff sickness affecting their rate of recovery.
Number of 52-week RTT pathways (incompletes): Zero tolerance of over 52-week waits	At the end of June, published figures showed 4,385 Shropshire patients had been waiting over 52 weeks for treatment. Waiting list backlogs will continue to be addressed taking full account of clinical priority to recover the numbers waiting. The system only had patients 99 waiting >104wks vs a plan of 99 at the end of June, which were a combination of patient choice and complex spinal. The system is working towards zero patients waiting >104wks by the end of October, and to achieve zero patients waiting 78 weeks by April 2023. We have commissioned support with mutual aid from the independent sector, and nationally the NHS is coordinating mutual aid across the region wherever possible. The system transformation work is expected to yield efficiencies that will help with recovery of long waits by preventing unnecessary face-to-face appointments for patients and improving theatre efficiencies.
Diagnostic waiting times: Patients waiting for a diagnostic test should have been waiting fewer than six weeks from referral	Waiting times for diagnostic tests have not been achieved regularly throughout the year and were at 38.1 per cent in June. We have responded to the recovery by holding clinics outside of the current operating model, commissioning additional staffed MRI and CT capacity, and we have received funding for a Community Diagnostic Hub that will come online during 2022. Performance has plateaued Q1 across the system as a result of targeted local actions being planned for later in the year based on planned recruitment.
A&E waits: Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	The start of the new financial year was still feeling the impact of the COVID-19 pandemic, and the emergency departments continued to have increased staff absences and a decreased flow through the hospital. Improvement plans within SaTH remain focused around increasing productivity throughout the hospital to achieve quicker progress through A&E and earlier discharge, to reduce ambulance conveyances by developing alternate options other than A&E and implementing national recommendations around Same Day Emergency Care (SDEC). Work continues with

	appropriate signposting of the public to NHS 111 to encourage patients to use other appropriate alternative services. The wider system continues to work on reducing demand to the front door via the Single Point of Access which is showing a reduction in the number of ambulances conveyed. Infection control measures, which were enhanced due to COVID-19, have continued to return to pre-COVID standards This will contribute to increased throughput of patients, which will help recover the position in overall performance.
Cancer waiting times: First outpatient appointment for patients referred urgently with suspected cancer by a GP	Performance remains challenged due to balancing resource and loss of treatment capacity arising from the impact of COVID-19. Challenges continue to exist across staffing capacity for all tumour types. There is a national shortage of radiographers which is having an impact locally. Across Shropshire Telford & Wrekin providers have embarked upon an international recruitment campaign which is on track to deliver additional capacity from the end of Q2 Recovery in 2 week breast symptoms has begun in Q1. The system has responded by commissioning additional community-based services. The evidence suggests that there remains at this time an unknown demand that we are unable to quantify at this time of patients that have not presented or presented late due to the pandemic. The CCG is one of eight systems working with the West Midlands Cancer Alliance on a three-year trial in early diagnostic and intervention with identifying cancer with a simple blood test.
Category 1 ambulance calls: Category 1 calls to have an average emergency response within seven minutes and reach 90 per cent of calls within 15 minutes	The CCG has not achieved the targets locally during Q1 2022/23 for category 1 responses. For calls in categories 2 the performance continued to be challenged in Q1 but is expected to improve in Q2. We have restoration plans to help further recover category 2 performance in 2022/23 and to improve waiting times for category 1 based on improved ambulance handover delays.
Mental health and primary care indicators	The CCG has seen challenges in waiting times for children's eating disorder services in Q1 that has continued from Q4. Investment in these services has been made and recruitment is planned which will help recover waiting time targets as 22/23 progresses. The system continues to respond to the demand in recovery of the services following the pandemic and has invested to reduce waiting times in services for children and young people in mental health crisis during the remainder of 22/23.

Performance analysis

Primary care

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

The primary care team is led by an associate director of primary care with two primary care partnership managers acting as the first point of contact for individual practices and Primary Care Networks (PCN). The team also includes leads for workforce, estates and contracts, with project and administration support across all work streams.

Linked to the team is the newly established Training Hub, which leads and coordinates the delivery of training and development initiatives.

Primary Care Networks

The CCG has 51 GP practices across four localities (North Shropshire, South Shropshire, Shrewsbury and Atcham, and Telford and Wrekin). Practices make up the membership of our 8 PCNs:

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

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

These include:

- **Enhanced access** providing additional routine and same day appointments on weekday evenings 6.30pm – 8.00pm and on Saturdays 9.00am – 5.00pm from 1st October 2022
- **Structured medication reviews** (SMR) supported by the Medicines Management team to prioritise patients who benefit from an SMR
- **Enhanced Health in Care Homes:** provide a lead GP for each care home; create a simple plan with local partners as to how the care home multidisciplinary team will

operate; introduce a weekly home round, building on the work from 2021/22 to establish a Care Home Enhanced Support team; development work has continued on a system approach to support care homes with integration into the work on anticipatory care
- **Early cancer diagnosis** including review of the referral practice for suspected cancers
- **Social prescribing and care co-ordination** taking a personalised care approach to supporting patients' non-clinical needs
- **Cardiovascular disease (CVD) prevention and diagnosis:** improve diagnosis of hypertension and the number of blood pressure checks delivered
- **Tackling health inequalities:** identify a population within the PCN who are experiencing inequality in health provision and/or outcomes and deliver a plan to tackle their unmet needs.
- **Anticipatory Care:** contribute to the development of ICS delivery plans.
- **Personalised Care**: by September 2022 contribute to a targeted programme of social prescribing to an identified cohort with unmet needs.

We have continued to support PCNs to develop their workforce plans to progress recruitment into new roles that are part of the Additional Roles Reimbursement Scheme (ARRS). Clinical pharmacists, social prescribing link workers, first contact physiotherapists and mental health practitioners have been the main roles to be recruited to with over 140 ARRS-funded staff now in post.

Access to general practice

There has been media coverage nationally and locally highlighting patient concerns about not being able to access their local GP surgery in a timely way, particularly regarding accessing face-to-face appointments.

Compared to pre-pandemic, general practice is providing more appointments than before, despite there being fewer GPs now than in 2015. There has been a reduction in the number of face-to-face contacts, but this has been more than offset by the significant rise in telephone consultations. That said, it is important to note that 7 out of 10 patients are being seen face to face.

Although there are more appointments available than in 2019, the demands on primary care have increased significantly due to the elective backlog, as primary care are having to manage patients whilst they wait for their elective treatment.

Community Pharmacy Consultation Service: There are now 30 GP practices referring patients to community pharmacy for low acuity conditions, such as hay fever, bites and stings, coughs and colds.

Primary care workforce

There have been many achievements in strengthening the primary care workforce, in addition to the PCN roles mentioned previously. Examples include:

- Production of the STW General Practitioner Strategy along with an action plan designed to improve the attraction, recruitment and retention of GPs
- supporting twenty five newly-qualified GPs and four newly-qualified general practice nurses on the NHS England and NHS Improvement funded Fellowship Programme across the Shropshire, Telford and Wrekin footprint
- ten GP mentors supported to deliver mentoring sessions to colleagues
- continued funding for newly-appointed GPs, providing support for GPs in the early part of their careers
- an enhanced Training Hub across the Shropshire, Telford and Wrekin footprint has enabled the delivery of a number of training programmes, including continuing professional development (CPD) for around 240 general practice nurses.
- Successful roll-out of the Lantum digital staff platform, improving the ability of practices to book GP, and other clinical locums
- An increase in the number of practices able to employ staff on Skilled Worker visas
- Recruitment of two GP Champions – one for ethnically diverse staff and the other for locums
- An increase in the number of facilitators for ARRS and other staff – now covering FCPs, Paramedics, Physician Associates, Nurses, AHPs and HCAs

Primary care estate

In the period, the new build at Shawbirch opened its doors to patients, and planning has continued as part of NHS STW being one of six pioneer projects across the country for the development of an integrated health and wellbeing hub in the south of Shrewsbury. This hub will provide the opportunity for 6 GP practices to re-locate to a single purpose-built premises, and the co-location of a range of other community and voluntary services. A further period of public engagement was undertaken which is being used to inform the potential service configuration in the building.

Cancer care co-ordination

The Macmillan Team are working with nine practices to deliver holistic Cancer Care Reviews alongside the clinical element completed by practices to people living with cancer, within 12 months of their diagnosis. Phase two of the pilot has been an offer out through PCNs to engage with the project. 339 Cancer Care Reviews have been completed. Expansion to 2 new Telford practices started in June 2022. A patient feedback survey was launched in June 2022. Initial findings are very positive and will be shared shortly. Planning is underway for an independent evaluation of the pilot project.

Learning disability annual health checks

General practice has continued to prioritise learning disability annual health checks throughout the pandemic, in line with the national guidance to reduce health inequalities and proactively engage those at greatest risk of poor health.

Despite the challenges of COVID-19, practices have continued to prioritise this work, reaching the position of 65 per cent of people on learning disability registers receiving an

annual health check before the end of March 2022. During the first quarter of 2022-23 the focus has been to identify those who are overdue a Learning disability annual health check and encourage attendance.

Afghanistan Relocation and Resettlement Scheme

In collaboration with Telford and Wrekin Local Council, NHS STW supported the 200+ evacuees that arrived in the Telford area, ensuring that the residents were all registered with a GP practice and received an initial health check.

Ukrainian refugees

In collaboration with Shropshire and Telford and Wrekin local councils, NHS STW is supporting the refugees from Ukraine with registering with a GP practice in the area where they will reside, and guidance on obtaining an initial health check.

Transformation and commissioning

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

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

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

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

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

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

These areas, described in more detail below, include:

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

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

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

These pieces of work and priorities continue in 2022 and beyond and are described below in more detail.

Urgent and emergency care transformation

Following the development of an initial Shropshire, Telford & Wrekin (STW) Urgent and Emergency Care (UEC) Improvement Plan in 2021/22, work has been completed on a refreshed plan for the 2022/23 period. The plan sets out to ensure an agreed set of improvement priorities, developed by the system, are in place to identify and tackle areas of service improvement, transformation and redesign, to ensure that we are providing the best services for our residents and addressing areas where performance is below the standard we would want.

The Shropshire, Telford & Wrekin system has experienced a number of challenges over a period of time in relation to the delivery of Urgent and Emergency Care (UEC). This has

been exacerbated recently by unprecedented levels of demand, not only in UEC but across the health and care sector. Into April 2022 we have seen the highest level of COVID-19 patients in our hospitals, the highest numbers of care homes closed to admissions and the highest numbers of staff sickness absence than at any other time during the pandemic. This has exacerbated some of our underlying challenges and has informed the development of our UEC Improvement Plan.

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

Following a series of system workshops, focus groups and discussions with individual stakeholders the refreshed UEC Improvement Plan was developed to focus on three key areas:

- Pre Hospital Improvement
- In Hospital Improvement
- Discharge Improvement

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

In developing this plan there has been excellent engagement from stakeholders and the areas agreed for inclusion were deemed to offer the best opportunity to positively impact UEC performance.

Mental health, learning disabilities and autism

Adult mental health

Organisations across Shropshire, Telford and Wrekin continue to work in partnership to support all individuals with a mental health condition, those living with a learning disability, or who have autism.

During 2021/22, we undertook a significant amount of work to better understand the services we offer and the gaps we have locally.

An adult mental health strategy has been developed with a vision and implementation plan:

Our vision: 'residents of Shropshire, Telford and Wrekin experience their best mental health and wellbeing and have easy access to the right treatment and support services, which are underpinned by hope and optimism.'

Increasing investment means that we now have:

- mental health workers who are working alongside GPs in practices offering advice, guidance, and brief interventions
- Calm Cafés across our localities supported by mental health professionals
- a specialist mental health service for women who have a fear of birth or who have lost a baby
- invested in psychiatric intensive care beds in Royal Hospital Cheadle so people do not have to travel so far across the county
- peer support for people discharged from the Redwoods Hospital where there are complex needs
- made SMI physical health checks a priority, with numbers increasing and systems working together to increase uptake.

This investment will continue to grow through 2022/23 as we transform our service offer in the community for adults with mental illness. We will be focusing on the physical health needs of people with mental illness, 18-to 25-year-olds with mental health problems, adults with eating disorders, people who need help to resettle in the community after spending time in hospital and increasing access to psychological therapies for people with complex needs.

Dementia

There has been significant co-production with people living with dementia and their carers to agree a vision and new model to support them:

'People living with dementia and their unpaid carers are enabled to live the life that they choose that enhances and preserves their wellbeing.'

Our focus this year has been developing the Admiral Nurse role for Shropshire, who are specialist nurses who will support individuals living with dementia and their carers.

We have agreed our priorities for 2022/23: supporting GP practices to become dementia aware, developing a living plan, and making sure our website has clear information.

Children and young people (CYP)

CYP Mental Health Long Term Plan

The Shropshire, Telford and Wrekin Transformation Plan for Children and Young People's Mental Health and Wellbeing was refreshed in 2021. This report details an update since

2020, areas where improvements have been made and where services and plans are being developed to meet the actions.

Areas of improvement include:

- an increase in early intervention mental health, via programmes such as Anna Freud across the county schools, and the mental health trailblazer in school service
- both council websites containing improved communications and understanding of the mental health support that is available
- no waits for mental health services over 18 weeks. Children and young people referred to BeeU Access are triaged within one week and contacted by service within four weeks, but usually within two weeks. The only pathway that has CYP waiting over 18 weeks is autism spectrum disorder (ASD) diagnosis
- Shropshire's recent Special Educational Needs and Disability (SEND) inspection concluded in a written statement of action. One of the areas of concern is 'Significant waiting times for large numbers of children and young people on the ASD and attention deficit hyperactivity disorder (ADHD) diagnostic pathways'. An ASD diagnostic team within Midlands Partnership NHS Foundation Trust (MPFT) has been in place since September 2020. It is then envisaged that all CYP will start their assessments within 12 weeks of referral – as per National Institute for Health and Care Excellence (NICE) guidance
- all children and young people in crisis are triaged within four hours and seen by the crisis homecare team within 72 hours. This meets the national target
- since January 2021, a 24/7 crisis care for children and young people ran by MPFT has been in place with increased funding from mental health transition monies.

Areas still under development:

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

System governance

During 2020/21, a children and young people (CYP) workstream was developed. The key elements include:

- the development of a recovery, restoration and 'new normal' governance structure within the health and care system, which has highlighted a need for a stronger CYP voice
- the foundations of a healthy and fulfilled adult life are laid in childhood and adolescence
- there are some excellent examples locally of partnership working to support improved outcomes for CYP

- there are many components and services that are interdependent and explicitly linked to each other underpinning successful outcomes for the CYP and their families
- an initial group met in June 2020 to discuss appetite, benefits and barriers. The group has met monthly since October 2020
- it is proposed that a CYP pathway group will pull together and co-ordinate the elements of the CYP service across the health and care system
- short, medium and long-term actions have been developed to demonstrate commitment to getting this right.

The aims of the group are to:

- work in partnership with CYP and their families to develop shared outcomes
- lead and improve partnership working across the system
- lead and inspire local partnerships to deliver an integrated approach across the wider system to ensure families experience a joined-up offer of provision
- make best use of available resources preventing duplication and silo working
- be the voice and advocate for CYP and their families across the health and care system
- build upon community capacity and assets whilst reflecting local issues and needs which will inform service delivery
- use innovative approaches to identify health and wellbeing needs to target interventions and prevent needs from escalating across the system
- share information effectively and efficiently with partner agencies
- develop an approach that supports the ethos of ‘getting the right help at the right time’, whilst considering the need for local adaptations
- develop a CYP strategy setting out our agreed partnership priorities for the next three years.

Future work for 2022/23

There are plans in place to develop a partnership with CYP and their families across the health and care system. The aim is to support the delivery of CYP transformation as recognised in the NHS Long Term Plan.

Community physical health

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

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

During 2020/21, a number of service reviews began. Findings will be published during 2022; these will include new pathways that have been co-produced across the system and with support from children and young people, their parents, and carers. These include speech and language therapy and special school nursing.

A joint project to improve the care of children with asthma is underway, increasing the number of senior nurses who will undertake annual reviews and reviews of those who have been in hospital. This is a team working across our hospitals, in the community, and within primary care.

Personalised care

NHS England has commissioned a number of projects in relation to supporting our population through person-centred care interventions. Priority areas for these projects focussed on children and young people's mental health, and children and young people with a diagnosis of asthma.

An ICS Asthma Group has been formulated and is utilising Personalised Care as a basis for its activities. Activity to date has included:

- the appointment of 2 x CCNs to provide 48 hour reviews and asthma education for children and young people, with a focus on Personalised Care.
- the rollout of an Asthma App to support self-management of the condition in children and young people. This is live in Primary Care Services across STW and is also being promoted through the CCN service and secondary care.
- referrals to creative activities designed to support children with Asthma.
- delivery of asthma training across all local services who work with children.
- engagement with children and young people to explore Asthma through public health events and close working with the Shropshire Youth Association.
- development of an Asthma diagnostic hub to enable early help, and provision of appropriate care.

Creative Health activities to support children and young people suffering with mental health were commissioned and referrals were initiated over the summer period. Referrals came from Social Services, schools' mental health leads, as well as from across the BeeU Service. Feedback on the activities to date has been very positive, with providers reporting a beneficial impact on the wellbeing of children who attended. The activities are to continue throughout 2022/23 and referrals are to be extended through the virtual schools. A Personalised Care and Support Plan has been developed which can be used by the activity providers, which enables children to further identify their goals and support mechanisms and better self-manage their mental health outside of the activity environment.

A Personalised Care and Support Plan (PCSP) was co-produced with children and young people who access the Social Prescribing Link Worker Service in South West Shropshire. The PCSP is being used within the service in Shropshire, which is now being expanded through recruitment of six additional Healthy Lives Advisors to support children in additional Shropshire PCN areas.

We have also been involved in artist facilitated co-production of a resource for young people on waiting lists for the Eating Disorder Service by young people with lived experience. This work was jointly presented recently at the All-Party Parliamentary Group on Arts, Health and Wellbeing (APPG AHW) Webinar on Young People, Co-production, Creativity & Mental Health Services

A pilot project has been launched to support people in Oswestry who are experiencing poor mental health and/or substance misuse. The Health Equalities Partnership Programme (HEP), funded by NHS England, is a collaboration between Shropshire Council, Shropshire Telford and Wrekin CCG, Shropshire Mental Health Support (MHS), Designs in Mind, Midlands Partnership Foundation Trust and We are With You, and is designed to improve the wellbeing and mental health of Oswestry residents. Using creative resources in the community, MHS and Designs in Mind will introduce people to new tools to use as coping mechanisms, increase self-confidence, and teach people to manage their conditions using non-clinical interventions.

A project is being delivered in Telford in relation to developing materials used to promote cancer screening within ethnic minority groups. A number of community organisations have been consulted around the promotional materials to identify health literacy needs. The project has successfully recruited four health champions who will be further involved in the CORE 20 PLUS projects working in partnership with the Lingen Davies Cancer Fund. The CORE 20 PLUS project is additional inequalities funding that will see Cancer Champions being developed across Shropshire and Telford and Wrekin.

Finally, Parents Opening Doors in Telford have been commissioned to support children on the CCG's Dynamic Support Register with learning disabilities or autism, who are at risk of being admitted to a specialist learning disability or mental health hospital. Parents Opening Doors will be providing mentoring support to children and families as well as identifying and promoting social prescribing opportunities to improve health, wellbeing, and family relationships.

The local Personalisation Programme has initiated contact with leads across the CCG to facilitate opportunities in the following areas.

- Personalised care and support plans for maternity and cancer
- My Planned Care
- NHS @Home
- Palliative and End of Life Care

These projects have been complemented by a package of workforce training which has reached across our local healthcare system as well as our voluntary sector and health and wellbeing practitioners. All commissioned training was accredited by the Personalised Care Institute and promoted shared decision making, health coaching and motivational interviewing. Further training has been commissioned in 2022/23 to further develop the social prescribing link workers in Telford and Shropshire.

Special Educational Needs and Disability (SEND)

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

A joint SEND Inspection by the Care Quality Commission (CQC) and Ofsted took place in Shropshire across health, social care and education between 27th and 31st January 2020. The final letter was published on 6th May 2020 and identified many strengths, including the positive education outcomes for Shropshire children and young people with an Education, Health and Care Plan (EHCP) that attend mainstream schools and colleges.

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

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

A reinspection from OFSTED and CQC is anticipated to take place in Summer/Autumn 2022, and the development of the Self Evaluation Framework (SEF) has been developing and shaping an accelerated action plan and refinement of the Key Performance Indicators (KPIs) within the areas of concern. The final Joint Strategic Needs assessment has been presented to the board, which will be revisited quarterly to provide updated data and information.

Learning from COVID-19

The SEND COVID-19 operational group was very successful in bringing different partners together across the system. They were able to develop solutions to problems together very quickly and easily. An example is offering fit mask testing to support workers in educational settings and parents with a child with aerosol generating procedure (AGP) from community health services.

The group carried out a strengths, weaknesses, opportunities and threats (SWOT) analysis. The wider CYP tactical group looked over and agreed many of the SWOTs were the same across the CYP economy. This piece of work has been taken forward by the new system governance plan for CYP.

The main elements which the group felt were invaluable were:

- improved communications across organisations
- reduction to barriers across organisations

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

Learning disabilities and autism

Within learning disabilities services, we have increased our offer for those most in need of intensive support based on positive behavioural support principles. We continue to focus on the completion of annual physical health checks to improve the current inequalities experienced by people with a learning disability who are over the age of 14 years.

To ensure we understand the needs of people with learning disability and autistic people we have employed champions who are there to challenge the system to always consider the needs of these individuals.

The Keyworker project funding has been approved by NHS England, and development of the mobilisation plan and job descriptions for keyworkers etc have been co-produced with Barnardos and Parent Carer Forum.

An Autism in Schools launch event took place early in the financial year targeting senior school leaders setting the context for the project. We also ran an event with schools, local authorities, and PCF to coproduce the Learning and Development programme. 6 Training Modules were developed and delivered, with an average of 10 out of the 12 schools in attendance at the sessions. The project also delivered training and annual access to Widget online which was well received.

Parent Carer Forums worked with the schools to engage parent carer communities, establishing school-based participation groups, both face to face and online. These are supported by WhatsApp and closed Facebook groups, which support information sharing and peer connections.

Family support sessions with Educational Psychologists have been extended with funding for a further 2 years.

Elective care transformation and recovery

In addition to the longer-term transformation planning and potential impact, in the short-term NHS England required a number of rapid improvements from August 2021 onwards to help expedite rapid recovery, continuing throughout 2022/23.

These include:

- addressing health inequalities

- increased used of Advice and Guidance (and conversion to prevented face-to-face appointments)
- virtual consultations (and conversion to prevented face-to-face appointments)
- patient-initiated follow-ups (and conversion to prevented face-to-face appointments)
- improved capturing and reporting of the above in system data.

To further ensure the most efficient and effective use of available hospital capacity, ICS systems were also asked to implement a number of recommendations made by Getting it Right First Time (GIRFT) as part of the Midlands Elective Delivery Programme (MEDP).

Shropshire, Telford and Wrekin ICS was chosen as an early pilot for the first three specialties (ear, nose and throat (ENT), orthopaedics and ophthalmology), including the use of elective hubs (where possible) and innovation around surgical areas of 'High Volume, Low Complexity' activity, theatre utilisation and efficiencies, and improved and streamlined pathways. A second phase then commenced with the expansion to urology, gynaecology and general surgery. The whole programme is clinically led, and the local system has had to select clinical leads for each specialty.

Systems are being monitored and benchmarked against top decile performance and evaluation of the programme will include consideration of:

- clinical outcomes
- equity of access (clinical priority and waiting times)
- theatre and outpatient productivity
- improved patient and staff experience.

Prior to the pandemic, a forum already existed for the system-wide management of elective care performance including cancer, and this has since been expanded and reinvigorated to become a Shropshire, Telford and Wrekin Planned Care Recovery and Operational Group that oversees all of these aspects of elective care including performance, recovery, and transformation.

The Planned Care Operational Group sits within the emerging ICB structure, with operational and BI involvement and standing membership from system partners including SaTH, RJAH and SCHT. This group oversees the delivery of elective and cancer recovery. The group, operating on behalf of the CCG, governs all areas including recovery of elective care, cancer, and performance.

A broader Shropshire, Telford and Wrekin Planned Care Programme Board was also established that would manage oversight of this recovery and performance work as well as the elective care transformation programmes. All groups, programmes and areas of work ultimately report into this Planned Care Board that feeds upwards into the system chief executives. Any service changes, developments, or redesign report into the CCG Strategic Commissioning Committee, along with quarterly progress reports.

An additional group, the System Elective Delivery Plan Steering Group, is also being established by SaTH that will drive through delivery of the operational efficiencies and improved pathways recommended within the MEDP work and will report into the Planned Care Operational Group.

This group and its work cover the following six specific specialties:

- musculoskeletal (MSK)
- ear, nose and throat (ENT)
- ophthalmology
- gynaecology
- general surgery
- urology.

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

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

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

The programmes and the work being planned provides the opportunity to properly review and redesign elective care and move away from individual specialty appointments, and more towards patient pathways, experience and journeys. Always with the patient at the centre, making outpatients and accessing care simple, effective and efficient – Right Care, Right Person, Right Place, Right Time. As broad high-level aims, it is expected that through Elective Care Transformation for the system we would:

- better manage increasing demand for elective care services
- improve patient experience and access to care
- provide more integrated, person-centred care.

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

- improved utilisation of secondary care resource – physical space and clinical time
- optimised use of shared information and improved pathways
- improved clinical outcomes through patients receiving expert advice more quickly and follow-ups based on clinical need – rather than arbitrary schedules
- improved co-ordinated care for patients with multiple conditions
- improved patient experience through improved timely access to the right service, more informed and more empowered
- better use of patients' time through preventing what may be unnecessary trips to hospital

- reduced environmental impact, through decreasing journeys to hospital therefore emitting fewer CO2 emissions, resulting in reduced environmental damage and risk of preventable deaths through air pollution
- financial efficiency to patients through not having to travel, and to the system through improved efficiency and utilisation of existing resource.

Outpatients transformation

Between 2021 and 2026, this programme aims to redesign outpatient services working in a phased way through the specialties, underpinned by the aims of improving referral processes and a 33 per cent reduction in face-to-face outpatient activity through methods such as Advice and Guidance, remote consultations, one-stop clinics, and patient-initiated follow-ups.

A clinically led but locally-owned review and redesign of pathways; also taking into account learnings and recommendations that will come out of stakeholder and public involvement and engagement sessions.

The scoping, baseline data modelling and analysis, and preparatory work was completed as well as a series of preliminary engagement sessions that are underway to gather feedback on current Outpatient services, the outputs from which will inform future design and development options on new ways of working and new ways of providing Outpatient care. This also links closely with work happening in digital and workforce transformation across the system to ensure large-scale transformation and innovation is enabled effectively with new technologies and strategic workforce planning.

In addition to the longer-term transformation work, a lot of initiatives and activities are now underway to accelerate any of the potential changes and benefits in-year, with the aim of optimising the use of things like advice & guidance, patient initiated follow ups, and virtual consultations. These innovative and efficient new ways of working generate a certain amount of efficiency, helping to free up resource to support on the recovery of waiting lists; so doing what we can from a number of directions to try and get back to a position of patients being seen in a timely manner – with the right care, provided by the right person, in the right place at the right time - first time.

The programme excludes MSK and ophthalmology as they are managed separately, and the impact of the transformation counted within their own programmes of work.

Cancer

Improving cancer pathways continues to be a priority and is at the heart of the ICS approach to recovery of cancer services. Key actions have been undertaken during 2021/22 and the first quarter of 2022/23 including:

- The Shropshire, Telford and Wrekin Cancer Strategy was approved with an action plan for its delivery now being finalised.
- the Macmillan Cancer Care Review (CCR) project secured additional funding until May 2023 and work is ongoing to meet the objectives outlined within the project

initiation document for that work. There has been really positive feedback and data gathered so far on the impact and benefit of this work, with additional practices becoming involved and an independent evaluation being planned.

- Faecal Immunochemical Testing (FIT) has been implemented for all colorectal urgent suspected Cancer patients from 1st April 2022. A procurement is due to be undertaken for the new service commencing April 2023.
- Work continues on the rollout of a non-site-specific pathway but has had to be delayed for now in the absence of a clinical lead. Work ongoing to appoint into this role so that the work can continue.
- The Community Breast Pain Clinic was established in November 2021 and has secured additional funding for a further 12 months. An interim evaluation of impact and benefit is underway.
- Work as a system with the West Midlands Cancer Alliance as part of the Galleri blood test trials along with Cancer Research UK, Kings College London and the American company GRAIL. The trial is around undertaking diagnostic blood tests on individuals to identify any markers as early indicators of Cancer, enabling earlier interventions. We are currently in year 2 of a 3-year national trial, that will then undergo a full evaluation.
- We are looking to develop a pilot for the use of teledermatology as a first step towards having this provision across the county. Having this would help with the effective and efficient remote review and triaging of suspected skin cancer referrals and thereby significantly reduce the need for face-to-face appointments in the acute hospital.
- Work continues as a system on the restoration of 62-day performance and delivery of the faster diagnosis standard.
- Living Well sessions continue to take place virtually, and SaTH is developing a health and wellbeing app that will help further support Cancer patients in a number of other ways.

Eye care transformation

Between 2021 and 2024, this programme aims to review and redesign integrated end-to-end eye care services and pathways across the county, spanning primary, community and secondary eye care provision.

With a scope based on the same principles as the outpatients transformation programme, it aims to improve referral processes and information sharing, shared decision-making, and reduce face-to-face outpatient activity through methods including advice and guidance, remote consultations, one-stop clinics, community-based diagnostics, nurse-led telephone follow-ups, and clinically-led review and redesign of pathways; also taking into account learnings and recommendations that will come out of stakeholder and public involvement and engagement sessions.

The phases of the programme will cover:

- rethinking referrals and integrated pathways (primary, community and secondary care)
- outpatient transformation

- multispecialty pathways (Giant Cell Arteritis and Hydroxychloroquine Monitoring).

All of these phases will cut across eye care in general in terms of pathways, processes and ways of working, but include particular areas such as:

- general outpatient eye care services
- children's eye care services
- urgent eye care services
- glaucoma
- cataract
- medical retina
- macular degeneration
- sight loss access to services.

The scoping, baseline data modelling and analysis, and preparatory work were completed between July and October 2021, when it was approved to launch the programme. A number of difficulties and pressures however including winter pressures, staffing shortages and the impact of the Omicron COVID-19 outbreak meant that this had to be paused and was eventually launched in February 2022.

After the Shropshire, Telford and Wrekin system agreed to be an early adopter and one of the 11 ICSs in the Midlands, and with the NHS England and NHS Improvement Midlands procurement of software underway, we are moving ahead earlier with one aspect of eye care transformation, which is the rollout of electronic eye care referrals. The project plan is currently being developed with NHS England colleagues and will involve stakeholders, GPs, patients and public.

The project will see an improved flow of direct referrals between optometrists, the Referral Assessment Service (RAS) and Telford Referral and Quality Services (TRAQS), GPs and secondary care with the ability to transfer high resolution digital images directly from optometrists to secondary care consultants and enabling effective virtual consultations to take place without the need for the individual having to visit hospital.

The project is progressing well and following a series of initial engagement sessions, the outputs have been consolidated and analysed, and are now being used in the design and development of proposed future models of eye care that will be shared at a later date for consideration and feedback.

Musculoskeletal (MSK) transformation

The MSK transformation programme, since 2021, has been looking to incorporate the work completed to date and build upon this in a three- to five-year programme. This programme aims to improve the MSK health of our local population, whilst ensuring when MSK care is required, that patients are cared for at the right time, in the right location by the right person.

The services currently in scope of this work are:

- referral and triage (SOOS/TEMs)
- therapies
- orthotics

- pain services
- rheumatology
- surgical services
- delivering recovery of the COVID-19 backlog of patient care without additional resource
- workforce planning.

The objectives of the programme are:

- delivering good outcomes and patient experience
- achieving outstanding patient safety
- providing timely access to patient care
- spending our money wisely
- patients are cared for by the right person, at the right location at the right time
- improve citizens' MSK and pain health.

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

The MSK transformation programme is phased as follows:

- Phase 1 (Year 1) – Strengthening of rheumatology
  - consolidation and standardisation of community MSK provision
  - focus on patient-initiated follow-ups plus implementation of a standard interface model for referral and triage. This includes Rheumatology but not at this stage due to capacity challenges.
- Phase 2 (Years 2 and 3) – Optimisation of orthopaedics
  - outpatients improvement project (aligned to the transformation programme)
  - review and redesign of pain services
  - maturing of system provision to support primary care
  - falls, fractures and osteoporosis (dependent on decision on trauma scope)
  - A decision to be made about whether trauma will be in scope for the programme
- Phase 3 (Years 4 and 5) – supporting those with long-term MSK conditions
  - development of self-management models.

Local care and community transformation

System changes

During the 2021/22 year, some major changes contributed to shifts in how the system needed to operate, including the response to COVID-19 and the impact it had on services, patients, and staff. This focused our system on working together as one cohesive team and as a combined force with the same aims and objectives. We also worked closely with our partners to accelerate areas of innovation and change where possible and appropriate. Work also continued to align commissioning to become one integrated strategic commissioning organisation spanning the whole Shropshire, Telford and Wrekin footprint.

As the system, its structure had to be redefined to take into account:

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

This restructuring of the system saw the development and establishing of three programme boards that would be accountable for all of this work associated with their areas. These groups were:

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

As described, as COVID-19 took hold in the UK, resources were pulled into crisis response roles and therefore the decision was made to pause all transformation programmes in March 2020. In September 2020, it was agreed to re-start the transformation work across the system but with the need to revisit and refresh the scope, aims, objectives and anticipated outcomes. This work would be governed by a new system structure and programme boards.

Specifically for community-based services, this saw the establishing of the Local Care Programme Board and its programme board. Shropshire Integrated Place Partnership (SHIPP) Board and the Telford and Wrekin Integrated Place Partnership (TWIPP) Programme Board became the operational and delivery arms of this work.

As the structure of the ICS developed over 2021, the National Ageing Well Programme which included the previous model of the Care Closer to Home Programme was realigned under the umbrella of the local care transformation programme. This programme of work is linked to SHIPP and TWIPP.

Telford and Wrekin Integrated Place Partnership (TWIPP)

Telford and Wrekin Integrated Place Partnership (TWIPP) was established in 2019 as a partnership board between the clinical commissioning group, Telford and Wrekin Council, local healthcare service providers and representatives from the primary care networks.

TWIPP has six key priorities, which were reviewed and updated across partners in May 2021:

1. Integrated care and support pathways
2. Integrated advice, information and access to support
3. Building community capacity and resilience
4. Integrated response to tackling health inequalities
5. Prevention and healthy lifestyles

6. Maintaining the identity of Telford and Wrekin whilst supporting the system.

Key achievements against our shared priorities during April to end of June 2022

- Delivery of the COVID-19 vaccination programme as a combined health and social care programme using real-time data from primary care to assist in directing vaccination activities to areas of lower uptake, including using outreach methods to engage with our communities more fully
- In regard to prevention and healthy lifestyles, the local authority has launched the 'Year of Wellbeing'. The CCG has launched an NHS England digital weight management offer via primary care for those with hypertension and diabetes as part of a system-wide approach. This is connected into the wider pathways and assistance available from local authority healthy lifestyle advisors and as part of our strength-based assets approach within communities for adopting healthier lifestyles. In addition, a programme of work to introduce NHS-funded tobacco prevention in acute inpatient settings and further development of the tobacco prevention model in maternity has continued. The Shrewsbury and Telford Hospital NHS Trust have also been successful in securing funds for an alcohol care team to deliver inpatient services at the Princess Royal Hospital. Shropshire Community Health NHS Trust have commenced the implementation work for the community diagnostic hub in Telford
- Telford and Wrekin Council continue to offer services from the independent living smart house that allows for the showcase of technology that supports people at home as well as supporting skills and means of digital access
- The Integrated Health and Social care team have continued to provide a valued service over this period and the care home team element of our community services have continued to develop advanced care planning documentation and processes to support individuals in receiving care in their own environment
- As part of our integrated response to health inequalities, we have established joint working groups to look at addressing inequalities around cancer access and outcomes and in the detection and management of hypertension. During April to end of June 2022 this has included connections to the Core Cancer Champion Inequalities work.
- Working with our partners in the voluntary and community organisations, a programme of work has been implementing to co-produce the development of the Telford Ageing Well Strategy which will seek to address at place level the particular challenges of the rapidly ageing population in Telford.

Find out more about TWIPP.

Shropshire Integrated Place Partnership (SHIPP)

SHIPP is a partnership board of commissioners, providers of health and social care, the voluntary and community sector, and involvement leads, in Shropshire.

The Board focusses on joining up work, integrating where possible as well as collectively delivering its objectives and outcomes. It is a partnership of equals with shared collaborative

leadership and responsibility, enabled by the ICS governance and decision-making processes.

Clinical/care leadership is central to the partnership, including leadership from our Primary Care Networks, to ensure that services provide the best quality evidence-based care and support for our people, improving outcomes and reducing health inequalities.

It is expected that through the programmes of SHIPP, and routine involvement and co-production with local people and workforce, we are able to inform and influence system strategy and priority development.

SHIPP has six key priorities:

1. Health and Wellbeing – including Children and Young People's Strategy, encouraging healthy lifestyles and mental health
2. Community capacity and resilience with the voluntary sector
3. Local care and personalisation
4. Supporting the primary care networks
5. Integration and one public estate
6. Tackling health inequalities.

Key achievements against our shared priorities

The Board has made great progress with regard to personalisation. Despite the pandemic the Social Prescribing programme grew throughout 2021/22 and continues to grow, demonstrating a large increase in referrals, and outcome data demonstrates significant improvement in wellbeing. We had over 1,975 referrals for 2021/22 and in the first quarter of 22/23 we have received 782 referrals (more than 100 per cent increase on the same period last year).

We introduced Personalisation Contract schedules for Shropshire Community Health NHS Trust, The Shrewsbury and Telford Hospital NHS Trust and The Robert Jones and Agnes Hunt Orthopaedic Hospital, which relate to personalised care and the uptake of Personalised Care Institute (PCI) accredited training.

We provided grant funding to bolster the voluntary and community sector infrastructure, including volunteer brokerage, VCSE development, community development, mental health and data and evaluation. This work is extremely important as part of our strategy to increase opportunities for people to improve their health and wellbeing in the communities where they live. The volunteer brokerage works hand in hand with Social Prescribing community development in order to improve the community offer and connect volunteering opportunities with people and communities. This work also links heavily with Community Mental Health Transformation and the delivery of the Children, Young People and Families Early Help and Prevention Strategy.

As part of our developing Children, Young People and Families Early Help and Prevention Strategy, we have launched a programme to deliver multiple projects to improve outcomes for children and their families, the focus included early years, school, access and social prescribing, looked-after children and workforce through place-based pilots.

Additionally, as part of personalisation and support for children and young people (CYP), we implemented a CYP Social Prescribing pilot, which included a provider collaborative to provide additional activities and support for CYP. We co-produced CYP Creative Health activities to support them with a diagnosis of asthma and low-level mental health issues. Furthermore, we commissioned support to develop and deliver personal care and support plans for children with complex mental health needs on the Dynamic Support Register (DSR) to avoid complex high-cost placements.

For local care, we have expanded rapid response across Shropshire and implemented a new Case Management and Community Respiratory pathway. A core element of SHIPP's work is to connect Local Care, Personalisation, Prevention (including Proactive Prevention) and Community workstreams together (including influencing how programmes work with local communities to co-produce health and care). Key areas of work agreed in early 2022/23 are Proactive Prevention, Engagement with Primary Care and Service Users/ Shropshire People, Respiratory Transformation, Alternative to Hospital. Additionally, SHIPP has requested some detailed work on the Falls pathway (primary prevention through to tertiary prevention).

Tackling health inequalities is core to our work, and we developed a Shropshire Inequalities Plan, secured NHSE funding to launch a Shropshire, Telford and Wrekin system Cancer Champion project, which will be delivered by the voluntary and community sector. We also supported primary care networks to deliver further inequalities projects. Additionally, through the Vaccination Programme and our Community Outreach offer we are delivering mini health checks alongside vaccinations in very local communities. This work is data driven and targeted at our most vulnerable communities.

The development of our locality based Joint Strategic Needs Assessment (JSNA) supports the system to understand our very local communities to inform decision making across programme and improves our connections with our communities (especially our very rural areas) as part of our involvement ethos and plays a central role in reducing health inequalities. This work has been developing in earnest since Quarter 4 2021/22, and is progressing well in Highley, Oswestry, Whitchurch and Bishop's Castle. All 18 Shropshire Place Plan Areas will have a Locality JSNA by 2024.

Local care transformation programme

The STW system continues to work together on our ambitious programme to build our integrated community base service.

We have seen during the last quarter of 2021/22 the successful implementation of our new models of care that are alternatives to hospital admissions. The new models of care are supporting residents across the county, through a coordinated response using the skills, knowledge and expertise of our health and care practitioners.

This ambitious programme will continue to build an integrated community-based infrastructure that will support residents to their own homes or in a community setting that is able to respond to their needs. We will continue to work collaboratively as partners to shift

our focus from providing a reactive offer of health and care to supporting residents through proactive prevention and early interventions.

The next 6 months will see our system co-designing and producing the following new models of care:

- Neighbourhood teams (adults)
- Neighbourhood teams (children)
- Ageing well
- Integrated discharge team
- Integrated therapy / AHP service
- Primary Care alignment to Integrated care services
- Proactive prevention
- Anticipatory care
- Virtual ward
- Community Bed based Model
- Respiratory Transformation
- Advance Care Planning in Care Homes Phase 2

We strongly believe that through our partnership with residents and communities, we will see the implementation of new models of care and new ways of working that have a focus on what matters to residents and communities in STW.

Palliative and end of life care

A system-wide review of adult palliative and end of life care commenced in the autumn of 2020. Phase one of the review was completed, and during 2021 three task and finish groups were established to work on a number of key actions for improvement identified in the first phase.

The Shropshire, Telford and Wrekin Integrated Palliative and End of Life Care Strategy (Adults) 2022-25 was ratified and launched in May 2020. The key priorities of the strategy are the improvements that people with the experience of caring for a loved one at the end of their life would like to see. These improvements include a named care coordinator and 24-hour access to advice and support.

A strategy implementation plan has been developed with a number of working groups in place with the responsibility to develop the actions within this plan.

Since the beginning of the year these groups have worked on a number of initiatives to include:

- Improving the process to access, prescribe and administer ‘Just in Case’ medication
- standardising the Fast-track process to reduce duplication and support quicker access to care and earlier discharge from hospital
- mapping out current Children and Young People services to identify any gaps and to identify development priorities in order to inform a Children and Young Persons Palliative and End of Life Strategy for Shropshire Telford and Wrekin

- working with libraries across the region to support the Death Positive Libraries programme in offering advice on advance care planning to the public.

During 2022 the Clinical Development Group has the opportunity to work with the NHS England National Palliative and End of Life Team on the Getting to Outstanding programme, which means that the Group will have access to quality improvement expertise and tools to support a development that is a key priority for improving the care of people in their last year of life.

Community Beds Review

A programme of work was launched to undertake a full review and potential repurposing of our available community beds. Phase 1 of this programme, the review of current bed availability and use, has now commenced working with key stakeholders across the system to understand the current community bed base across Shropshire, Telford & Wrekin. This includes an assessment of value for money and fitness for purpose, and the identification of any current issues regarding community bed provision. The outputs of this review will be used to inform Phase 2; the development of the future requirements for community beds, alongside other interdependent programmes of work across the system that have links to community-based beds.

Community Equipment Service

A programme of work commenced to scope the possibility of developing and commissioning a joint whole-county community equipment service across Shropshire, Telford & Wrekin, incorporating Shropshire County Council, Telford & Wrekin Council, and Shropshire, Telford and Wrekin CCG. This involves understanding and evaluating how community equipment is commissioned and provided currently, and engaging with professional stakeholders, service users and carers to understand the future requirements for an improved joint service and how this may best be provided.

Other

Other pieces of large-scale work include the neurology service delivered at SaTH that was successfully transferred to The Royal Wolverhampton NHS Trust (RWT) in May 2021 after being challenged for many years, primarily due to workforce limitations. These challenges led to patients experiencing long waits to see a consultant, which in turn led to the decision to close new referrals. Following system agreement that the local service could not be reopened in that form, agreement was reached between the CCG, SaTH and RWT to develop a sustainable neurology service across Shropshire, Telford and Wrekin.

The transfer was successful and is being monitored throughout 2022 prior to an evaluation and series of engagement sessions including clinical, patient and public and wider system stakeholders as an opportunity to undertake a full review and redesign, where necessary, of the local neurology service.

Work also continues on a review and redesign of audiology services in the county, including ear irrigation. Future plans not yet developed include the need to review and redesign cardiology and cardiovascular prevention, dermatology and irritable bowel services.

Medicines optimisation

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

The goal of medicines optimisation is to help patients:

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

Our medicines management team works closely with patients and members of the public, clinicians and commissioners to help achieve these goals.

Medicines optimisation clinical projects

Respiratory

Working with clinicians in SaTH and Shropshire Community Health NHS Trust, the Chronic Obstructive Pulmonary Disease (COPD) treatment guideline was updated to reflect the latest evidence-based guidance for the treatment of COPD (NICE).

Inhaler choices for this guidance were considered, along with the wider respiratory formulary choices to ensure carbon impacts are reduced where possible. Carbon impact guidance was also produced to aid safe, cost-effective prescribing across the system.

A clinical focus project for COPD was conducted across all practices in Shropshire, Telford and Wrekin to level-up previous work undertaken across most Shropshire practices, providing opportunity for a clinical catch-up programme across primary care. The project involved optimising inhaler therapy in COPD patients, reducing inhaled corticosteroid prescribing where appropriate/optimising triple therapy. This movement has been reflected by changes in prescribing data, with reduced inhaled steroid prescribing and increased uptake of triple therapy. Optimisation of treatment was to reduce harm from inappropriate steroid use and prevent further decline of patients with poorly controlled COPD, which may lead to hospital admission.

Cardiovascular disease (lipid management and atrial fibrillation)

Work to support the NHS Long Term Plan in reducing cardiovascular deaths includes:

- a cardiovascular focus project that was conducted across primary care, focusing on atrial fibrillation (AF) and the optimisation of anticoagulation management in these patients to reduce stroke risk. Patients' therapy was reviewed by practices across primary care and optimised in line with the new NICE AF management guidance. A lipid management project has also been running alongside this, ensuring patients with high risk of cardiovascular events are appropriately treated and optimised to reduce the risk of further cardiovascular disease (CVD) events
- guidance and searches being developed by the team (alongside secondary care) to support these projects, along with a training programme run in conjunction with local clinicians and the West Midlands Academic Health Science Network (WMAHSN)
- the medicines management team establishing a working group with specialist cardiologist and lipidologist leadership, to focus on lipid management and develop a system approach to support the implementation of inclisiran and reduce health inequalities.

Medicines optimisation in care homes

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

The rolling training programme for care homes has been progressed to an online learning resource offering a blended learning approach throughout COVID-19. Nine modules have been added to the Learning Management System available to all care settings, including Antimicrobial Resistance and Medicines Management in Care, and a task group has been developed to create STOMP, medicines reconciliation and error training.

Throughout a very challenging time for care homes training attendance was still high, with five Medicines Management in Care training sessions delivered in collaboration with local authorities and Shropshire Partners in Care.

Medicines formulary

Medicines are approved for use locally after careful consideration of the supporting evidence at the Area Prescribing Committee and they are included on a formulary when they are considered to offer clinical benefits over what is already available. Medicines which are given a positive appraisal by NICE are automatically included on the formulary without further local consideration.

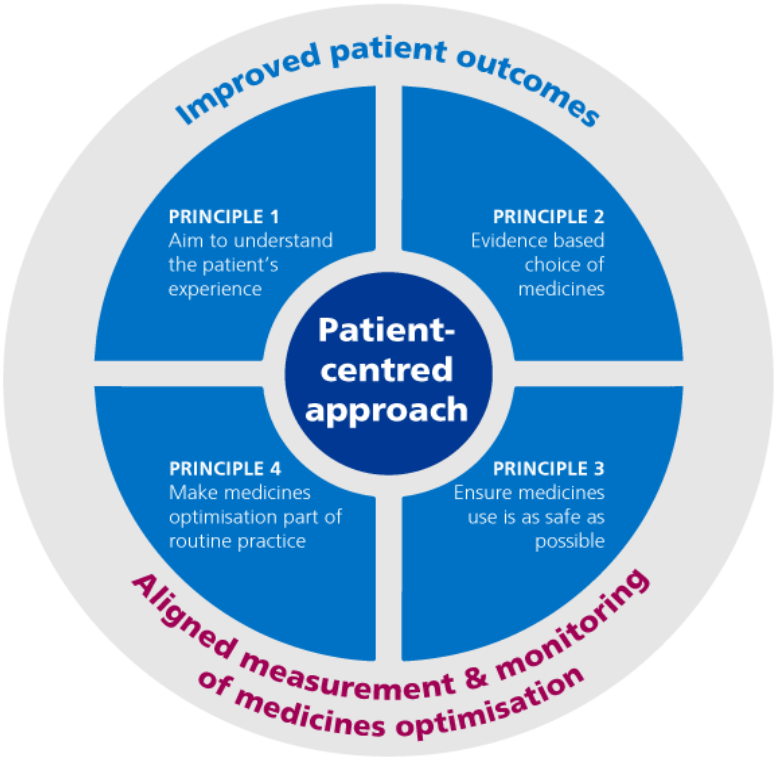
Formulary medicines represent the best choice from a value perspective which means that they will achieve the best treatment outcome at the least cost, this is different from simply using the cheapest medicine.

Medicines optimisation looks at the value which medicines deliver, making sure they are clinically effective and cost-effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team.

Prescribing support systems

Scriptswitch continues to ensure that safety and savings messages remain current, strengthening engagement with practices, delivering savings and exceeding the planned target figures. Information and safety messages have been updated, following a procurement process following the SBS framework, to move to one prescribing support system.

From 1st June 2022 Scriptswitch became the sole system in use in NHS STW. Scriptswitch already has more than 9,000 messages on the system with weekly updates which has been rolled out to all practices. Additional improvements include the integration and roll out of the Eclipse system support tool within Scriptswitch to alert practices to high-risk prescribing. This has had positive feedback and will, moving forward, become an integral safety system within GP practices.



ECLIPSE – Patient safety

ECLIPSE Live provides a suite of Radar Admission Avoidance Alerts which identifies patients that fall within a prescribing safety risk category. These risk categories capture the latest 'UKMI Drug Monitoring in Adults in Primary Care' suggestions and NICE current best practice. The suite of alerts is a risk stratification system which can be utilised to help identify patients who may be at an increased risk of harm from medicines.

Following a drive for implementation from the medicines management team, 50 of the 51 GP practices across the CCG now actively utilise the alert system to identify patients with reversible risk, reducing complications, exacerbations and hospital admissions.

Formulary and medication switches/cost-effective prescribing

Cost-effective medication switches across Shropshire, Telford and Wrekin were impacted by redeployment due to COVID-19, however they still exceeded planned target QIPP

figures. To further support our cost-effective prescribing programme and realisation of efficiencies in prescribing across the system, we implemented the Accelerate cost-effective prescribing programme, working with Optum.

This programme allowed medication switches to be performed quickly to realise efficiency savings over a short time period, maximising in-year savings opportunity whilst team capacity was low.

Antimicrobial resistance

The UK's five-year national action plan for tackling antimicrobial resistance 2019-2024 remains to be embedded in our antimicrobial workstreams to ensure the appropriate and necessary use of antimicrobials.

One of the greatest steps we have taken in relation to antibiotics stewardship, is starting a development committee for a new service which will allow for intravenous antibiotics to be administered in a community setting. This will improve quality and efficiency of care and reduce risk of harm in patients with infection who would otherwise be hospitalised for IV antibiotic therapy.

A true, system-wide project, the development of this proposed service has been contingent on effective collaboration between all providers and stakeholders. We have held regular meetings with input from all disciplines including microbiology, transformation, pharmacy and nursing teams and have collaboratively moved towards the creation of a cohesive and integrated service proposal. We are working collaboratively to improve patient flow, appropriate optimisation of antimicrobial use and boost out of hospital care. This will not only reduce bed occupancy in hospitals by bringing care closer to home, but will also reduce the risk of hospital acquired infections.

Moving forward we will have an integrated approach to optimising and monitoring antimicrobial use through a new Antimicrobial Resistance Strategy Group, bringing together secondary and primary care providers to develop and deliver a shared strategy.

Improving patient safety

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

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

The following three medicine classes warrant a more proactive planned approach to safety monitoring: the anticoagulants, valproate in pregnancy prevention programme, and

high dose opioids. A collaborative approach across all our NHS providers is underway.

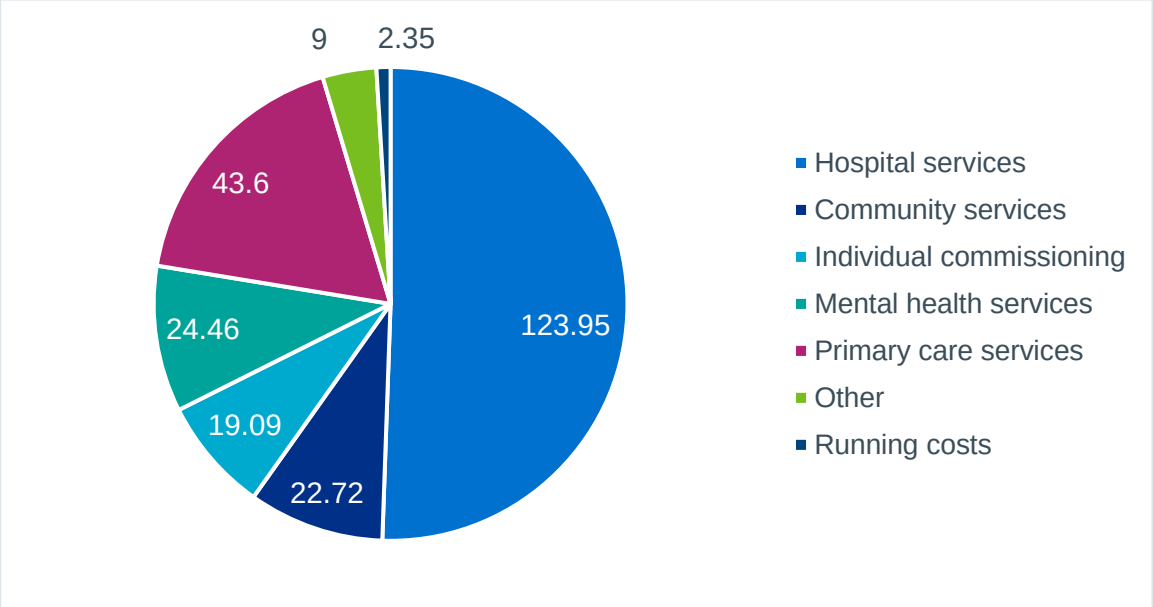
Working collaboratively with our local hospitals and community provider

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

Finance

In the three months to 30th June 2022 the CCG received a total allocation of £245 million to spend on the healthcare of its residents. The chart below shows a breakdown of the CCG's expenditure for the period by spend type:

Net Expenditure 2022/23 (£245 million)



Further analysis of expenditure, by type

	30/06/2022 Total £'000
Pay	3,473
Purchase of goods and services	
Services from other CCGs and NHS England	1,621
Services from foundation trusts	36,853
Services from other NHS trusts	120,108
Purchase of healthcare from non-NHS bodies	35,268
Prescribing costs	21,145
General Ophthalmic services	177
GPMS/APMS and PCTMS	22,835
Supplies and services – clinical	409
Supplies and services – general	2,455
Consultancy services	86
Establishment	211
Transport	81
Premises	196
Audit fees	100
Other non statutory audit expenditure	
· Other services	6
Other professional fees	306
Legal fees	8
Education, training and conferences	(55)
Total Purchase of goods and services	**241,809**
Depreciation and impairment charges	
Depreciation	**65**
Total Depreciation and impairment charges	**65**
Provision expense	
Provisions	(36)
Total Provision expense	**(36)**
Other Operating Expenditure	
Chair and Non Executive Members	110
Grants to Other bodies	8
Expected credit loss on receivables	(6)
Other expenditure	
Total Other Operating Expenditure	**112**
Total Expenditure	**245,423**

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

	30-Jun-22	2021-22
	£'000	£'000
Total Non Current Assets	1,044	-
Current assets:		
Trade and other receivables	2,910	3,618
Cash and cash equivalents	104	375
Total current assets	**3,014**	**3,993**
Total assets	**4,059**	**3,993**
Current liabilities		
Trade and other payables	(61,172)	(64,902)
Lease liabilities	(1,046)	-
Provisions	(2,219)	(2,406)
Total current liabilities	**(64,437)**	**(67,309)**
Non-Current Assets plus/less Net Current Assets/Liabilities	**(60,378)**	**(63,316)**
Non Current Liabilities	-	-
Assets less Liabilities	**(60,378)**	**(63,316)**
Financed by Taxpayers' Equity		
General fund	(60,378)	(63,316)
Total taxpayers' equity:	**(60,378)**	**(63,316)**

Sustainable development

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

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

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint. The CCG had a board-level Sustainability Champion and although we had planned to develop a Sustainability Policy during 2021/22, due to capacity constraints resulting from the pandemic and then the changes planned to dissolve CCGs and replace with Integrated Care Boards we were prevented from completing this work.

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

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

Energy

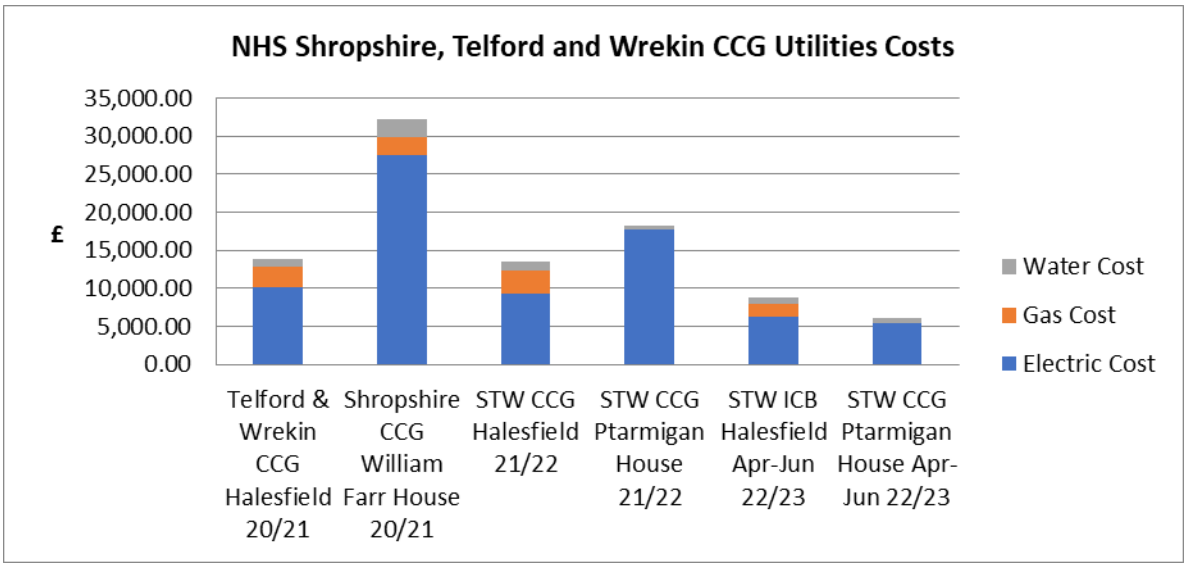
The CCG does not own or have control over any estate, other resources, natural capital or landowning that require reporting in this annual report.

The graph below shows the position for 2020/21 across the two sites occupied by the then separate CCGs, Shropshire CCG at William Farr House and Telford and Wrekin CCG at Halesfield. In May 2021 following the two CCGs being dissolved, a single CCG was created and staff based at William Farr House were moved to a new site at Ptarmigan House.

Utilities costs 2021/22 and 2022/23

The graph below shows there has been the same level of usage of energy at the Halesfield site in water costs, gas and electricity costs during 2021/22, which is partly due to the CCG staff working from their homes for significant periods during 2020/21 whilst the country was subject to restrictions to combat COVID-19 pandemic, although the impact is less on energy costs as some staff still had to base themselves at the CCG's headquarters during these periods and so the buildings continued to require heat, light and water.

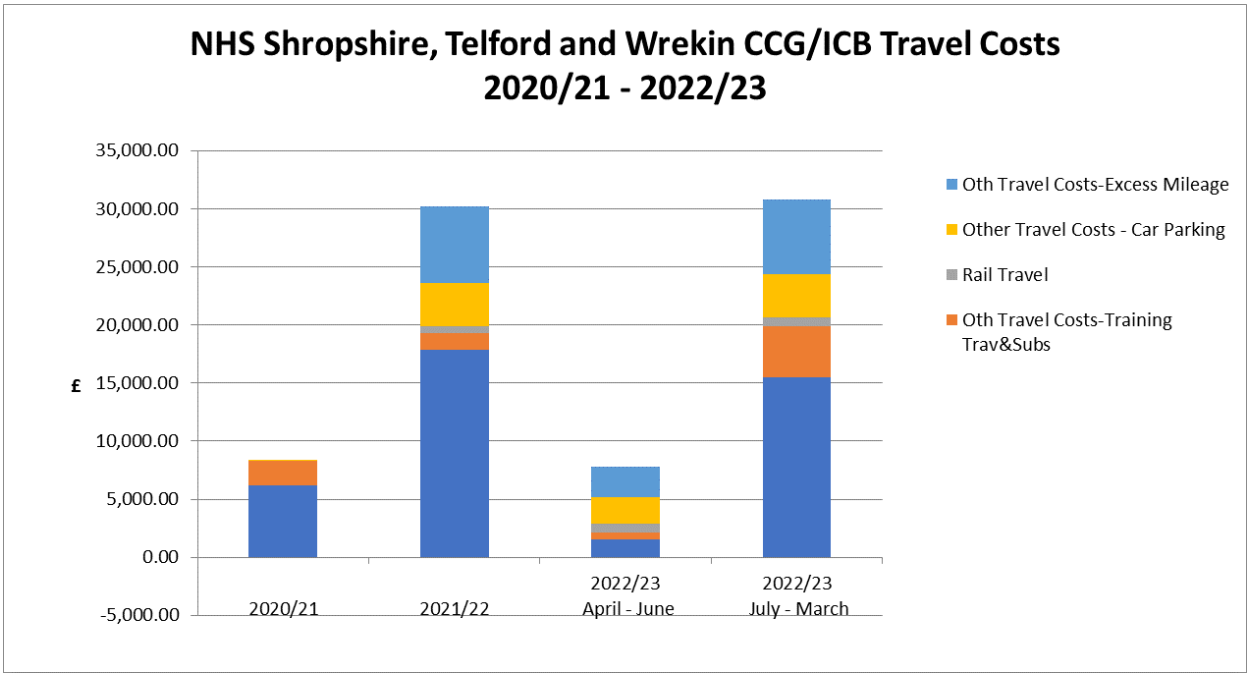
The landlord of Ptarmigan has been unable to provide the CCG with energy usage data for the building, so we are unable to make any direct comparisons with last years figures and also evaluate positive and negative impact from the relocation from William Farr House to Ptarmigan House and as this was the first year of occupation, we are unable to provide estimates based on previous energy consumption at this site.



Travel

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

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



Consumables and waste management

During the period 1st April to 30th June 2022 the CCG used a total of 70 reams of paper, this is in comparison to a 25% proportion of 54.25 reams of paper from the total of 217 reams of paper used in 2021/22. Contracts for waste are overseen by landlords of each of the properties where CCG staff are based and so the CCG does not have access to waste management information for reporting purposes.

Procurement

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

Efficiency programme

In order to fund increases in activity, demography and any additional cost pressures, the CCG has been required to deliver recurrent efficiency plans year on year.

During the first quarter of 2022/23, the CCG had a target to deliver £2.5m of savings as part of its internal efficiency plan and system transformation programmes. In June of this year £3m of efficiencies were reported which were predominantly achieved by Medicines Management and Individual Commissioning teams.

As part of the development of the system financial sustainability plan, all system organisations continue to work towards delivering a 1.6% internal efficiency target. In addition to this, system partners are working together to deliver large scale transformation programmes which will provide further efficiencies and value for money.

Monitoring the quality of services

Quality assurance principles and processes

NHS Shropshire, Telford and Wrekin CCG hold the following statutory responsibilities for quality under the Health and Social Care Act 2012:

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

Until 30 June 2022, the CCG remains responsible for securing comprehensive services within the financial resources available to meet the needs of the population of Shropshire, Telford and Wrekin. In doing so, the CCG continues to be assured of the quality of the services commissioned during the transition arrangements to the new quality governance framework and the anticipated statutory functions of the ICS.

The CCG commissions services from independent providers and all the main NHS trusts in the area:

- The Shrewsbury and Telford Hospital NHS Trust (SaTH)
- Midlands Partnership NHS Foundation Trust (MPFT)
- West Midlands Ambulance Service University NHS Foundation Trust (WMAS)
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)
- Shropshire Community Health NHS Trust (SCHT).

All Care Quality Commission ratings for the above can be found on the CQC website

Patient safety and quality

Quality is only achieved when three key elements are met:

- clinical effectiveness
- patient safety
- patient experience.

The role of the CCG's Quality team is to ensure that the services we commission are safe, effective and in line with the needs of the population.

We work collaboratively with all providers of health and social care across Shropshire, Telford and Wrekin to monitor and review information from a range of sources to ensure that safe, effective and high-quality, caring health services are commissioned and delivered for local people. Quality concerns and risks are reported to our monthly CCG Quality and Performance Committee (QPC). The Quality team holds its own risk register which is updated as required and reviewed on a quarterly basis. High risks are included in the CCG corporate risk register and reviewed monthly.

Quality assurance is sought from a variety of methods, including agreed quality schedules, regular formal contract reporting and quality review meetings with all providers. This is in addition to quality assurance visits and listening to the experiences of service users. Together, these provide a robust insight into the quality of local service delivery. We work collaboratively with partners to identify key areas for quality improvement, share best practice across the system, and ensure that incidents, complaints and events inform service improvements.

Alongside the CQC, we support providers to celebrate areas of strength and improvement and target areas of challenge. Over the past 3 months, we have worked with providers to identify several quality areas which required further in-depth analysis and understanding including urgent and emergency care and palliative and end of life care. CCGs hold the responsibility for the performance management of the Serious Incidents (SIs) reported by commissioned services. The CCG ensures that all incidents are investigated, and we develop action plans which we then monitor to completion. Changes in practice are tested through quality assurance visits.

SIs are integral to the patient quality and safety agendas and have been reported through monthly quality reports. We seek to ensure that lessons are learned from all incidents and that findings are shared wherever possible in order to mitigate the risk of recurrence.

Quality assurance visits are undertaken by commissioners to gain assurance about the quality and safety of all commissioned services. The visits can also improve local service provision and understanding and offer opportunities to improve patient experience.

Key issues and risks

Key quality risks during April to June 2022 have been the overall quality of services delivered by SaTH which is placed in NHS England System Oversight Framework (SOF) 4 (Recovery Support Programme) and currently rated inadequate by the CQC following its inspection November 2021, and although there was notable progress in some areas ratings remained the same.

Maternity services continue to be under external review relating to concerns raised about standards of safety and care and compassion published in the final Ockenden Report. The Local Maternity and Neonatal Services (LMNS) and the Trust continue to report steady progress which is supported through triangulation with reduced serious incidents.

Focus remains on the four key pillars of the report.

1. Safe Staffing

2. Training including multidisciplinary training
3. Learning from incidents
4. Listening to families.

A range of improvement work, and the development of different models of care delivery continues for Children and Young people in care, working with system partners across all relevant providers. We are also providing safeguarding assurance visits to inpatient settings to offer a good level of assurance that care delivery is centred around children and young people.

Partnership working across health and social care continues in our infection prevention and control (IPC) services as we learn to live with COVID-19 and other infectious diseases. We continue to work in partnership to deliver support, expertise and training, as well as maintain an oversight role where infection outbreaks or variances in standards occur.

In April 2021 Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust was placed into NHS England System Oversight Framework (SOF) 3 due to concerns over the leadership of infection prevention and control. A rapid improvement plan has been initiated with immediate improvement to the estate and an expected completion by October 2022.

Ensuring quality in care homes and the domiciliary care home sector is equally challenging and complex. Through partnership working between the local authorities, their quality functions, and public health and the CCG, there has been a combined effort to support improved quality of care and maintain effective infection prevention and control supporting providers to deliver high-quality services and improvement plans. This contributes to the sustainability of out-of-hospital care and keeps these vulnerable groups safe.

Finally, all partners have been engaged in the management of urgent are pressures with the CCG team supporting improved processes and oversight of changes in pathways and processes to expedite out of hospital care.

Emergency Preparedness Resilience and Response (EPRR)

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

During the early part of 2022/23 the CCG has continued to support the system during the ongoing COVID-19 Incident, which although downgraded to a level 3 incident has still required significant EPRR oversight. COVID-19 has continued to be present and has dominated service planning and delivery. We have continued to apply the principles of EPRR to manage our response and to ensure the continued collaboration and support of all partners in our system. To this end, we have retained our incident management infrastructure throughout this period.

NHS Shropshire, Telford and Wrekin CCG has continued to lead the multi-agency system response to the pandemic, ensuring a responsive, multi-agency approach to a complex, demanding and evolving incident.

We have used a range of emergency system responses to manage the service pressures that have manifested. These have included re-deployment of staff to critical areas, stepping down non-critical services, and working with partners to create additional bed capacity.

EPRR self-assessment

Throughout this reporting period, the CCG was preparing for the initiation of Integrated Care Boards (ICBs) from 1st July 2022. ICBs are required to operate as category 1 responders for Emergency Planning, Resilience and Response (EPRR) purposes, and as such this places new duties on them that Clinical Commissioning Groups did not have as category 2 responders.

As part of the transition from the CCG to the ICB and in preparation for this year's annual NHS England EPRR assurance process, the CCG worked closely with NHS England to undertake the necessary preparatory work but also to review policies in procedures to ensure that they reflect learning form the pandemic.

The CCG continued to maintain a director on call rota for 24 hours a day, 365 days of the year – not only to support the incident response but to ensure other critical or major incidents and business continuity matters could be addressed in tandem.

Risks of fraud and error in COVID-19 support schemes

To reduce the risk of fraud and error in COVID-19 support schemes, we put the following in place:

- all claims for COVID-19 costs validated and signed off by the budget holder
- additional hours paid for COVID-19 support identified and signed off within timesheets by the budget holder
- COVID-19 goods and services commissioned in line with CCG procurement policy
- all Continuing Care expenditure confirmed by the CCG Continuing Healthcare team.

The CCG was audited in respect of COVID-19 expenditure in September 2021 (by CW audit services) and found to have 'significant' assurance in the following areas:

- Controls are in place to ensure key procedures/processes/Scheme of Delegation supporting ordering and payments have been reviewed. These are reasonable and being complied with
- Cost centres to enable appropriate monitoring and reporting of COVID-19 expenditure are controlled and on a sample basis appear to be used appropriately
- Prompt payments to suppliers are subject to appropriate monitoring with actions put in place where possible to move towards the seven-day payment turnaround target set by NHS England
- Financial reporting content specifically related to COVID-19 to those charged with governance is appropriate and provides transparency around key decisions made and processes followed
- Revised financial reporting and contracting guidance for 2020/21 is being applied and monitored against.

Whilst the audit related to 2020/21, the same level of controls have remained in place for 2021/22 and 2022/23.

Safeguarding

The Safeguarding team (designated nurses for children and looked-after children, designated lead professional for adults, named GPs) continued to offer advice, guidance, support and training across the health economy to professionals including dentists, pharmacists and GPs.

The CCG remained committed to being an equal partner within the Safeguarding Partnership Board arrangements for both Shropshire and Telford and Wrekin local authorities, leading and contributing to key strategic and operational workstreams. Some of the key safeguarding risks have been:

- reduced contact with children and vulnerable adults due to greater remote working within health, social care and education since the advent of lockdown measures
- a noted increase in harm to babies under 12 months old, with parental stress cited as the significant factor
- children and young people presenting with more complex mental health needs requiring additional specialist health service support and access to tier 4 specialist inpatient bed provision (for example eating disorder and complex behavioural cases) – this is not only a local issue but a national trend with a shortage of specialist facilities and services nationally
- an increase in the number of children in care from out of county moving to Shropshire, Telford and Wrekin, which can result in young people experiencing delays in placement when their care needs escalate.

Our key safeguarding activities during April-June 2022 include:

- Preparing for changes in requirements for adult safeguarding statutory legislation, including the awaited changes to Mental Capacity Act/Deprivation of Liberty safeguards (MCA/DOLs) and, in particularly Liberty Protection safeguards when these are published
- Responding to our safeguarding internal audit findings which will allow us to strengthen the level of assurance that the CCG is carrying out its statutory duties appropriately.

The CCG Safeguarding team continues its activities:

- Working closely with local authority partners to assess levels of risk and prioritise and respond to changing needs
- Maintaining our quality monitoring of and improvement approach to all our providers
- Working directly with NHS Trusts to review and advise on best practice approaches to ensure safeguarding practice is robust and resilient
- Ensuring a child-centred approach in services for children and young people in crisis
- Maintaining a strong focus on attending to the health requirements for looked-after children

- Developing and implementing the training and support we offer to GP practices
- Investing in additional Multi-Agency Safeguarding Hub safeguarding capacity regarding the prevention of harm to children and young people, more health representation at key statutory child protection agency meetings and promoting the improvements in information sharing across agencies in the risk assessment process
- Completing Child Safeguarding Practice Reviews within tight timescales to identify learning across agencies and improve safeguarding provision.

Learning from deaths (LeDeR programme)

The Learning Disabilities Mortality Review (LeDeR) programme is a national programme to review the deaths of all patients with learning disabilities. The programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths and take forward that learning into our LeDeR steering group and Learning Disabilities and Autism (LDA) Board.

Between April and June 2022 we have renewed our governance structure to enable us to fully learn from the LeDeR reviews and implement our LeDeR policy and the three-year LeDeR strategy that will build on our successes. It will further strengthen partnership working to actively improve the lives and deaths for those with learning disabilities or autism. Achievements will be evidenced and monitored by:

- a reduction in the early deaths of people with a learning disability
- positive feedback from reviews of the quality and standards of care
- achievements/progress of identified actions from our local LeDeR action plan
- auditing/reviewing the action plan to ensure we are capturing all the learning and recommendations from the completed LeDeR reviews
- identifying specific learning around COVID-19 positive reviews during the reporting period.

View the NHS Shropshire Telford and Wrekin CCG LeDeR Annual Report 2021/22

ICS quality developments

In collaboration with our partners, over the next year we are focused on embedding our quality processes and structures which have been strengthened as we have run them in common with existing processes with quality monitoring metric development. This will lead to the development of a System Quality Strategy, which will reflect the changing priorities of the ICS from July 2022. The Quality Strategy describes improved opportunity for co-production, quality improvement and partnership-working at the organisational and system level, involving those who experience care, and enables us to ensure that improving quality is at the heart of everything we do.

In line with the national direction, our key quality priorities for 2022/23 will focus on ‘making quality everybody’s business’ and ensuring the delivery of consistently high-quality care. We will develop an integrated and collaborative approach to quality governance and assurance across the Shropshire, Telford and Wrekin system that minimises duplication, reduces

variation and delivers tangible improvements for our local population. We will work to develop a shared definition, vision and understanding of quality to establish a single view of quality across health and social care, including the voluntary and third sector and ensure:

- there will be an ICS approach to risk management and escalation
- there is monitoring through a quality monitoring dashboard
- we will use existing and developing metrics to understand the impact of quality improvements within our system.

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

- **Infection prevention and control:** preventing avoidable healthcare-associated infections and building on the good work undertaken as part of the COVID-19 pandemic across our county.
- **Improving pathways for children and young people:** with a key spotlight on mental health.
- **Improving palliative and end of life care:** ensuring people are identified as being in the last months and years of life and have opportunities to plan and live the best lives possible at this time.
- **Maternity transformation** and improvement priorities ensuring safe care for women and babies.
- **Learning from deaths:** including a system focus and the new requirements of the LeDeR programme.
- **Experience of care:** with a focus on co-production and quality improvement.
- **Quality improvement**: embedding quality improvement at all levels of the ICS to ensure we can effectively tackle quality issues and grow as a system.

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

- improved quality and safety of services for individual service users
- better outcomes and better service user experience for our population
- a safe and sustainable healthcare system.

Engaging people and communities

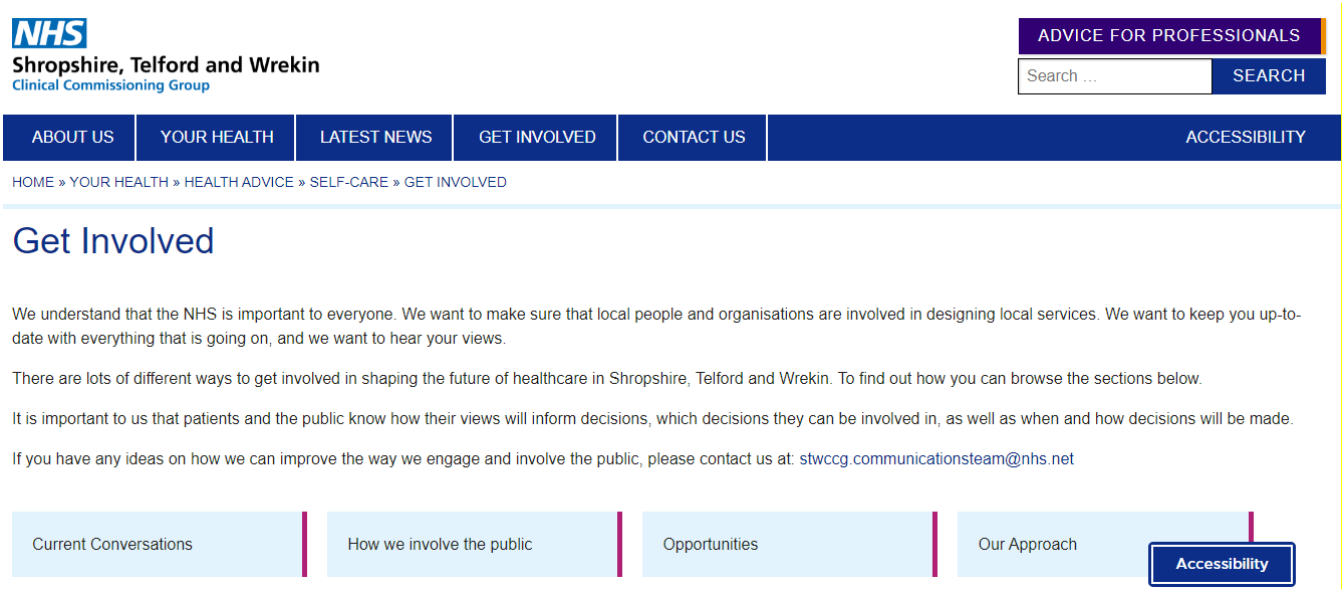
As a commissioning organisation, we have a legal duty under the National Health Service Act 2006 (as amended) to involve the public in the commissioning of services for NHS patients ('the public involvement duty'). For NHS Shropshire, Telford and Wrekin CCG, this duty is outlined in Section 14Z2 of the Act.

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

- the planning of services
- the development and consideration of proposals for changes, which if implemented, would have an impact on services
- 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 depend on the way we interact with and empower patients and the public to be involved in their own healthcare.

As a CCG, we were always keen, and continue to be keen, to hear the views of and provide opportunities for local people to be involved in shaping health and care across our system. There were numerous ways for people to share their views and get involved. Below is a screenshot of the CCG website to show the range of ways that people can do so.



Our approach to listening to people and involvement and engagement varies according to what we are engaging on and who we need to engage with.

We use all available routes, including:

- events
- surveys – online and paper
- face-to-face interviews
- focus groups
- co-production in service design and development
- workshops
- social media
- direct contact and through our partner networks
- patient representatives
- insight and data.

Governance and assurance

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

Our commitment

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

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

Engagement assurance

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

- Audit Committee – lay member chair
- Remuneration Committee – two lay members attend, and one is chair
- Primary Care Commissioning Committee – lay member chair
- Quality and Performance Committee – lay member chair
- Finance Committee – lay member chair
- Joint Individual Funding Committee – lay member chair
- Joint Individual Funding Appeal Panel – lay member
- Strategic Commissioning Committee – lay member chair
- Assuring Involvement Committee – patient chair.

The Assuring Involvement Committee

The CCG Governing Body received assurance on the robustness of its involvement and relationship with the public through the Assuring Involvement Committee (AIC), which was established in 2021.

The AIC comprised of 9 volunteers from across Shropshire, Telford and Wrekin, along with the two lay members for patient and public involvement of the CCG's Governing Body. Its role was to provide assurance and oversight to the CCG Governing Body and its committees, and to ensure that meaningful patient and public engagement is embedded in the commissioning process. The AIC also ensured that equality and diversity activity is undertaken in the most effective way and meets the CCG's statutory and legal duties to involve patients, carers and the public, and the NHS mandatory guidance relating to public involvement.

CCG officers were asked to attend the AIC to update on the programme or scheme they are working on, including an update on the communications and engagement strategy in place for that specific piece of work. This approach provides the AIC with oversight and opportunities to offer constructive guidance.
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Examples of the work of the AIC include:

- the Shrewsbury Health and Wellbeing Hub
- the musculoskeletal transformation programme
- end-of-life care review
- cardiology inpatient services
- renal dialysis services
- high intensity service review
- the eye care transformation programme.

You can find more information about the AIC on our website.

Engagement activities

Eye care transformation programme

The CCG along with the wider health and care system in Shropshire, Telford and Wrekin embarked on a programme of work to transform local eye care services.

The aim was to provide effective eye care services that are more joined up so that adults and children get the best care possible when and where they need it. We ran several engagement activities that enabled us to capture valuable insight, including a public survey, outreach in clinics and the community, and a series of workshops.

Whilst most people told us that they had had a good experience of our services, we also heard about areas that could be improved. The programme team is now using all the learning gathered to design the future model.

The Shrewsbury Health and Wellbeing Hub

The CCG carried out a second phase of engagement activity to ask local communities to share their views on proposals for a new, state-of-the-art health and wellbeing hub in Shrewsbury.

The hub proposal, if successful, will pilot a new approach to providing local health and wellbeing services that work seamlessly under one roof to offer high-quality care for the local community.

The most recent activity builds on public feedback already gathered in 2021 via an online questionnaire and telephone interviews.

This included a series of focus groups, in person and online, that were held throughout May during which participants were asked to tell us about their experiences of using GP practices in the area, their understanding about why GP services need to change and the benefits of change, the future of GP services in Shrewsbury, and what people would like to see in the proposed health and wellbeing hub.

Engaging people by working with others

Place engagement

'Place' involves commissioners, community services providers, local authorities, primary care, the voluntary and community sector, and public representatives working together to meet the needs of local people. They met in two Place alliances covering the whole of Shropshire, Telford and Wrekin, aligned to the footprint of the local authorities.

Place is a transformative work stream and aims to enable new models of care, integration and cost efficiencies by creating the environment and opportunity for organisations and the populations they serve to think, transform and work differently together, so that people can be well connected, and access coordinated services.

This way of working will inform and support the system leadership as it develops a new architecture and culture for system working which integrates good health and wellbeing support for those who live and work in Shropshire, Telford and Wrekin.

Place relies on organisations working better together to enable improved health outcomes for our population. Each Place alliance holds regular meetings, with a wide range of representation from principal system organisations and other relevant local organisations/groups.

Voluntary sector

The CCG has a history of strong links with the voluntary sector in Shropshire, Telford and Wrekin. We have continued to work closely with them in relation to our plans, particularly

with regard to Place. We used their networks as well as our own direct contacts to reach out to more voluntary sector organisations and into diverse communities across the patch.

Patient participation group networks

We worked with our patient participation group (PPG) networks, which bring together PPGs from across the county. The meetings provided a forum to inform patient representatives about national and local NHS developments and provide opportunities for involvement. PPG networks are also help shape our engagement techniques.

Shropshire, Telford and Wrekin Maternity Voices Partnership

The Maternity Voices Partnership (MVP) is an independent team made up of women and their families, commissioners, service providers and local authorities.

The function of the MVP is more than simply to listen. It brings people together to design and improve maternity care by discussing challenges and solutions across Shropshire (including Powys) and Telford and Wrekin.

Healthwatch

Healthwatch is an important partner for the CCG. They are regularly involved in formal and informal meetings including Governing Body and service transformation programmes. They attended the Quality and Performance Committee and are invited to input into the Patient Experience Report tabled there.

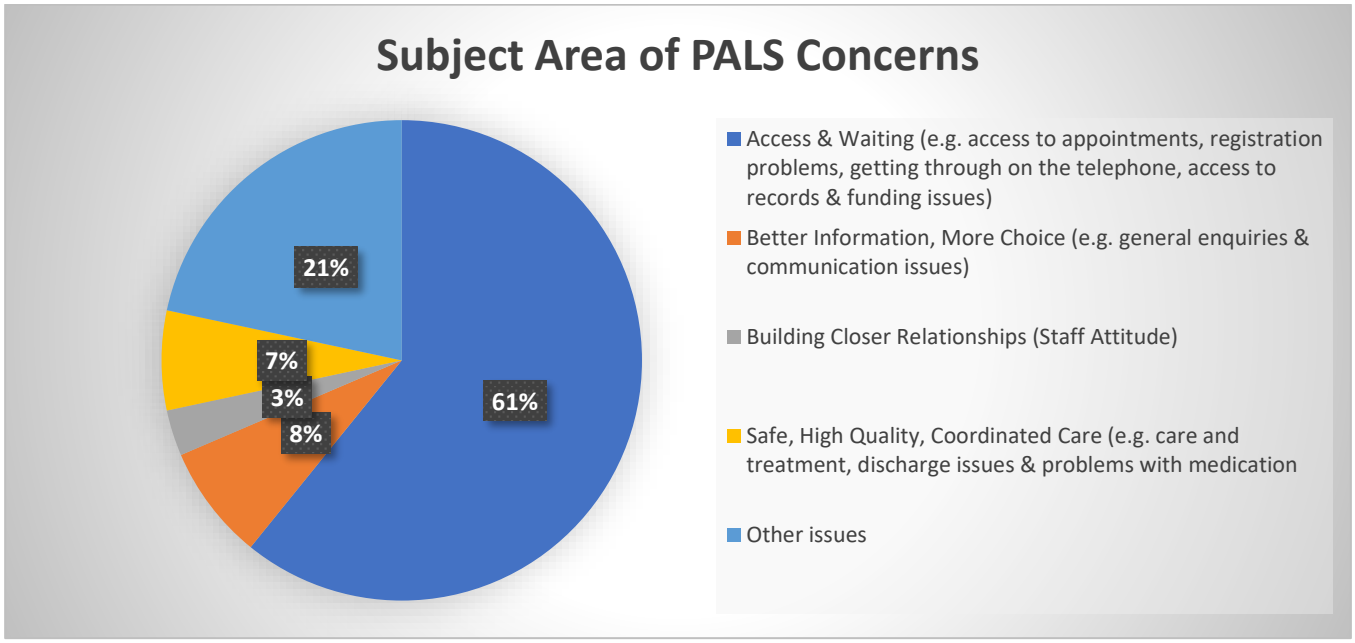
Healthwatch have supported the CCG to establish processes that support involvement and feedback mechanisms for patients and members of the public. These help the CCG gather insight to feed into service learning and development. Healthwatch also regularly provide Patient Engagement Reports. These reports are a valuable source of information for service reviews.

Patient Advice and Liaison Services (PALS)

PALS was integral to NHS Shropshire, Telford and Wrekin CCG's commitment to working closely with patients and staff to improve services. It is an informal and impartial way to resolve the concerns of patients, relatives, carers and members of the public.
The service is intermediary and a useful source of information, often signposting people to the healthcare they need. All enquiries received through PALS are recorded on a database and used to improve services.

Due to the CCGs being dissolved on 30th June 2022, this report is for Q1 of 2022/23 only. During Q1 2022/23, 194 PALS enquiries were received via NHS Shropshire, Telford and Wrekin CCG Patient Services Team. This is a decrease on the 278 PALS enquiries received across NHS Shropshire, Telford and Wrekin CCG during Q1 2021/22.

The chart below illustrates the 'domains of patient experience' that the PALS enquiries received during Q1 2022/23 related to.



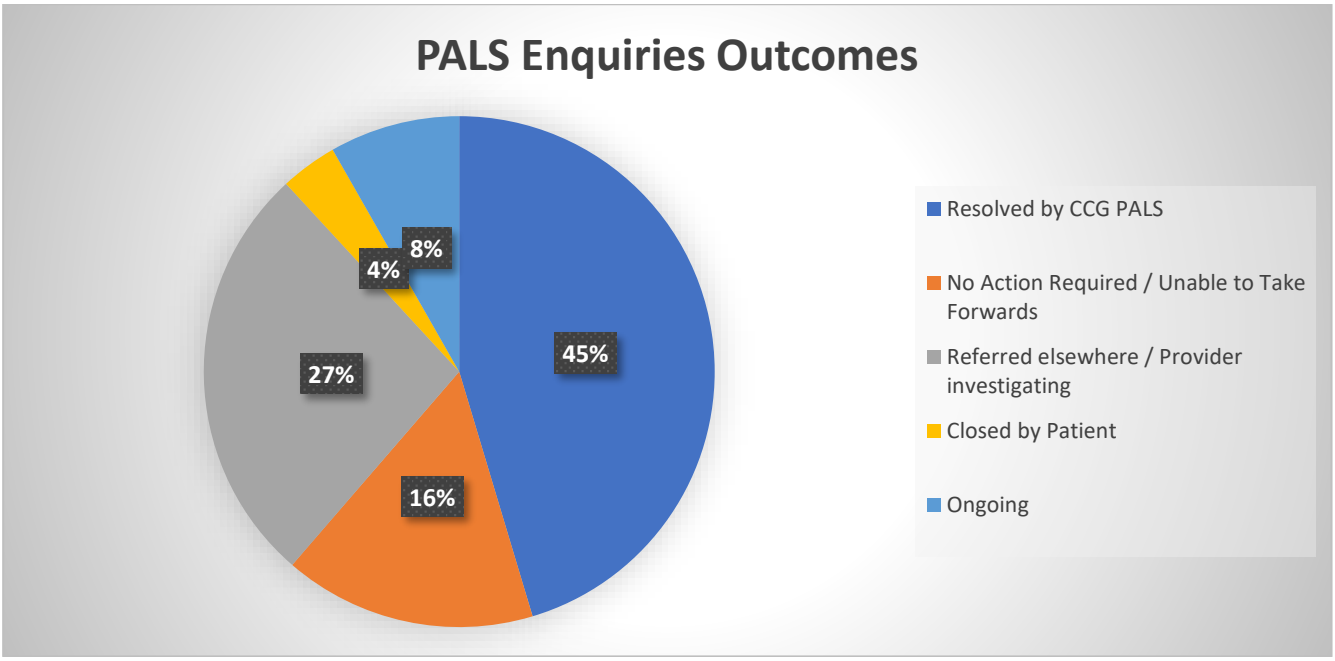
Similar to the previous year, more than half the PALS enquiries the CCG received raised concerns around gaining access to services.

Of the enquiries received, 54 related to GP Practices, a high proportion of these were around accessing appointments.

There were 29 enquiries relating to hospital services, 20 of these were around access to appointments.

74 enquiries related to CCG services, with 14 of these being around COVID-19 and access. 10 related to the Prescription Ordering Department and were mostly around access via the telephone. 9 related to the Individual Commissioning Team and were around delays with Continuing Health Care assessments and poor communication. The rest of the enquiries were around commissioning decisions, relating to various services and including changes to prescribing.

The chart below shows what happened with the queries and concerns received by the CCG Patient Services Team.



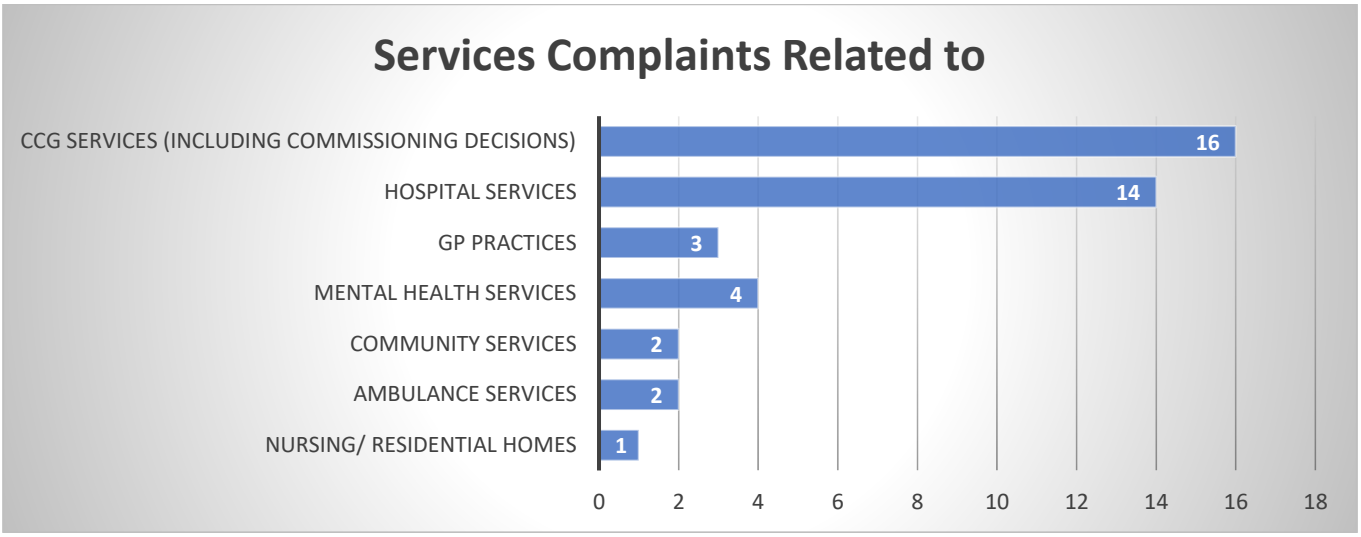
Nearly half of the enquiries received were resolved by the CCGs Patient Services Team.

Complaints

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

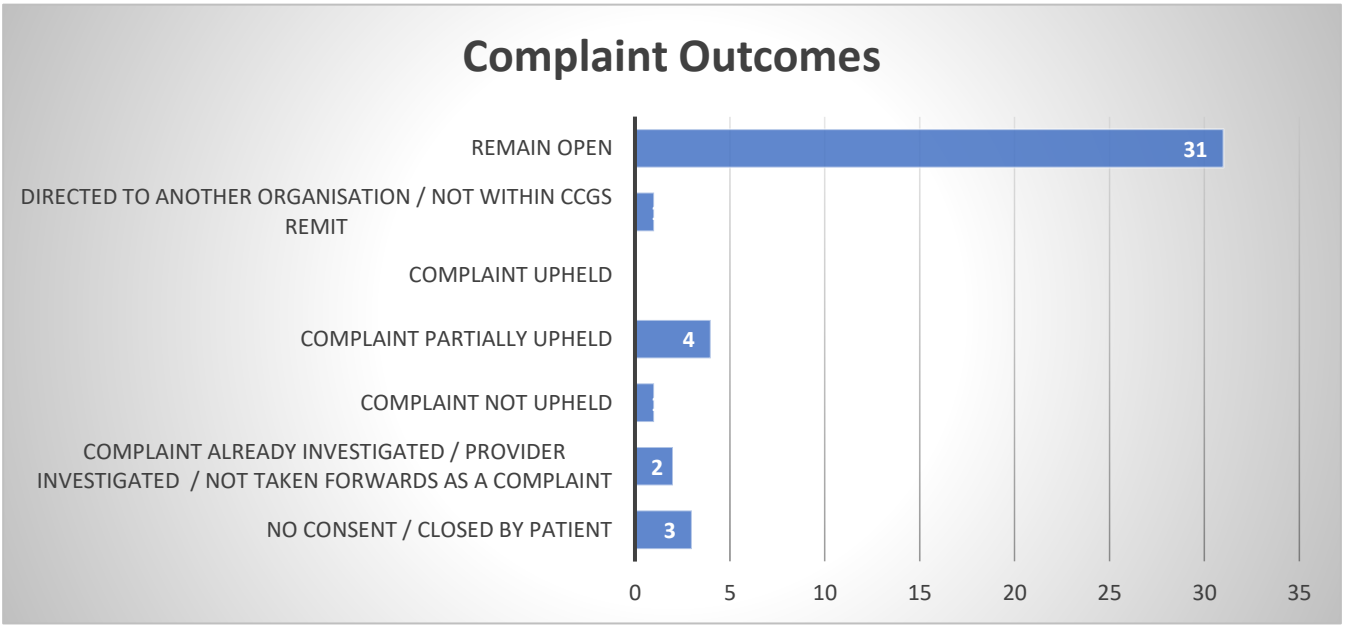
During Q1 2022/23, NHS Shropshire, Telford and Wrekin CCG received 42 complaints, which is a slight increase on the number of complaints received across NHS Shropshire, Telford and Wrekin CCG during Q1 of 2021/22.

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



Of the complaints received by NHS Shropshire, Telford and Wrekin CCG, 16 related to CCG services; 4 of these related to the Individual Commissioning Team and were around delays with the Continuing Health Care assessment process. 6 related to medicines management, 5 of which were around the Prescription Ordering Service, getting through to this services and attitude of staff

Of the 42 complaints received, 31 are ongoing. The graph below shows the outcomes for complaints where the process has been completed during 2022/23.



Ombudsman

The public have the right to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for review if they are not satisfied with the CCG's response. The CCG has been contacted by the PHSO in relation to 3 cases during Q1 of 2022/23. All of these

cases are still ongoing and there have therefore been no recommendation made to date. Any recommendations received, will be picked up by NHS Shropshire, Telford and Wrekin Integrated Care Board once the PHSO process has been completed.

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

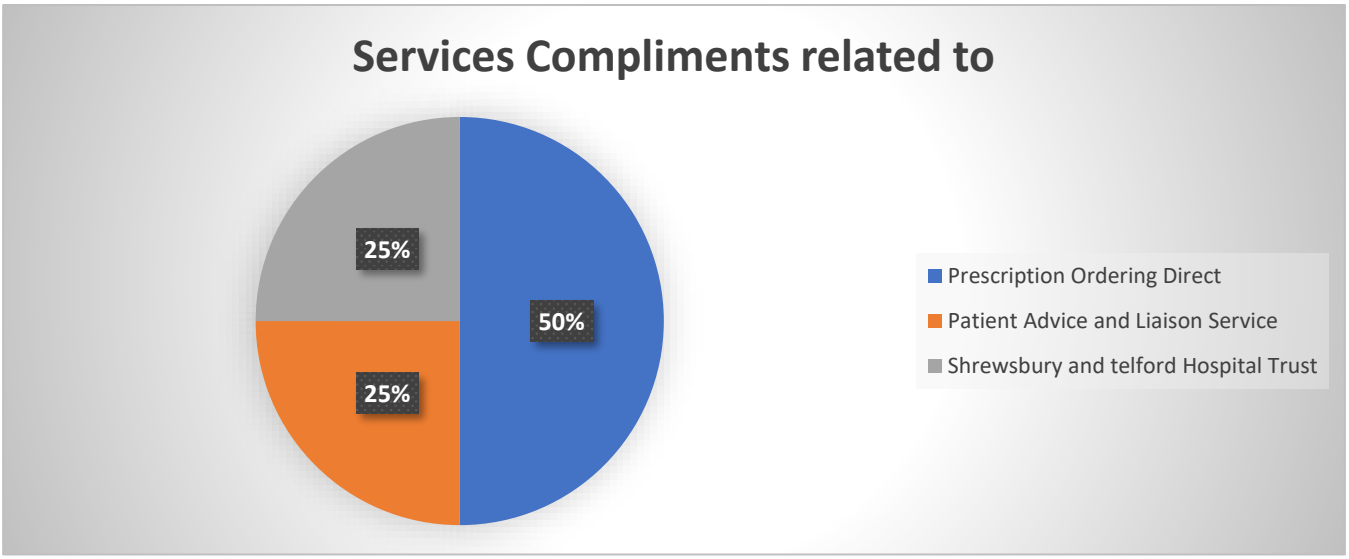
https://www.ombudsman.org.uk/publications/complaints-parliamentary-and-health-service-ombudsman-2019-20-and-2020-21

MP letters

During Q1 2022/23, NHS Shropshire, Telford and Wrekin CCG received 23 letters/emails from local Members of Parliament (MPs) relating to the healthcare of their constituents. 20 of these enquiries related to access to services. 11 enquiries related to GP Services and included getting through on the telephone, access to appointments and concerns around the care provided. The rest of the enquiries related to a variety of services. There were no other themes.

Compliments

In addition to dealing with complaints, concerns and enquiries, the CCG also receives positive feedback in the form of compliments. 4 compliments were received during 2022/23 and the chart below highlights the services that these compliments related to.



Learning from Feedback received

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

What we Heard	What has Happened
A patient raised concerns about not being able to choose which hospital his referral was sent to.	This issue was around out of county services restricting where referrals were being received from, due to the impact of the COVID-19 pandemic on waiting lists. During the investigation it was discovered that the referral process had also changed. This information had not been shared with NHS Shropshire, Telford and Wrekin CCG, as it was out of county. Staff within the referral assessment service and GPs have now been made aware of this change, so that referrals can be processed correctly in future.

Equality, Diversity and Human Rights Report

We believe that equality and inclusion involves addressing health inequalities and should be at the heart of all our commissioning activity. It is our overriding aim to provide equality of opportunity to all our patients, their families and carers, and to proactively attempt to eliminate discrimination of any kind within the services we commission.

We have developed a wide-ranging programme of engagement which enables measurable involvement and ensures that the CCG listens to the views and experiences of our wider population, taking care to reach into our communities to influence commissioning decisions.

We have continued to engage regularly with a multitude of key partners and stakeholders, including voluntary and community groups who support and advocate on behalf of people facing the greatest health inequalities, as well as patient groups and both Healthwatch organisations. We have also introduced new roles to include increased capacity for continued, meaningful community engagement with key populations, as well as a more insight-led approach. With dedicated resources towards reviewing data, better identifying trends within our populations, and outreach activities, we have been able to develop more targeted campaigns and materials to tailor our communications and engagement.

We are committed to involving local people in continuing to monitor and develop the health services we commission and ensuring our providers meet the duties set out in the Equality Act 2010. Under the Equality Act 2010 and the Public Sector General Equality Duty, organisations must publish sufficient information to demonstrate that, in the exercise of its functions, it has a due regard to:

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

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

The nine protected characteristics are as follows:

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

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

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

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

We continue to score ourselves as 'developing' in most areas because, although significant strides have been taken to improve the utilisation of information sources, for example more insight-led approaches, we are still in a phase of development to continue strengthening and improving our position. We also recognise that we need to further understand the needs of individuals accessing healthcare services and ensure we can evidence how we have acted to promote equalities.

A key source of information utilised by the CCG, to help understand in more detail how different groups access healthcare and influence commissioning decisions, is the Joint Strategic Needs Assessment (JSNA) for the resident population of both Shropshire and Telford and Wrekin. This assessment analyses the health, wellbeing and social care needs

of the population and aims to improve overall outcomes and reduce inequalities. The JSNA also informs the Joint Health and Wellbeing Strategy.

The JSNAs for Shropshire and Telford and Wrekin can be found on the respective council websites along with the population profiles, by ward, for both footprints. We utilise the standard NHS contract which places a requirement on providers to ensure that they consider the needs of individuals in the delivery of their services, including disability access and equity of access. Providers who bid for NHS services through our procurement processes are required to demonstrate compliance with the Equality Act 2010 and the Human Rights Act 1998.

We expect providers to clearly demonstrate the ability to make reasonable adjustments when accessing their services. This is monitored as part of the contract monitoring process. To improve our developing rating, we intend to work more with providers on their recording and reporting of protected characteristics.

It is acknowledged that a new, equal partnership with the VCSE sector could hold numerous opportunities. Through this initiative we have the chance to work differently and more collaboratively, to improve health outcomes and reduce health inequalities for the people of Shropshire, Telford and Wrekin.

A Memorandum of Understanding was co-produced and signed in October 2021 by respective leading members of the VCSE and ICB to kick start this integration process. In brief, the document outlines why the CCG/ICB wishes to work in partnership with the VCSE on shared ambitions and how we aim to achieve this over the coming years.

We have been developing a VCSE Alliance that will include strategic representation from the sector and will build upon this partnership. This Alliance will be plugged into the governance of the ICB and will provide this crucial representation within decision-making forums. In those areas of common interest, the two sectors will come together to effectively support each other and maximise all opportunities.

The Assuring Involvement Committee (AIC) for NHS Shropshire, Telford and Wrekin CCG was set up in 2021 to ensure the CCG is effectively engaging its local population to support service redesign. The Committee is made up of 9 members of the public and is tasked with looking in-depth at communications and engagement strategies produced as part of service redesign projects.

The Committee is responsible for ensuring effective and meaningful engagement and involvement with patients and the public, as well as providing insight and recommendations to help strengthen proposals and produce better engagement and involvement outcomes.

The AIC has reviewed the following communications and engagement strategies:

- The Shrewsbury Health and Wellbeing Hub
- Musculoskeletal Transformation Programme
- End of Life Care Review
- Cardiology Inpatient Services
- Renal Dialysis Services

- High Intensity Service Review
- The Eye Care Transformation Programme.

Find more information about the AIC on our website.

As part of the process undertaken for proposed service change, an Equality Impact Assessment (EQIA) is completed to determine the impact of plans to local patients and residents, particularly vulnerable groups, and aims to mitigate negative impact.

The EQIA is then considered at executive level as part of the agreement to proceed with projects and commissioning decisions. All papers presented to the CCG's Governing Body have a mandatory section with regard to the impact of the report on equality and diversity. The EQIAs have a risk scoring system for any negative impact identified. A Stage 2, fuller EQIA will be required for risks of nine and above.

As part of the work of the AIC, the CCG's Governing Body has an appointed Lay Member for Patient and Public Involvement (PPI) – Equality Diversity and Inclusion to provide a greater focus at Governing Body level on these important issues.

Culturally, we as a CCG linked into community groups and other local charities to demonstrate our commitment to an integrated approach to community. This has included our Lay Members for PPI attending external groups to listen to issues and answer questions.

The CCG has also encouraged senior managers to apply for the locally run Inclusive Leadership Programme which seeks to address managers awareness of inequalities in the workplace.

With regard to complaints, we continued to record equality monitoring data as part of our complaints function. Quality monitoring of patient experience reports from providers was also undertaken to identify themes and trends, and ensure actions are put in place.

The CCG's complaints service encouraged anonymous completion of equality monitoring forms by complainants, as well as feedback of the complaint handling process. This was then used to identify any themes or trends in experiences of specific protected characteristics.

A total of 4 forms were returned during the period 1st April to 30th June 2022, these indicated that complaints had been received from a variety of age ranges and have been received from people who are considered to have protected characteristics, as highlighted below:

- 25% identified as being transgender.
- 25% identified as not being White/British.
- 50% identified as having a disability.

Historically, the complaints team has attended engagement activities to promote the complaints process to various groups in order to ensure equality of access. It is hoped that this will be more of a possibility as we continue to move out of the COVID-19 pandemic.

We continued to ensure that we are reinforcing the Accessible Information Standard via a staff policy to help ensure that those people suffering from a visual or sensory impairment can specify how we communicate with them about their medical treatment.

The CCG required all provider contracts to contain equality and diversity clauses, notably as per Service Condition 13 of the NHS Contract. This applied to all the nine protected characteristics. Compliance with this service condition was monitored as part of routine quality monitoring of each contract.

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

The Workplace Race Equality Standard (WRES) required us to ensure employees from black and minority ethnic (BAME) backgrounds had equal access to career opportunities and received fair treatment in the workplace.

The most recent workforce representativeness of ethnicity was reported in August last year for the financial year ending March 2021, when there were two separate CCGs in the ICS area.

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

- NHS Shropshire CCG WRES Report 2020/21
- NHS Telford and Wrekin CCG WRES Report 2020/21.

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

The CCG recognised 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, nationality, religion or belief, national or ethnic origins, gender reassignment, pregnancy or maternity, marriage or civil partnership or trade union membership.

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

We remained committed to ensuring that staff receive up-to-date and relevant equalities and inclusion training, which is described in the CCG's Equalities and Diversity Policy, which sets out the CCG's vision that all employees should follow.

Health and Wellbeing Strategy

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

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

There are two local Health and Wellbeing Boards as NHS Shropshire, Telford and Wrekin CCG covered the boundaries of the two separate local authorities. Each of these Boards are in place to reflect the areas they serve, and they have different priorities and schemes of work. Throughout April to end of June 2022, NHS Shropshire, Telford and Wrekin CCG have fulfilled their commitment for senior leadership attendance as members of the two HWBBs through the Accountable Officer and /or a director level representative.

Telford and Wrekin Health and Wellbeing Strategy

In summer 2020, Telford and Wrekin Health and Wellbeing Board approved a new Health and Wellbeing Strategy 2020-23. The four key priorities of the strategy are to:

- develop, evolve and deliver our Telford and Wrekin Integrated Place Partnership (TWIPP)
- tackle health inequalities
- improve emotional and mental wellbeing
- ensure people's health is protected as much as possible from infectious diseases and other threats.

The strategy provides more detail about what is planned and meant by each of these headings.

NHS Shropshire, Telford and Wrekin CCG was an active member of the TWIPP and has contributed to both its further development as well as to the delivery of associated programmes of work. Examples include the Health and Social Care Integrated Rapid Response Review and developing an Ageing Well Strategy.

Shropshire Joint Health and Wellbeing Strategy

Shropshire Health and Wellbeing Strategy was refreshed in March 2022 and is available on Shropshire Councils website

The four main cross-cutting priorities for the Shropshire HWBB are to:

- Reduce health inequalities
- Joined up working
- Improving Population health

- Working with and building strong vibrant communities

The CCG has supported these priorities through joint appointments with the local authority including a post with a focus on prevention. The CCG has continued to support the development of the local care programme and the introduction of an integrated rapid response service to assist individuals to remain in their own homes over April to end of June 2022.

The CCG contributed to the formation of the draft strategy for the period 2022-27, which was developed through careful analysis of local and national data and reports, and insight from Board members via a series of workshops.

NHS Shropshire, Telford and Wrekin CCG is an active member of the Shropshire Integrated Place Partnership (SHIPP) and have contributed to both its further development as well as to delivery of programmes of work associated with it.

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

Reducing health inequalities

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

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

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

All committee reports require the author to consider how their report relates to equalities in general and to ensure that due regard is given to the general equality duty.

When project leads complete an Equality Impact Assessment it helps us identify those who may face barriers to accessing services and those groups with protected characteristics who may be affected should a plan or service be changed.

This information helps us to ensure that when we look at the possible impact of policy or project change, we ensure that we speak to those people or groups on whom the impact would be most felt. This targeted approach is built into our communication and engagement plans.

Our surveys also ask a core set of demographic questions to allow us to understand who is completing the survey and if they meet the general demographics of the geographical or service area. The questions that we ask relate directly to the nine protected characteristics.

Working with our partners across the system, including both Healthwatch and the VCSE, is critical in enabling us to engage with and understand the experiences of people within our communities who are experiencing the greatest health inequalities. We are continuing to develop our contacts and relationships with different groups and organisations that represent the diversity of our population.

Addressing inequalities in COVID-19 vaccine uptake

The communications and engagement plan specifically included activity and approaches to increase uptake and reduce hesitancy amongst groups experiencing the greatest health inequalities.

Shropshire, Telford and Wrekin Vaccination team has come up with a novel and highly effective solution to help address low vaccination uptake in some of its most vulnerable communities, tackling health inequalities with three vaccination buses, and targeted community engagement.

Working in close collaboration with a range of partners including both local authorities and the military, the Vaccination team utilised three vaccination buses to help them to respond to the fast-spreading Omicron variant during the booster sprint in December 2021.

The vehicles were sourced and repurposed into mobile vaccination units with changes such as privacy screens, power connections and heating added to allow NHS teams to set up the clinics wherever they parked. The buses, affectionately named Bob, Betty and Basil, have been run by a variety of staff including Telford and Wrekin Council, Shropshire Council, the military, NHS staff and volunteers. All staff members have gone above and beyond, working weekends and holiday periods to ensure its efficient running, and as part of the effort to get the vaccine to as many people as possible by the New Year.

This unique approach has been recognised as exemplary and was presented to Regional and National Vaccination teams. This work has also been successfully shortlisted for a Local Government Award.

Using a combination of data and insight – backed up by a comprehensive and imaginative communications campaign that included tailored text messages to unvaccinated patients and calls to residents encouraging them to get their jab – the vaccination buses have improved access to vaccination, particularly in the county's most disadvantaged, diverse and rural communities, significantly increasing the number of vaccinations delivered to these groups of people.

The Equalities Group continues to meet to review data and work with (and provide feedback to) local communities. The engagement carried out to support the vaccination programme, which supports our work to reduce health inequalities, provides a sound basis on which to build in future.

Accountability Report

Corporate Governance Report
Members' Report

NHS Shropshire, Telford and Wrekin CCG was a membership organisation composed of the 51 GP practices located within the geographical area coterminous with the boundaries of Shropshire Council and Telford and Wrekin Council. When the members of the group met to conduct business as the CCG, this was known as the CCG Membership Forum.

The CCG also had four Locality Forums that were used to engage on a regular basis with member practices. Each member practice nominated one GP representative to represent the practice in all matters considered at the Membership or Locality Forum, and if necessary, exercise a vote. The Member Forum delegated the majority of decision-making to the CCG Governing Body. This was outlined in the CCG Constitution.

The member practices are outlined below:

Practice name	Address
Albrighton Medical Practice	Shaw Lane, Albrighton, Wolverhampton, WV7 3DT
Alveley Medical Practice	Village Road, Alveley, Bridgnorth, WV15 6NG
The Beeches Medical Practice	1 Beeches Road, Bayston Hill, Shrewsbury, SY3 0PF
Belvidere Medical Practice	23 Belvidere Road, Shrewsbury, SY2 5LS
Bishop's Castle Medical Practice	Schoolhouse Lane, Bishop's Castle, SY9 5BP
Bridgnorth Medical Practice	Northgate Health Centre, Northgate, Bridgnorth, WV16 4EN
Broseley Medical Centre	Bridgnorth Road, Broseley, TF12 5EL
Brown Clee Medical Practice	Ditton Priors, Bridgnorth, WV16 6SS
Cambrian Surgery	Oswestry Health Centre, Thomas Savin Road, Oswestry, SY11 1GA
The Caxton Surgery	Oswald Road, Oswestry, SY11 1RD
Charlton Medical Centre	Lion Street, Oakengates, Telford, TF2 6AQ
Churchmere Medical Group	Trimpley Street, Ellesmere, SY12 0DB
Church Stretton Medical Practice	Easthope Road, Church Stretton, SY6 6BL
Claremont Bank Surgery	Claremont Bank, Shrewsbury, SY1 1RL
Cleobury Mortimer Medical Centre	Vaughan Road, Cleobury Mortimer, Kidderminster, Worcestershire, DY14 8DB
Clive Surgery	20 High Street, Clive, Shrewsbury, SY4 5PS
Court Street Medical Practice	Court Street Medical Centre, Court Street, Madeley, Telford, TF7 5DZ
Craven Arms Medical Practice	20 Shrewsbury Rd, Craven Arms, SY7 9PY

Dawley Medical Practice	Webb House, King Street, Dawley, Telford, TF4 2AA
Donnington Medical Practice	Wrekin Drive, Donnington, Telford, TF2 8EA
Highley Medical Centre	Bridgnorth Road, Highley, Bridgnorth, WV16 6HG
Hodnet Medical Centre	18 Drayton Road, Hodnet, Market Drayton, TF9 3NF
Hollinswood and Priorslee Medical Practice	Downmeade, Hollinswood, Telford, TF3 2EW
Ironbridge Medical Practice	Trinity Hall, Dale Road, Coalbrookdale, Telford, TF8 7DT
Knockin Medical Centre	Knockin, Oswestry, SY10 8HL
Linden Hall	Station Road, Newport, near Telford, Shropshire, TF10 7EN
Marden Medical Practice	25 Sutton Road, Shrewsbury, SY2 6DL
Market Drayton Medical Practice	Market Drayton Primary Care Centre, Maer Lane, Market Drayton, TF9 3AL
Marysville Medical Practice	Brook Street, Belle Vue, Shrewsbury, SY3 7QR
The Meadows Medical Practice (Clun and Knighton)	Penybont Road, Knighton, Powys, LD7 1HB
Much Wenlock and Cressage Medical Practice	Kingsway Lodge, Much Wenlock, TF13 6BL
Mytton Oak Surgery	Racecourse Lane, Shrewsbury, SY3 5LZ
Plas Ffynnon Medical Centre	Middleton Road, Oswestry, SY11 2RB
Pontesbury and Worthen Medical Practice	Hall Bank, Pontesbury, Shrewsbury, SY5 0RF
Portcullis Surgery	Portcullis Road, Ludlow, SY8 1GT
Prescott Surgery	Baschurch, Shrewsbury, SY4 2DR
Radbrook Green Surgery	Bank Farm Road, Shrewsbury, SY3 6DU
Riverside Medical Practice	Barker Street, Shrewsbury SY1 1QJ
Severn Fields Medical Practice	Severn Fields Health Village, Sundorne Road, Shrewsbury SY1 4RQ
Shawbirch Medical Practice	5 Acorn Way, Shawbirch, Telford, TF5 0LW
Shawbury Medical Practice	Poynton Road, Shawbury, SY4 4JS
Shifnal and Priorslee Medical Practice	Shrewsbury Road, Shifnal, TF11 8AJ
South Hermitage Surgery	South Hermitage, Belle Vue, Shrewsbury, SY3 7JS
Station Drive Surgery	Station Drive, Ludlow, SY8 2AB
Stirchley Medical Practice	Sandino Road, Stirchley , Telford, TF3 1FB
Teldoc	Malinslee Surgery, Church Road, Malinslee, Telford, TF3 2JZ
The Surgery	Wellington Road, Newport, near Telford, Shropshire, TF10 7HG
Wem and Prees Medical Practice (Wem Site)	New Street, Wem, Shrewsbury, SY4 5AF
Wellington Medical Practice	The Health Centre, Victoria Avenue, Wellington, Telford, TF1 1PZ
Westbury Medical Centre	Westbury, Shrewsbury, SY5 9QX

Woodside Medical Practice	Woodside Health Centre, Wensley Green, Woodside, Telford, TF7 5NR

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

CCG Governing Body composition during the period 1st April 2022 to 30th June 2022 was as follows:

Governing Body members up to 31 March 2022	Board Role
Dr John Pepper (voting)	GP Chair
Dr Mike Matthee (voting)	GP/Healthcare Professional Member
Mrs Rachael Bryceland (voting)	GP/Healthcare Professional Member
Dr Mary Ilesanmi (voting)	GP/Healthcare Professional Member
Dr Adam Pringle (voting)	GP/Healthcare Professional Member
Dr Martin Allen (voting)	Secondary Doctor Member
Mrs Audrey Warren (voting)	Independent Nurse Member
Mr Geoff Braden (voting)	Lay Member – Governance
Mr Meredith Vivian (voting)	Lay Member – Patient Public Involvement (PPI)
Mrs Donna McArthur (voting)	Lay Member – Primary Care
Mr Ash Ahmed	Lay Member – Patient Public Involvement (PPI) – Equality, Diversity and Inclusion (EDI)
Mr Mark Brandreth (voting)	Interim Accountable Officer
Mrs Claire Skidmore (voting)	Executive Director of Finance
Mrs Zena Young (voting)	Executive Director of Nursing and Quality
Dr Julie Garside (voting)	Director of Performance responsible for the Executive Director of Transformation portfolio
Ms Claire Parker (non-voting)	Director of Partnerships
Miss Alison Smith (non-voting)	Director of Corporate Affairs
Mrs Sam Tilley (non-voting)	Director of Planning
Dr Deborah Shepherd (non-voting)	Medical Director
Dr Stephen James (non-voting)	Interim Chief Clinical Information Officer
Rachel Robinson (non-voting)	Director of Public Health for Shropshire Council
Liz Noakes (non-voting)	Director of Public Health for Telford and Wrekin Council
Lynn Cawley (non-voting)	Chief Officer – Healthwatch Shropshire
Barry Parnaby (non-voting)	Chair – Healthwatch Telford and Wrekin

Committee(s) including Audit Committee

So that the CCG Governing Body could provide strategic direction to the CCG and to assure itself of the CCG's internal control infrastructure, it 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 was as follows:

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

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

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

Information governance incidents

NHS Shropshire, Telford and Wrekin CCG has reported a total of 6 incidents during the period of 1st April to 30th June 2022. All of these incidents were graded as non-reportable – very low risk and therefore not reportable to the Information Commissioner's Office (ICO).

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

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

Statement of Accountable Officer's Responsibilities

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

Simon Whitehouse
Accountable Officer
NHS Shropshire, Telford and Wrekin
29th June 2023

Governance Statement

Introduction and context

NHS Shropshire, Telford and Wrekin CCG is a body corporate established by NHS England on 1 April 2021 under the National Health Service Act 2006 (as amended), which set out the CCG's statutory functions.

The general function of the CCG is to arrange the provision of services for people for the purposes of the health service in England. Specifically, it is 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 of 1st April 2022, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The CCG was dissolved on 30th June 2022 and its functions transferred to the NHS Shropshire Telford and Wrekin Integrated Care Board (ICB) on 1st July 2022. This governance statement covers the period of operation from 1st April 2022 to 30th June 2022.

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG is a clinically-led membership organisation comprising GP practices within the geographical area of Shropshire, which is coterminous with Shropshire Council, and Telford and Wrekin, which is coterminous with Telford and Wrekin Council. The members of the

CCG are responsible for determining the governing arrangements of the organisation, which they are required to set out in the CCG's Constitution, found on our website.

The year 2022/23 has continued to see an impact from COVID-19 pandemic on the CCG, in that staff and resources have continued to be redeployed to support frontline services and the mass COVID-19 vaccination programme. The governance processes for the CCG have, in line with national guidance and to support transition to the new ICB, also needed to change temporarily to fit this dynamic situation. Some committees of the Governing Body and membership have met less frequently, agendas have been streamlined, and risk management processes have focused on the CCG Board Assurance Framework (BAF) and system Gold Command emergency response. The CCG undertook these changes to ensure that its focus and resources continued to be reserved to meet the challenges from COVID-19 and to provide a seamless transition to the new ICB during the first quarter of 2022/23.

Membership Forum

The membership of the CCG is made up of 51 GP practices which are outlined in the Constitution. When the members of the group meet to conduct business as a group, this is known as the CCG Membership Forum. Each member of the group has nominated one practice representative to represent the practice in all matters, and vote on behalf of the practice at CCG Member Forum meetings.

The Membership Forum ensures that there is accountability between the CCG Governing Body and the group's member practices. It also makes decisions and exercises powers reserved to the membership, as listed in the Scheme of Reservation and Delegation that forms part of the Constitution.

The Membership Forum did not meet during the first three months of the 2022/23 financial year. The full list of the Membership Forum can be found in the Accountability section of this Annual Report.

Locality Forums

The CCG also has four Locality Forums – local geographical groupings ('localities') of practice members which comprise the respective practice representatives of the practices within each locality. They provide a forum for discussion and involvement with member practices.

The CCG has constituted four localities: North Shropshire, Shrewsbury and Atcham, Telford and Wrekin, and South Shropshire.

Locality Forum members and attendance are listed below:

The North Shropshire Locality Forum

Name	Title	Medical Practice	Attendance
Dr Adam Booth	General Practitioner	Baschirch	0
Tracey Wilcocks	Practice Manager	Baschurch	0

Dr T W Lyttle	General Practitioner	Churchmere Medical Group	0
Ms Jenny Davies	Practice Manager	Churchmere Medical Group	1
Dr A Schur	General Practitioner	Clive	1
Mrs Zoe Bishop	Practice Manager	Clive	0
Dr J Mehta	General Practitioner	Hodnet	0
Mrs Rosemary Mehta	Practice Manager	Hodnet	0
Dr J Davies	General Practitioner	Knockin	1
Mrs Mary Herbert	Practice Manager	Knockin	1
Dr Michael Matthee	General Practitioner	Market Drayton	1
Mrs Michele Matthee	Practice Manager	Market Drayton	0
Dr S Eslava	General Practitioner	Oswestry - Cambrian	1
Ms Nicola James	Practice Manager	Oswestry - Cambrian	0
Dr S Lachowicz	General Practitioner	Oswestry - Caxton	0
Mr James Bradbury	Practice Manager	Oswestry - Caxton	0
Dr Y Seenan	General Practitioner	Oswestry - Plas Ffynnon	1
Mr Nicolas Storey	Practice Manager	Oswestry - Plas Ffynnon	1
Dr A C W Clark	General Practitioner	Shawbury	0
Ms Clare McDermott	Practice Manager	Shawbury	1
Dr C Rogers	General Practitioner	Wem and Prees	0
Ms Caroline Morris	Practice Manager	Wem and Prees	1
Dr K Lewis (Chair)	General Practitioner	Westbury	1
Mrs Helen Bowkett	Practice Manager	Westbury	0

The Forum met formally once in the period 1st April 2022 to 30 June 2022 as committees in common with the other Locality Forums. A summary of the areas discussed at the Forum are outlined below:

- Outpatient Redesign
- Appointment Process for Primary Care Board
- Primary Care Leadership for ICB
- Podiatry and Foot Health Services
- GP Strategy

Telford and Wrekin Locality Forum

Name	Title	Medical Practice	Attendance
Dr D Sharp	General Practitioner	Charlton Medical Practice	1
Anne Thorpe	Practice Manager	Charlton Medical Practice	0
Dr Teresa McDonnell	General Practitioner	Court Street	1
Maria Humphries	Practice Manager	Court Street	1
Dr H Bufton	General Practitioner	Dawley Medical Practice	1
Nicki Blackburn	Practice Manager	Dawley Medical Practice	1

Dr J Hudson	General Practitioner	Donnington Medical Practice	1
Jason Shelley	Practice Manager	Donnington Medical Practice	0
Dr R Mishra	General Practitioner	Hollinswood / Priorslee MP	0
Mala Mishra	Practice Manager	Hollinswood / Priorslee MP	0
Dr S Eli	General Practitioner	Ironbridge Medical Practice	1
Anna Rogers	Practice Manager	Ironbridge Medical Practice	0
Dr S Waldendorf	General Practitioner	Linden Hall, Newport	1
Karen Sloan	Practice Manager	Linden Hall, Newport	0
Dr C Freeman	General Practitioner	Shawbirch Medical Practice	1
Ruth Waldendorf	Practice Manager	Shawbirch Medical Practice	0
Dr M Innes / Dr N Gureja	General Practitioner	Stirchley Medical Practice	1
Tracie Craddock	Practice Manager	Stirchley Medical Practice	1
Dr I Chan (Chair)	General Practitioner	Teldoc	1
Elaine Edwards	Practice Manager	Teldoc	0
Dr D Ebenezer / Dr N Singh	General Practitioner	Wellington Medical Practice	0
Dr K Douglas	General Practitioner	Wellington Road, Newport	0
Lynn Kupiec	Practice Manager	Wellington Road, Newport	0
Dr M Thompson	General Practitioner	Woodside Medical Practice	1
Teresa Beasley	Practice Manager	Woodside Medical Practice	0
Dr Saritha Eli	General Practitioner	Ironbridge Medical Practice	1
Anna Rogers	Practice Manager	Ironbridge Medical Practice	0

The Forum met formally once in the period 1st April 2022 to 30 June 2022 as committees in common with the other Locality Forums. A summary of the areas discussed at the Forum are outlined below:

- Outpatient Redesign
- Appointment Process for Primary Care Board
- Primary Care Leadership for ICB
- Podiatry and Foot Health Services
- GP Strategy

The Shrewsbury and Atcham Locality Forum

Name	Title	Medical Practice	Attendance
Dr Kate Leach	General Practitioner	Belvidere	1
Ms Caroline Davis	Practice Manager	Belvidere	1
Dr M Fallon	General Practitioner	Claremont Bank	0
Ms Jane Read	Practice Manager	Claremont Bank	1
Dr E Baines (Chair)	General Practitioner	Marden	1
Mrs Zoe George	Practice Manager	Marden	1
Dr J Visick	General Practitioner	Marysville	0

Mrs Izzy Culliss	Practice Manager	Marysville	1
Dr S Watton	General Practitioner	Mytton Oak	0
Vacancy	Practice Manager	Mytton Oak	0
Dr A Adams	General Practitioner	Pontesbury and Worthen	0
vacancy	Practice Manager	Pontesbury and Worthen	0
Dr C Hart	General Practitioner	Radbrook Green	1
Dr H Bale	General Practitioner	Radbrook Green	0
Dr Benjamin Roberts	General Practitioner	Radbrook Green	0
Ms Angela Treherne	Practice Manager	Radbrook Green	0
Dr P Rwezaura	General Practitioner	Riverside	1
Ms Amanda Lloyd	Practice Manager	Riverside	0
Dr D Martin	General Practitioner	Severn Fields	0
Ms S Griffiths	Practice Manager	Severn Fields	0
Dr L Davis	General Practitioner	South Hermitage	0
Mrs Caroline Brown	Practice Manager	South Hermitage	0
Dr E Jutsum	General Practitioner	The Beeches, Bayston Hill	1
Ms N Perks	Practice Manager	The Beeches, Bayston Hill	0

The Forum met formally once in the period 1st April 2022 to 30 June 2022 as committees in common with the other Locality Forums. A summary of the areas discussed at the Forum are outlined below:

- Outpatient Redesign
- Appointment Process for Primary Care Board
- Primary Care Leadership for ICB
- Podiatry and Foot Health Services
- GP Strategy

The South Shropshire Locality Forum

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

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

The Forum met formally once in the period 1st April 2022 to 30 June 2022 as committees in common with the other Locality Forums. A summary of the areas discussed at the Forum are outlined below:

- Outpatient Redesign
- Appointment Process for Primary Care Board
- Primary Care Leadership for ICB
- Podiatry and Foot Health Services
- GP Strategy

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

Governing Body

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

CCG Governing Body met once during the period 1st April 2022 to 30th June 2022 in total. The names of members and their attendance are listed below:

Governing Body members up to 30 June 2022	Board Role	Meetings attended during 2022/23
Dr John Pepper (voting)	GP Chair	1
Dr Mike Matthee (voting)	GP/Healthcare Professional Member	1
Mrs Rachael Bryceland (voting)	GP/Healthcare Professional Member	1
Dr Mary Ilesanmi (voting)	GP/Healthcare Professional Member	1
Dr Adam Pringle (voting)	GP/Healthcare Professional Member	1
Dr Martin Allen (voting)	Secondary Doctor Member	1
Mrs Audrey Warren (voting)	Independent Nurse Member	1
Mr Geoff Braden (voting)	Lay Member – Governance	1
Mr Meredith Vivian (voting)	Lay Member – Patient Public Involvement (PPI)	0
Mrs Donna McArthur (voting)	Lay Member – Primary Care	0
Mr Ash Ahmed	Lay Member – Patient Public Involvement (PPI) – Equality, Diversity and Inclusion (EDI)	0
Mr Mark Brandreth (voting)	Interim Accountable Officer	1
Mrs Claire Skidmore (voting)	Executive Director of Finance	1
Mrs Zena Young (voting)	Executive Director of Nursing and Quality	1
Dr Julie Garside (voting)	Director of Performance responsible for the Executive Director of Transformation portfolio	1
Ms Claire Parker (non-voting)	Director of Partnerships	1
Miss Alison Smith (non-voting)	Director of Corporate Affairs	1
Mrs Sam Tilley (non-voting)	Director of Planning	1
Dr Deborah Shepherd (non-voting)	Medical Director	0
Dr Stephen James (non-voting)	Interim Chief Clinical Information Officer	0
Rachel Robinson (non-voting)	Director of Public Health for Shropshire Council	0

Liz Noakes (non-voting)	Director of Public Health for Telford and Wrekin Council	0
Lynn Cawley (non-voting)	Chief Officer – Healthwatch Shropshire	1
Barry Parnaby (non-voting)	Chair – Healthwatch Telford and Wrekin	0

Audit Committee

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

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

Audit Committee members	Meetings attended during 2022/23
Mr Geoff Braden – Lay Member for Governance (Chair)	3
Mr Meredith Vivian – Lay Member PPI	2
Mrs Donna MacArthur – Lay Member Primary Care	2
Mr Ash Ahmed – Lay Member PPI – EDI	1

Throughout quarter 1 of 2022/23, the Committee has received regular reports on the following:

1. Assurance and oversight of due diligence of transition from NHS Shropshire, Telford and Wrekin CCG to Integrated Care Board.
2. assurance gained from and further development of the Board Assurance Framework (BAF) and Executive Risk Register
3. assurance gained from overseeing the continued development and self-certification of the CCG against the Information Governance (IG) toolkit
4. assurance on quality process for triangulating information to monitor provider quality and ensuring high standards of safeguarding
5. assurance on the CCG's emergency planning and business continuity processes
6. assurance on the counter fraud measures in place and on continuing work around preventing and addressing fraud
7. assurance gained from Internal / External Audit reports
8. assurance on the content of the annual accounts and annual report audit by external auditors

Remuneration Committee

The Remuneration Committee recommends to the Board appropriate salaries, payments and terms and conditions of employment. The Remuneration Committee has met twice as required during the period 1st April 2022 to 30th June 2022.

Remuneration Committee members up to 1 August 2020	Meetings attended during 2022/23
Mrs Donna MacArthur – Lay Member Primary Care (Chair)	2
Mr Meredith Vivian – Lay Member PPI	2
Mr Ash Ahmed – Lay Member PPI – EDI	2

Throughout the first quarter, the Committee has received reports on:

- implementation of national guidance in relation to pay awards.
- consideration and ratification of National Guidance in relation to ICS Transition Management of Change Process for CCG staff
- review and support for two retire and return applications presented to the committee which recognised the recruitment challenges and the need to retain specialist skills and corporate memory.

Quality and Performance Committee

The Quality and Performance Committee oversees and provides assurance on performance and quality of commissioned services. The committee met 3 times during the year. The Committee continued to meet during quarter 1 in common with the shadow ICB Quality and Performance Committee to enable a seamless handover.

Quality and Performance Committee members	Meetings attended during 2022/23
Mr Meredith Vivian – Lay Member PPI (Chair)	3
Mrs Audrey Warren – Registered Nurse	2
Mrs Rachael Bryceland – GP/Healthcare Professional	1
Dr Martin Allen – Secondary Care Doctor	1

Throughout the first quarter, the Committee received reports on:

- SaTH CQC Condition Notices for CYP/Mental Health
- ASD
- Safeguarding
- ICS Quality & Safety Strategy
- Continuity of Carer
- Serious Incidence
- CHC Quarterly Update
- NICE
- SEND
- ICS Training Hub
- LMNS Update
- Ockenden Update
- Primary Care Quarterly report
- Ambulance on Scene of Times during the Pandemic

- Harm Review
- IPC Quarterly report
- LeDeR Update
- Patient Experience
- NHS 11 First
- Breast Cancer Updates

Finance Committee

The Finance Committee oversees and provides assurance on the financial delivery of commissioned services. The committee met 3 times during 2022/23.

Finance Committee members	Meetings attended during 2022/23
Mr Geoff Braden – Lay Member Governance (Chair)	3
Mr Ash Ahmed – Lay Member PPI – EDI	2
Dr John Pepper – GP Chair	1
Dr Mike Matthee – GP / Healthcare Professional	3
Dr Martin Allen – Secondary Care Doctor	2

Throughout the first quarter, the Committee has received reports on:

- Month 12 Finance Report
- 22/23 Finance Plan
- 2021/22 Value for Money Report including progress on 2022/23 Plans
- ICS Due Diligence
- Board Assurance Framework and Directorate Risk Register 2021/22
- 2022/23 Efficiency Plan Update
- M2 CCG Finance Report
- M2 Efficiency Plan Update

The Strategic Commissioning Committee

The Strategic Commissioning Committee oversees and provides assurance on the commissioning of services. The Committee has met once during the period 1st April 2022 to 30th June 2022 which is included in the attendance table below.

Strategic Commissioning Committee members	Meetings attended during 2022/23
Mrs Audrey Warren – Registered Nurse (Chair)	1
Mr Ash Ahmed – Lay Member PPI – EDI	1
Mrs Donna MacArthur – Lay Member Primary Care	1
Dr John Pepper – GP/Healthcare Professional	1
Mr Mary Ilesanmi – GP/Healthcare Professional	1

Throughout the first quarter the Committee has received reports on:

- Prescribing Development scheme 22/23
- Rapid Access Chest Pain Proforma
- Assurance Report (Q3 2021/22 Insight Report)
- Local Care Update (Presentation)
- Community Diagnostic Centre Business case

Primary Care Commissioning Committee

This committee oversees the commissioning of primary care under delegated decision-making authority from NHS England. The committee met eight times during the year.

The Primary Care Commissioning Committee has met twice as scheduled during the period 1st April 2022 to 30th June 2022.

Primary Care Commissioning Committee members	Meetings attended during 2022/23
Mrs Donna MacArthur – Lay Member Primary Care (Chair)	1
Mr Meredith Vivian – Lay Member PPI	2
Independent GP - vacancy	n/a
Mr Mark Brandreth – Interim Accountable Officer	0
Mrs Claire Skidmore – Executive Director Finance	1
Mrs Zena Young – Executive Director of Nursing and Quality	0
Claire Parker – Director of Partnerships	2
Dr Julie Garside – Director of Planning	2

Throughout the first quarter, the Committee has received reports on:

- Finance update
- Primary Care Update
- Primary Care Practice Visits Update
- GP Strategy
- Risk Register
- Winter Access Fund
- GP Patient Survey
- Draft Caretaking Policy

Individual Funding Committee

The IFC approves commissioning decisions for individual funding requests as part of a three-stage process, with the Committee fulfilling the second stage decision-making on behalf of the Group.

The IFR stage one screening panel considers IFR requests for funding for individual exceptional patients on behalf of the CCG. The Individual Funding Request Stage one screening panel did not meet during the period 1st April 2022 to 30th June 2022.

IFR stage one screening panel members	Meetings attended during 2022/23
Gabriel Agboado – Consultant in Public Health Medicine	n/a
Michele Rowland-Jones – Senior Pharmaceutical Advisor	n/a

Between 1 April 2022 and 30 June 2022, no cases were taken to the IFR stage one panel for consideration and 1 case was passed to a stage two Individual Funding Committee. Therefore 1 decision was made.

Individual Funding Committee members (stage two)	Meetings attended during 2022/23
Barrie Reis-Seymour – Head of Transformation and System Commissioning – Elective Care	0
Tracey Jones – Deputy Director of Partnerships	0
Deborah Shepherd – GP	1
Kay Holland – Deputy Director Contracting	0
Meryl Flaherty – Contracts Business Partner	1
Gordon Kochane – Public Health Consultant	0
Francis Sutherland – Head of Transformation and Commissioning – Mental Health, Learning Disabilities and Autism	1
Liz Walker – Deputy Director Quality	0
Julie Garside – Director Transformation, Partnership and Commissioning	0
Angus Hughes – Associate Director of Finance – Decision Support	0
Angharad Jones – Finance Business Partner	0
Dr Adam Pringle – GP	0

Between 1 April 2022 and 30 June 2022, no cases were taken to the IFR stage three (appeal) review panel for consideration.

IFR stage three review panel members	Meetings attended during 2022/23
Dr John Pepper – GP	n/a
Zena Young – Executive Director of Nursing and Quality	n/a

Assuring Involvement Committee

The 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 Assuring Involvement Committee has met twice during the period 1st April 2022 to 30th June 2022.

Assuring Involvement Committee members	Meetings attended during 2022/23
Mr John Wardle (Chair)	2

Mr Ash Ahmed – Lay Member PPI – EDI	0
Mr Meredith Vivian – Lay Member PPI	2
Mrs Beverley Ashton – Assuring Involvement Committee Member	2
Mr Karl Bailey – Assuring Involvement Committee Member	1
Mrs Sherrel Fikeis – Assuring Involvement Committee Member	2
Mrs Valerie Graham – Assuring Involvement Committee Member	1
Mrs Rosemary Hooper – Vice Chair and Assuring Involvement Committee Member	2
Mrs Jackie Jones – Assuring Involvement Committee Member	1
Mr Patrick Spreadbury – Assuring Involvement Committee Member	2
Mrs Dawn Yapp-Altinsoy – Assuring Involvement Committee Member	2

Throughout the first quarter, the Committee received reports on:

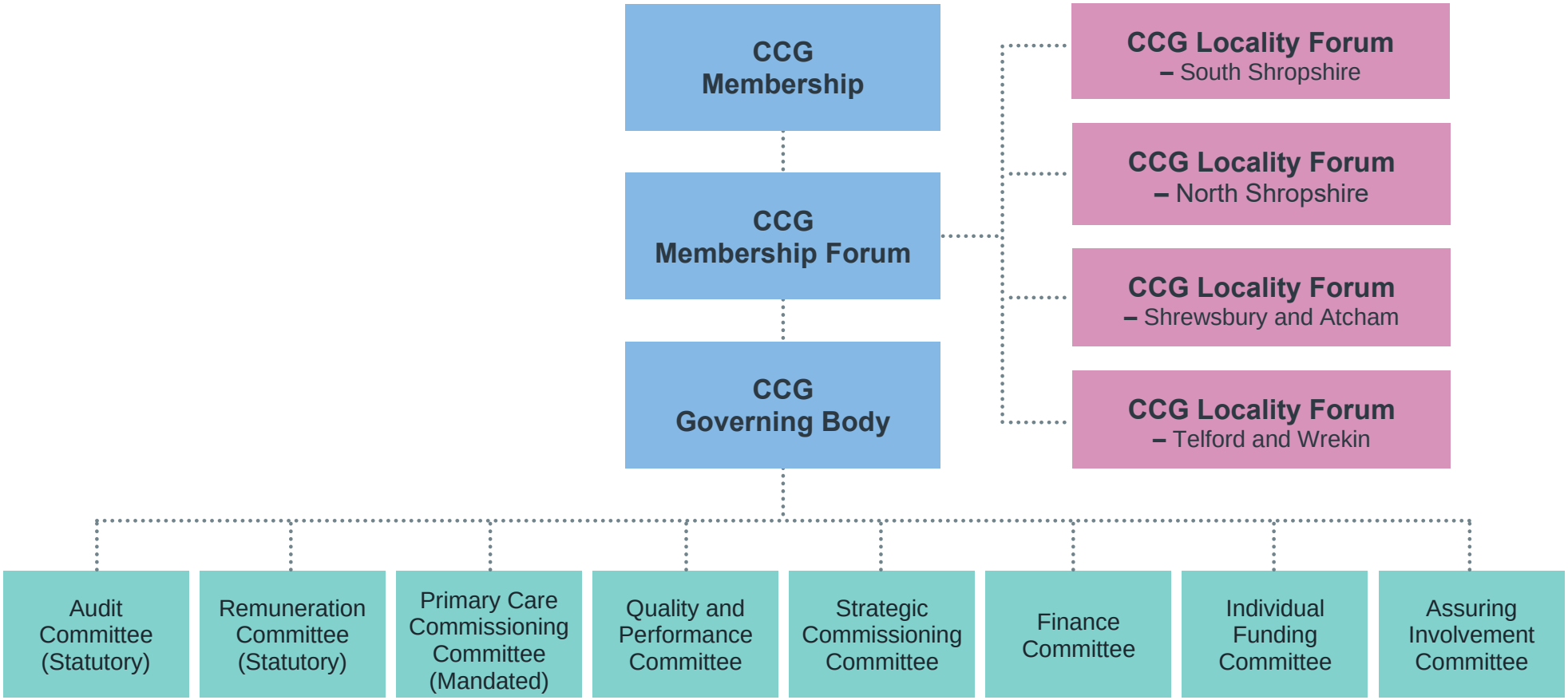
- The Shrewsbury Health and Well-being Hub
- Assuring involvement within the ICB

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

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

The CCG has reflected on its own effectiveness and performance as part the quarterly assurance checkpoints undertaken by NHS England for all ICS systems during 2022/23 and as part of the transition arrangements to the ICB. The outcomes of these have been reported to the CCG Governing Body and ICS Board.

Governance structure for NHS Shropshire, Telford and Wrekin CCG



UK Corporate Governance Code

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

Discharge of statutory functions

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

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

Risk management arrangements and effectiveness

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

The following information outlines the normal risk management practice the CCG follows. However, due to the COVID-19 pandemic, the CCG Governing Body agreed to continue to focus its attention during 2022/23 on the Board Assurance Framework to assist it in navigating a very challenging environment and conserving valuable staff resources and to provide a seamless transition to the ICB.

The CCG's Internal Auditors have reviewed the latest Governing Body Assurance Framework presented to the Audit Committee on 15th June 2022 and to the Governing Body on 8th June 2022 and have undertaken a high level review to confirm that it is broadly designed and operating effectively.

There were also some areas recommended for action which included the need to update some risks and actions and some inconsistency of detail and presentation of information. These recommendations were actioned in Q1 of 2022/23 financial year.

The coordinating body for receiving assurance on these strands of governance is the Audit Committee, which oversees integrated governance on behalf of the CCG Governing Body. In

addition, the other committees also oversee the risks within their specific remits, providing assurance to the Audit Committee where appropriate.

The CCG prevents risk arising wherever possible by:

- applying 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 (for example, legal, information governance, and human resources advice)
- internal audit.

The CCG also employs 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 managing them efficiently, effectively and economically.

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

The risk appetite was determined and approved by the Governing Body and the strategy outlines the processes for maintaining and monitoring the Board Assurance Framework and the Directorate 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 healthcare from
- to achieve this, we will maintain a lean and flexible governance and staffing structure, populated by people who think in a holistic, patient-focused way and with a keen sense of inventiveness
- we will accept risks graded as 'very low', avoid expenditure and use of resources on those graded 'low', manage in a cost-effective manner those graded moderate and enthusiastically seek to reduce those graded 'high'
- conversely, we will actively seek to implement actions to take opportunities graded 'high' and proportionately respond to those graded below this
- whilst we will ensure cost-effectiveness and a balanced budget, we seek quality and innovation towards best practice in patient-centred care.

Risk management is embedded in the activity of the CCG 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 Ulysses reporting system
- Information Governance (IG), raising concerns and ensuring fraud awareness and training has been provided to senior managers and staff
- training for staff and Board members is mandated for particular areas: health and safety, IG, safeguarding, safer recruitment, fire safety, business continuity/emergency planning, Integrated Single Finance System (ISFE) and conflicts of interest
- intelligence gathering through quality and performance contracting processes with providers
- complaints and Patient Advice and Liaison Service (PALS) enquiries
- NHS-to-NHS concerns reporting via Ulysses
- national reviews, inspections and guidance.

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

The following processes are used to identify risks:

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

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

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

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

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

Our capacity to handle risk

Leadership is given to the risk management process by the Accountable Officer whose role is to own the Board Assurance Framework (BAF). The BAF, which documents the principal risks to the CCG's objectives not being delivered, is underpinned by the Directorate Risk Register. This outlines the lower-level risks to each executive lead not meeting their 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 Directorate Risk Register. Both the Accountable Officer and directors are supported by the Director for Corporate Affairs. CCG staff are provided with a risk assessment code of practice and receive support and training on risk management from the Director of Corporate Affairs where required.

A summary of the major risks identified in this interim BAF during the first quarter of 2022/23 is set out below, and the actions being taken to mitigate the risks. The major risks to the CCG have been reviewed and revised bi-monthly where necessary and then presented to the Audit Committee and the CCG Governing Body.

Description of major risks added to the Board Assurance Framework during 2022/23	Existing controls	Further actions
1. Patient and Public Involvement There is a risk that the CCG fails to meet its statutory duty to involve patients and the public in planning commissioning arrangements, in development and consideration of proposals to change or cease existing services.	• Interim Communications and Engagement Strategy for STW CCG approved by Governing Body • Communications and Engagement teams working jointly across CCG, ICS and Providers providing more capacity and expertise in planning and delivery • Reports to Governing Body/Committees require section completing on patient involvement • Substantive ICS Director of Comms and Engagement now appointed and overseeing both ICS and CCG functions • Presence of Healthwatch for both areas at Governing Body meetings and Quality Committee • Lay Member for PPI and Lay Member for PPI - EDI in place on Governing Body to act as specific check and balance with regard to patient involvement • Assuring Involvement Committee as part of CCG Governance • Communications and Engagement teams are working jointly across the CCG, ICS and system partners	• Communications and Engagement Director overseeing the production of a Comms and Engagement Forward Plan to cover the period to the end of the financial year. The forward plan will then be used as a basis to formulate a more formal C&E Strategy for the ICS. • The Interim Director and Assistant Director have established processes with their new-look team and are now developing a forward plan of activity.

	providing more capacity and expertise in planning and delivery. • ICS board meetings are now held in public and board papers published to the ICS website to increase transparency.	
2. Transition to a statutory Integrated Care Board (ICB) There is a risk that the CCG does not have sufficient capacity and capability to undertake the transition to the ICS satisfactorily, which results in the ICB being unable to discharge its new statutory duties.	• Governing Body members taking lead roles in ICS governance and delivery functions. • CCG Directors have dual roles with CCG and ICS • Joint CCG/ICS management team meetings • Transition meetings taking place with CCG AO ICS Director, ICS Workforce, CCG Director of CA • ICS has been authorised by NHS England • Project lead identified by ICS • National guidance has now been released • ICS and CCG have now appointed an interim CEO for ICS • Transition group overseeing transition plan and due diligence via fortnightly meetings. • Work is being shared between ICS/CCG and providers, with key leads being identified • CS Transition Group involves CCG ED for F, ED for Quality and Nursing, D of Partnerships and Director of CA • Transition plan in place with PMO support. • Due Diligence plan approved, and work is ongoing with identified PMO lead.	• Guidance on model constitution and place and ICB structures have been released. and ICB is leading more work on place-based arrangement - July 2022 • Governance structure has been agreed and terms of reference and scheme of reservation and delegation are being developed
3. CCG workforce capacity There is a risk that due to the number of secondments, staff vacancies, recruitment freeze and staff sickness levels that the capacity, capability and resilience of our workforce is unable to meet the	• Work has been done to ensure that there a no duplication between the CCG and ICB meetings. • A reduced rhythm of CCG governance meetings has been agreed with the CCG Governing Body. • HR are continuing to collect information on secondments/ temporary staffing as part of due diligence process to provide an overview.	• Capacity issues in directorates to be captured in DRR May 2022

demands of ongoing requirements.	• Effective prioritisation of workload to system Big 6 priorities and other quality and safety priorities. ongoing • CCG participated in collective mutual aid with system to support level 4 incident management Jan - Mar 2022 through an internal coordination overseen by ED of Quality and D of CA.	
4. Financial sustainability There is a risk of failure to deliver the CCG element of the system financial sustainability plan.	• Detailed YTD and forecasting information provided at both organisation and system level • Regular CCG/ICB budget holder meetings and budget holder training programme in place • PMO function set up within CCG Finance directorate to help leads to develop efficiency programme and accurately monitor progress and delivery.	• Sustainability working group action plan updated in April to focus on 5 key themes to address the gap, with assigned leads to be invited to present deep dives. Actions being monitored through the group and reported to finance committee. • CCG finance team actively engaged in discussions and monitoring potential risks and cost pressures. Issues discussed at regular system finance group meetings and pressures considered at Investment Panel. [LC May 21]. • Business case documentation has been requested from all leads by the end of February. (Efficiency programme leads Feb 22).

5. System failure to deliver overall long-term sustainability plan The underlying financial position of the CCG and the system as a whole is currently a significant deficit. The system is therefore in a recovery process and unable to make investment decisions without being through the 'triple lock' process of organisation, system and NHS England approval. As well as delivering the CCG element of the sustainability plan, the CCG will also play a key part in the whole system delivering the longer-term sustainability plan and the approximately £30 million transformational saving every year.	• Risk management framework in place across the system as part of development of system sustainability plan. • System governance arrangements in place through sustainability committee and investment panel to ensure that new investments are not made unless recurrent resource is available.	• Significant work underway across system to model long term plan. Modelling task and finish group assembled and reviewing system wide financial model available from NHSEI. Future years of plan presented to the system in September- this included a ten year plan showing agreed high level assumptions. This was supported by system partners. System to organisation challenge meetings delivered improved planned deficit position for 22/23 Action plan held by ICB CFO for delivery in May and SROs to be assigned to programmes of work to deliver current gaps in transformation programmes and cost reduction targets. Long term plan to be refreshed following submission of final 22/23 plan. (CS May 22) • System wide development of 'big 6' underway with SRO assigned to each, further work on modelling underway to align to system financial

		plan. Operational delivery group meetings now in place fortnightly with SRO, programme lead, and finance leads to ensure progress. [Cherry West May '22] • System risk management framework to be adopted by the new ICB
6. Quality and Safety Without a robust quality governance framework in place, the system will not be able to monitor quality and safety and mitigate risks in a timely manner. Patients may experience poorer outcomes and experience.	• Development of an ICS Quality and Safety Strategy, co-produced with system health and social care partners and patient representative groups. Approved by ICS Board June 2021. • Establishment of our ICS governance structure including Quality & Safety Committee (a sub-committee of the ICS Board) and System Quality Group (SQG) which provides quality surveillance and improvement. • STW LMNS function is developing to encompass the new responsibilities for PNQSG, and ToR and risk register have been revised in light of this requirement. • SaTH Safety Oversight and Assurance Group (SOAG) in place, co-chaired by NHSE/ICS lead and with system membership. • SI reporting in accordance with NHS SI Framework, monthly SI review meetings between commissioner/provider in place. • Patient Safety Group in place with remit to ensure the NHS Patient Safety strategy is delivered across system. • System-wide IPC forum in place providing oversight and peer support.	• Further develop and embed the system-wide revised approach to quality governance during 2022/23, including quality governance at 'place'. Identify senior resource (DDoN) to lead this work. Q3 • Continue to monitor quality risks and workforce plans at provider level through existing mechanisms including a presence at SaTH internal quality governance. (nb. Workforce reported to ICS People Board which has agreed key priority areas for action). Ongoing • SaTH undertaking a programme of Quality Improvement Getting to Good

	• Vaccination quality governance forum in place to oversee C-19 delivery programme. • CCG/ICS quality and safety monitoring and reporting arrangements will run in parallel during 2022/23. • The model for system governance is confirmed. • There is a programme for monthly quality assurance visits including for maternity MVP and LMNS representatives are included in the Maternity and Neonatal Safety Champion quality visits monthly. • SaTH real-time (unvalidated) data submissions to MBRRACE-UK accessible through specialist midwife and perinatal mortality tool. • All women now on badgernet platform. Medway system now read only (May 22). • Regional escalation tool in place for maternity closures (May 22) • Quality metrics agreed and included in System Quality metrics from June 22 for oversight.	Programme - reported monthly to SOAG for oversight & scrutiny. SOAG is co-chaired by ICS and NHS England directors. • Further develop the maternity metrics dashboard at LMNS level - developments made with LMNS dashboard working with SaTH and CSU to establish validated metrics. Data Quality position report received to LMNS board March 2022, improvement expected by July 22. • Support to SaTH to further develop the content and accuracy of their internal maternity dashboard and improve exception reporting. • Continue to monitor Maternity service closure and impact, ensuring appropriate escalation process are followed in each occurrence. • Targeted quality improvement work relating to CYP MH in progress • Oversight of Safeguarding and LAC risks via

		system safeguarding assurance mechanisms. • Continue to monitor LAC standards (which are improving), supporting with revised referral processes. • Implement recommendations of CCG internal audit of Safeguarding Adult and Child processes. Oct 21 (June 22 completion) • Implement new statutory requirements for Liberty Protection Safeguards when national timelines and details are published. • System CYP MH Challenge event hosted jointly by SG partnership boards 13.06.22
7. Restoration of services post COVID-19 There is a risk that the restoration of health services following the COVID-19 pandemic will not keep pace with patient need resulting in patients suffering harm.	• Demand and Capacity Modelling • System Clinical prioritisation and approach to harm policy in place • Development of digital and virtual capabilities • Developing system infrastructure • 2022/23 operational plan • People Plan and workforce planning	• Elective Recovery trajectories set out in 2022/23 plan. Big 6 item re outpatient transformation and MSK addressing elements of sustainability and transformation • Demand and capacity and performance

		monitoring ongoing to track progress and allow for early mitigation if deviation from plan is evident. • Work ongoing on implementation of People Plan • Ongoing dialogue with NHSE regarding equipment and estate
8. Population Health Needs There is a risk that the CCG fails to understand its population health needs and how this contributes to health inequalities across the footprint resulting in widening health inequalities.	• Inequalities sits within the portfolio for Director of Planning and Partnerships and Population Health Management sits within the portfolio of the Director of Planning. JSNA work lead by Councils.	• First phase review of capacity and capability completed. Analyst network in place to support sharing skills and expertise and supporting a system approach. 2 x PHM posts (joint with LAs) recruited to. Refresh of PH Strategy completed to ensure system BI capacity is wrapping around the correct priorities. • PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. Further momentum needed in relation to digital developments • Engagement strategies being developed with the SCCtH and TWIPP boards. Joint posts with Local Authority to develop

		partnership and place based working to deliver the needs of the population • PHM SRO within ICS structure but reporting lines and working group arrangements to be developed • Funding requirement linked to output of the CSU Strategy Unit review
9.Safeguarding / Looked After Child (LAC) There may be insufficient capacity to carry out statutory safeguarding responsibilities for adults and children within our system.	• Robust safeguarding governance infrastructures for the two system Local Authorities, which is well attended by all statutory partners. • Regional safeguarding governance infrastructure which is well attended by CCG. • Experienced team members and good professional links between providers and commissioners of services across STW. • There is a Designated Doctor for LAC in post.	• Maintain attendance of designated and named professionals at safeguarding and LAC governance fora. • Continue to triangulate information and outcomes and address areas of concern. • Continue to undertake quality assurance visits. • Scope out development of a proactive/reactive support offer to CYP care homes with system partners. • Continue to support commissioners and providers in implementing new models of care.
10. Risk of sustained urgent and emergency care (UEC) pressure	• Daily Silver Call • Weekly Gold Call	• Several improvement workstreams in

There is a risk that demand for urgent and emergency care consistently outstrips capacity and that this will result in patients suffering harm.	• UEC Improvement Plan in place • Significant cost pressure for WMAS already factored into 22/23 financial plan • WMAS handover - quality issues - Alternative pathways in place using primary care and community services for assessment. • The acute provider is undertaking harm assessments, CCG are included in terms of reference • The Quality and Performance Committee received quality and performance data on which to gain knowledge and inform discussion. • CCG Quality Team act on WMAS incidents to ensure lessons are learned and UEC leaders are aware to address performance to prevent repeat.	place but capacity to deliver change has been limited due to the level of system pressure. There are signs that this is now beginning to ease. Learning from our current UEC improvement Plan and the approach to recent pressures has been consolidated and mapped into a refreshed UEC Improvement Plan which has been approved by the UEC Board. • 1b. Work to finalise sub-work programmes to be completed by the end of May22 • Significant collaboration between partners agencies, including our LAs in addressing current pressures has shown benefits • Winter Comms plan in place, Winter Plan and specific winter schemes in place. • CG UEC staffing resource structure developed and agreed. • Specific development in place regarding discharge and attendance avoidance • WMAS handover costs will be monitored closely

		through regular communication with WMAS and lead commissioner contracting and finance teams • Monitor WMAS Serious incidents for themes monthly at system quality group - July 22 • CCG Quality Team monitor the timeliness of incident investigation to ensure immediate and longer-term actions are addressed in a timely way and learning is maximised. The SOP is updated and to be published – June 22 • Systems to monitor patient and family feedback in relation to ambulance delays are to be established - July 22

Other sources of assurance

Internal Control Framework

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

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control has been in place and under review for the first quarter of 2022/23 and up to the date of the dissolution of the CCG.

The system utilised by the CCG is designed to identify and prioritise risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. There is appropriate monitoring of risks and the courses of action being employed to mitigate them.

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

The following control mechanisms are in place:

- risk management
- Constitution
- security management
- Counter Fraud Annual Plan
- Internal Audit Annual Plan
- performance monitoring of CCG providers and the CCG itself
- IG Toolkit submission
- incident and serious incident reporting
- quality and financial reporting
- contract/quality performance monitoring arrangements with providers
- policies and procedures
- risk assessments
- governance reporting between the Board and its committees/sub-committees
- adult and children's safeguarding annual reports
- emergency and business continuity planning/core standards
- external regulator reports on providers.

Annual audit of conflicts of interest management

The CCG has a Conflicts of Interest Policy which governs the process for employees, Governing Body members, CCG Members, contractors, and others undertaking functions on behalf of the CCG to declare their interests where these may conflict with those of the CCG.

The Policy outlines a process for individuals both employed by the CCG or those not employed but acting on behalf of the CCG, to declare these interests to ensure that decisions made on behalf of the CCG are not compromised. The policy and registers can be found on the CCG website: www.shropshiretelfordandwrekinccg.nhs.uk/about-us/conflicts-of-interest/

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 at the end of 2021/22 and the audit provided moderate assurance, with some recommendations for further action. All recommendations have been fully accepted by the CCG and mandatory training was up to date by 31st May 2022. Register of interests have been updated for Governing Body members and the senior management team and for practice members, with some of the latter still outstanding which had been escalated.

Due to the dissolution of the CCG on 30th June 2022 no further conflicts of interest audit has taken place for the period 1st April to 30th June 2022.

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

Data quality

The Board relies on the data quality elements in its contracts with providers that requires them to quality assure their data prior to submission. The CCG also uses NHS 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 Secondary Uses Service (SUS) data which is verified via the contracting process with providers.

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, particularly personal identifiable information. The framework is supported by a Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the CCG, other organisations and individuals that personal information is dealt with legally, securely, efficiently and effectively. The CCG has delivered a compliant DSPT for 2022/23 and submitted by the end of March 2022, ahead of the 30th June 2022 deadline.

The CCG places high importance on ensuring there are robust information governance (IG) systems and processes in place to help protect patient and corporate information. We have established an IG management framework and have developed processes and procedures

in line with the DSPT. We have ensured all staff undertake annual IG training and provide a staff IG handbook to ensure everyone is aware of their roles and responsibilities.

There are processes in place for incident reporting and the investigation of serious incidents. We have reported a total of 6 incidents during the first quarter of 2022/23 and all these incidents were graded as non-reportable – very low risk and therefore not reported to the Information Commissioner's Office (ICO). We have developed an information asset register which enables the CCG to identify high-risk assets through data flow mapping, and the CCG ensures that an information risk culture is embedded throughout the organisation.

The CCG receives an IG service from MLCSU. This enables us to receive a full, specialised service, which as a small organisation we could not reproduce in-house.

A work programme has been undertaken by MLCSU to ensure that the 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.

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 share with the Analytical Oversight Committee.

Third-party assurances

Third-party assurances are received annually from MLCSU for particular financial functions that are part of a service level agreement. Processes are in place to ensure that the CSU Internal Audit function shares its own audit findings of these functions with the CCG's internal auditor, who includes a precis of the findings in the Head of Internal Audit Opinion, which is part of this statement.

Raising concerns – freedom to speak up

The CCG has a policy in place to support staff to raise concerns (sometimes referred to as 'whistleblowing'). There have been no concerns raised by staff during the first quarter of year 2022/23. The CCG has appointed a Speak Up Guardian at Board level to support staff to raise concerns under the policy moving forward.

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

Control issues

The significant control issues that the CCG has been managing during the first quarter of 2022/23 that would require reporting in this Annual Governance Statement are as follows:

1. Financial deficit

The Shropshire, Telford and Wrekin system is part of the Recovery Support Programme – Level 4 of the NHS England System Oversight Framework. The system and CCG is therefore subject to significant scrutiny around finances and financial decisions. In 2022/23 the CCG (and the wider system) is reporting a deficit against the NHS England requirement of break-even.

System-wide financial reporting and governance has been implemented, including the system 'triple lock' process around all investment decisions. NHS England are involved in regular meetings across the system and have oversight of the development and progression of the system financial recovery plan.

2. Quality issues at local providers

The Shrewsbury and Telford Hospital NHS Trust (SaTH) remains the most challenged provider and cause for concern within the Shropshire, Telford and Wrekin healthcare system. The CCG continues to work with SaTH to manage significant performance and quality issues in year in relation to its acute provider, which is in special measures for quality and has also been subject to an independent review of maternity services by Mrs Donna Ockenden.

The CCG has a range of inputs to the provider to aid improvement and will be implementing revised system quality governance arrangements in readiness to operate as an ICS. The CQC recently published their Inspection Report following a number of visits across both sites at the Trust between July and August 2021. Core services of maternity, urgent and emergency care (UEC), medical wards and end-of-life care were inspected.

Overall, the Trust was rated as ‘inadequate’. Both Safe and Responsive remained as ‘inadequate’, Effective and Well-led improved to ‘requires improvement’ and Caring stayed the same at ‘requires improvement’. The report recognised areas of outstanding practice in maternity services, as well as areas which require further targeted work, particularly around end-of-life care and UEC. The Trust is working through the required and recommended actions identified in the report. Since the report, the CQC has revised the number of conditions in place with an overall reduction.

There have been infection prevention control issues identified at Robert Jones and Agnes Hunt Orthopaedic Foundation Trust. The issues highlighted are being addressed through an action plan that both the CCG and NHS England are monitoring closely.

3. Urgent and emergency care

Urgent and emergency care remained very challenged and do not currently meet Constitutional/national standards. There has been a national trend/uplift in the length of stay greater than seven days, and delays in complex discharges due to challenges in the care market. These particularly related to the impact of COVID-19 infection, prevention and control measures and the impact of COVID-19 on workforce availability.

This has impacted upon the ability to move patients quickly through the emergency department and onto the wards at SaTH. Bed occupancy remains exceptionally high, around 96 per cent across usable general and acute beds. The further impact of this has been an increase in ambulance handover delays.

Multi-Agency Discharge Events (MADE) have proved valuable and system-level demand and capacity meetings have mitigated some of the risk with forecasting the bed model required to achieve optimum flow. Outbreaks and staffing shortages due to COVID-19 have seen a number of system bed closures, which has severely impacted upon the ability to manage the back door and is reflected in this month's performance.

Trajectories for improvement were set with the provider in 2021/22 and can be seen in the urgent and emergency care (UEC) dashboard. In line with the continued need to manage the COVID-19 pandemic as a level 4 incident system, Silver and Gold calls have been in place daily to monitor UEC performance and agree actions to mitigate areas of concern.

4. COVID-19 pandemic

A continuing significant control issue is the impact of the continuing COVID-19 pandemic. A national emergency was declared in March 2020, which has required the NHS as a whole to respond on a scale not seen since the Second World War. The National Level 4 incident remains in place, and locally we continue to manage this in line with these requirements.

The CCG, in partnership with other key stakeholders, continued to lead the Local Health Resilience Partnership (LHRP) response to the emergency across Shropshire, Telford and Wrekin. Some clinical staff have continued to be redeployed to frontline services to support the significant challenge of COVID-19.

Non-clinical CCG staff have continued to be redeployed into identified critical services or have been trained to provide back-up to these services to cover any staff shortages. Where necessary, the CCG has secured additional service capacity.

The CCG has continued to lead on the restoration of services following the first national lockdown and the national COVID-19 vaccination programme during the year.

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

The Finance Committee and Quality and Performance Committee (QPC) give detailed consideration to the CCG's financial and performance issues to provide the CCG Board with

assurance that all issues are being appropriately managed and escalated where necessary. This includes the determination of key financial assumptions to underpin the CCG's medium-term financial strategy and scrutiny of monthly financial reporting, including delivery of Quality, Innovation, Productivity and Prevention (QIPP) schemes through the system Investment Panel, performance against central management costs and efficiency controls.

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

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

Delegation of functions

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

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

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

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

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 estimated contract value is £100,810 excluding VAT. The contract includes the core audit work of the financial statements and work on the economy, efficiency and effectiveness in the CCG's use of resources (Value for Money).

Counter fraud arrangements

The CCG adheres to the standards set by NHS Counter Fraud Authority in order to combat economic crime within the NHS. The CCG complies with the NHS Counter Fraud Authority anti-fraud manual and best-practice guidance from the Chartered Institute of Public Finance and Accountancy and the Institute of Counter Fraud Specialists.

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

The CCG does not tolerate economic crime. The CCG has an Anti-Fraud, Bribery and Corruption Response Policy in place which is designed to make all staff aware of their responsibilities should they suspect offences being committed.

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

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

The Executive Director of Finance, who is a member of the CCG Governing Body, is proactively and demonstrably responsible for tackling fraud, bribery and corruption and oversees that appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations. In addition, the LCFS role is further supported by a nominated Counter Fraud Champion who provides a senior voice within the organisation to champion the counter fraud agenda, and to enable and support the counter fraud programme of work.

Draft Head of Internal Audit (HOIA) Opinion

The purpose of this HOIA Opinion for the period April to end June 2022 is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Governing Body in the completion of its Annual Governance Statement related to this period, leading to transition of the CCG to ICB with effect from 1st July 2022.I have set out a summary of my opinion below with detailed supporting information. My overall opinion is that Moderate assurance can be given as weaknesses in the design, and/or inconsistent application of some controls, put the achievement of aspects of some of the organisation's objectives at risk in some of the areas reviewed.

Within my opinion I have noted that:

- The CCG has an effective Assurance Framework. It is important that the Board Assurance Framework is kept updated.
- Full assurance was provided for Financial Ledger and Significant Assurance for Debtors, Creditors and Payroll
- The implementation of agreed actions is effective at the CCG, however significant system challenges remain in relation to provider quality and financial sustainability.
- The CQC inadequate rating for Shrewsbury and Telford Hospital NHS Trust remained in place and the Ockenden Report highlighted repeated failures at the Trust's maternity service resulting in tragic consequence. Work/oversight has been handed over to the ICB.
- The CCG followed the transition arrangements designed by NHSE/I (with some local enhancements) as it progressed towards ICB status

I have highlighted the following Significant Issues that must be reported within your Annual Governance Statement: system underlying financial challenges; operational and quality challenges at the local provider.

The design and operation of the Assurance Framework and associated processes

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

The CCG Board Assurance Framework (BAF) and Directorate Risk Register (DRR) were reviewed and updated by the strategic risk owners during April/May 2022. Following this, both the DRR and BAF were reviewed by the Executive Director for Nursing and Quality, The Director of Corporate Affairs, the Deputy Director for Nursing and Quality and the Deputy Chief Finance Officer prior to presentation to Board. A final iteration of the CCG BAF and DRR was then reported to Governing Body on 08 June. The CCG continued to carry high levels of risk to the achievement of its strategic objectives, particularly around financial sustainability and this was reflected appropriately in the BAF. We noted some improvements that could be made to the BAF which are being taken forward by the ICB.

It is my view that an Assurance Framework has been established which is designed and operating within the period of April to end of June 2022 to meet the requirements of the Governance Statement that will be required for the 3 month period leading to the transition from CCG to ICB and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation during this time. It is important that the framework is kept up to date.

The system of internal control based on internal audit work undertaken

My Opinion also considers the range of work arising from the risk-based audit assignments that have been completed in the period leading to the CCG's transition to ICB with effect from 1st July 2022. A combined ICB and CCG internal audit plan for 2022/23 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 support the interim opinion, we have considered:
Transition to ICB

Transition process

The CCG followed the transition approach set out in guidance by NHSE/I with some local enhancements. A RAG rated checklist was used to provide assurance to Steering Groups and Audit Committee. Internal Audit were represented on the Due Diligence Assurance panel. The outcome of the work of the panel was presented to the Audit Committee in March 2022. The Audit Committee with representation from the shadow ICB Audit and Risk Committee on 20th May 2022, reviewed the evidence presented as part of this process and the panel and were assured by the process undertaken. This was then reported to the Governing Body in June 2022.

Additional Support

Whilst the wider NHS approach followed by the CCG for transition is reasonable and sensible, the CCG recognised the softer aspects of risk or plans and drive for improvement may not be fully captured. We helped with a facilitated approach to capture some of the softer intelligence that may be outside of the wider process. We agreed to attend a scheduled meeting with each of the Executives and their ICB counterparts, capture actions and act as a critical friend. In the end a total of ten meetings were attended and the outcome will be reported to the ICB Audit and Risk Committee.

The assurance levels provided for all assurance reviews undertaken is summarised below:
Full Assurance: Financial Ledger
Significant Assurance: Financial Systems (Payroll, Debtors, Accounts Payable)
Moderate Assurance: None
Limited Assurance: None

Board Assurance Framework – Level A – with recommendations for improvement including to keep updated.

Conflicts of Interest Management

The effective management of conflicts of interests within an organisation plays a pivotal role in providing assurances over governance arrangements and in particular transparency with key decision making. The CCG has a Conflicts of Interest Policy in place and declarations made have been recorded and managed within the Governing Body and committee

meetings held. Registers of Interest as at June 2022 have been published on the CCG's website. As part of the 2021/22 Audit Plan Conflicts of Interest at the CCG was given Moderate Assurance and an action plan was agreed. The CCG have signed off all the recommendations made as complete.

Data, Security & Protection Toolkit

The CCG submitted a "Standards Met" Data Security Protection Toolkit for 2021/22 on the 25th March 2022 ahead of the June deadline with an Information Governance training compliance rate of 95% in November 2021. Cyber arrangements were also included in the due diligence checklist.

Financial Position

On 28th April 2022, the system plan was submitted including a CCG deficit plan for the period ending 30th June 2022. Significant risks to the financial position were noted. The CCG had systems in place to ensure these risks are monitored. The Plan was then updated in June 2022. Against a national target of break even the local healthcare system submitted a planned 22/23 deficit of £19m. The CCG/ICB element of that plan is an £11.7m deficit (full year), but the CCG/ICB is also currently holding the system additional efficiency target of £13.9m, taking the overall CCG/ICB planned deficit with this adjustment held for the system to a total planned surplus of £2.2m. Financial pressures remain.

Following up of actions arising from our work

An important aspect of the internal audit process is follow up to ensure that agreed management actions are delivered. During the period to the 30th June 2022, we have asked management to report upon the completion of agreed actions. We can conclude that the organisation has made good progress with regards to implementation of agreed actions. We will continue to track and report upon outstanding actions. The Audit Committee took a robust stance and has also requested detailed updates. We noted improvements in our follow up of last year's Safeguarding Internal Audit Reviews (Adult and Children's). There is however one recommendation that related to the development of a Primary Care Estates Strategy that has been deferred and outstanding for some time. Challenging areas also remain in the system despite previous actions taken: for example, in relation to system affordability and quality.

Reliance on third party assurances

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

There are a number of significant and persistent quality challenges within the system. These challenges have included, amongst others, Urgent and Emergency Care performance, RTT, Cancer waiting times and lack of staff in key areas at the main provider. In November 2021 the CQC published their latest report on Shrewsbury and Telford Hospital NHS Trust (SaTH). Their " inadequate rating" was assessed as remaining in place. The Final Ockenden

Report (Independent Review of Maternity Services at SaTH) has been issued which highlighted serious and persistent failings with maternity services with tragic impacts on patient care and outcomes. The report stated that “Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures this message was lost in a wider healthcare system which was struggling with other significant concerns”. The report includes Immediate and Essential Actions. The CCG has established a quality governance structure together with SaTH for the monitoring of Ockenden actions. The handover of this oversight and in particular staffing – continuity of carer and organisational culture were highlighted in the transition arrangements to the ICB. We also note that operationally the system is also struggling to cope with demand peaks.

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

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed. I have been advised on the implications of the result of this review by:

- the Governing Body
- the Audit Committee
- the Finance Committee
- the Quality and Performance Committee
- internal audit
- other explicit reviews/assurance mechanisms.

The Head of Internal Audit Opinion contained within this report sets out an overview of the control issues we have faced which are also set against a number of external, ongoing challenges within the environment in which we commission services.

However, during the first quarter of 2022/23, progress has continued to be made in addressing these challenges. This Annual Report highlights many of the CCG’s achievements during this period and the Internal Audit opinion reflects the efforts by CCG staff to make the required improvements. Despite this progress, significant issues still remain, and the CCG has made preparations to handover the leadership on these issues and ensure a robust transition of the CCG’s internal system of control to the new Integrated Care Board (ICB) on 1st July 2022/23.

Conclusion

In conclusion, my review of the effectiveness of governance, risk management and internal control and the Head of Internal Audit Opinion have confirmed that the CCG maintained a generally sound system of internal control designed to meet the organisation's objectives, and controls were generally being applied consistently. Accepting the control issues identified above, and the actions that were taken to address these and the results of the internal audit reviews undertaken during the first quarter of 2022/23, I am confident that the organisation has had appropriate mechanisms in place to deliver good governance.

Simon Whitehouse
Accountable Officer
NHS Shropshire, Telford and Wrekin
29th June 2023

Remuneration Report

Remuneration Committee

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

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

Policy on the remuneration of senior managers

The remuneration of the Accountable Officer, executive directors and directors serving on our Governing Body is determined by the Governing Body on the recommendation of the Remuneration Committee, with reference to recognised national NHS pay scales and benchmarking with other CCGs. The Very Senior Manager (VSM) pay framework is used for the Accountable Officer and Executive Directors/Director.

The Remuneration Committee also recommends for determination by the Governing Body the remuneration of the GP practice members of our Governing Body. The rates payable are determined locally. Midlands and Lancashire Commissioning Support Unit (MLCSU) provide independent advice and support to the CCG and the Remuneration Committee in relation to employment and remuneration matters.

These tables are subject to audit by our external auditor.

A shadow ICB board had been in operation for the period 1 April 2022 to 30th June 2022. No remuneration or pension details have been disclosed in respect of these members since they have no voting rights or decision making powers.

Salary and pension benefits

Salary and pension benefits three months to 30th June 2022 – NHS Shropshire, Telford and Wrekin CCG - AUDITED

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Ahmed *	Astakhar	Associate Lay Member, Patient & Public Involvment for Equality, Diversity & Inclusion	01/04/22 to 30/06/22	0-5	-	-	-	-	0-5
Allen *	Martin	Secondary Care Clinician	01/04/22 to 30/06/22	0-5	-	-	-	-	0-5
Braden *	Geoff	Lay member, Audit	01/04/22 to 30/06/22	0-5	-	-	-	-	0-5
Brandreth	Mark	Interim Accountable Officer	01/04/22 to 30/06/22	40-45	-	-	-	40-42.5	85-90
Bryceland *	Rachael	GP/Healthcare Professional	01/04/22 to 30/06/22	5-10	-	-	-	-	5-10
Garside	Julie	Director of Performance	01/04/22 to 30/06/22	25-30	-	-	-	2.5-5	30-35
Ilesanmi *	Mary	GP/Healthcare Professional	01/04/22 to 30/06/22	5-10	-	-	-	-	5-10
James *	Stephen	Chief Clinical Information Officer	01/04/22 to 30/06/22	10-15				-	10-15
McArthur *	Donna	Lay Member	01/04/22 to 30/06/22	0-5	-	-	-	-	0-5
Matthee *	Michael	GP/Healthcare Professional	01/04/22 to 30/06/22	5-10	-	-	-	-	5-10
Parker	Claire	Director of Partnerships	01/04/22 to 30/06/22	25-30	-	-	-	5-7.5	30-35
Pepper *	John	Chair and GP/Healthcare Professional	01/04/22 to 30/06/22	25-30	-	-	-	-	25-30
Pringle *	Adam	GP/Healthcare Professional	01/04/22 to 30/06/22	5-10	-	-	-	-	5-10
Shepherd	Deborah	Medical Director	01/04/22 to 30/06/22	20-25	-	-	-	-	20-25
Skidmore	Claire	Executive Director of Finance	01/04/22 to 30/06/22	35-40	-	-	-	32.5-35	70-75
Smith	Alison	Director of Corporate Affairs	01/04/22 to 30/06/22	25-30	-	-	-	427.5-430	450-455
Tilley	Samantha	Director of Planning	01/04/22 to 30/06/22	25-30	-	-	-	-	25-30
Vivian *	Meredith	Deputy Chair, Lay Member for Patient & Public Involvement	01/04/22 to 30/06/22	0-5	-	-	-	-	0-5
Warren *	Audrey	Independent Nurse	01/04/22 to 30/06/22	0-5	-	-	-	-	0-5
Young	Zena	Executive Director of Nursing & Quality	01/04/22 to 30/06/22	30-35	-	-	-	-	30-35

* Not in the NHS Pension scheme in this employment

** Not in the NHS Pension Scheme in this employment.*

Salary and pension benefits 2021/22 – NHS Shropshire, Telford and Wrekin CCG

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Ahmed *	Astakhar	Associate Lay Member, Patient & Public Involvment for Equality, Diversity & Inclusion	01/04/21 to 31/03/22	5-10	-	-	-	-	5-10
Allen *	Martin	Secondary Care Clinician	01/04/21 to 31/03/22	10-15	-	-	-	-	10-15
Braden *	Geoff	Lay member, Audit	01/04/21 to 31/03/22	15-20	-	-	-	-	15-20
Brandreth	Mark	Interim Accountable Officer	01/09/21 to 31/03/22	100-105	-	-	-	80-82.5	185-190
Bryceland *	Rachael	GP/Healthcare Professional	01/04/21 to 31/03/22	25-30	-	-	-	-	25-30
Clare	Laura	Interim Director of Finance	01/04/21 to 31/08/21	50-55	-	-	-	50-52.5	100-105
Garside (previously Davies) #	Julie	Director of Performance	01/04/21 to 31/03/22	110-115	-	-	-	30-32.5	140-145
Ilesanmi *	Mary	GP/Healthcare Professional	01/04/21 to 31/03/22	25-30	-	-	-	-	25-30
Matthee *	Michael	GP/Healthcare Professional	01/04/21 to 31/03/22	5-10	-	-	-	-	5-10
McArthur *	Donna	Lay member, Primary Care	01/04/21 to 31/03/22	25-30	-	-	-	-	25-30
Parker #	Claire	Director of Partnerships	01/04/21 to 31/03/22	110-115	-	-	-	30-32.5	140-145
Pepper *	John	Chair and GP/Healthcare Professional	01/04/21 to 31/03/22	100-105	-	-	-	-	100-105
Pringle *	Adam	GP/Healthcare Professional	01/04/21 to 31/03/22	25-30	-	-	-	-	25-30
Shepherd	Deborah	Medical Director	01/04/21 to 31/03/22	85-90	-	-	-	22.5-25	110-115
Skidmore	Claire	Interim Accountable Officer	01/04/21 to 31/08/21	45-50	-	-	-	30-32.5	75-80
Skidmore #	Claire	Executive Director of Finance	01/09/21 to 31/03/22	90-95	-	-	-	42.5-45	135-140
Smith	Alison	Director of Corporate Affairs	01/04/21 to 31/03/22	105-110	-	-	-	45-47.5	135-140
Smith *	Fiona	GP/Healthcare Professional	01/04/21 to 31/07/21	40-45	-	-	-	-	40-45
Tilley #	Samantha	Director of Planning	01/04/21 to 31/03/22	110-115	-	-	-	30-32.5	140-145
Trenchard	Stephen	Executive Director of Transformation	01/04/21 to 28/11/21	80-85	-	-	-	20-22.5	100-105
Vivian *	Meredith	Deputy Chair, Lay Member for Patient & Public Involvement	01/04/21 to 31/03/22	15-20	-	-	-	-	15-20
Warren *	Audrey	Independent Nurse	01/04/21 to 31/03/22	5-10	-	-	-	-	5-10
Young #	Zena	Executive Director of Nursing & Quality	01/04/21 to 31/03/22	120-125	-	-	-	20-22.5	145-150

* Not in the NHS Pension scheme in this employment

salary includes payment of untaken 2020/21 annual leave due to the COVID crisis

Pension benefits - AUDITED

Surname	Forename		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 30 June 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 30 June 2022 £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Brandreth	Mark	Interim Accountable Officer	0-2.5	0-2.5	70-75	145-150	1,201	53	1,297	0
Garside	Julie	Director of Performance	0-2.5	0	25-30	40-45	485	11	515	0
Parker	Claire	Director of Partnerships	0-2.5	0-2.5	30-35	45-50	528	17	565	0
Shepherd	Deborah	Medical Director	0	0-2.5	15-20	25-30	301	1	314	0
Skidmore	Claire	Chief Finance Officer	0-2.5	2.5-5	50-55	95-100	718	25	754	0
Smith	Alison	Director of Corporate Affairs	20-22.5	0	60-65	0-5	572	320	914	0
Tilley	Samantha	Director of Planning	0-2.5	0	35-40	65-70	577	9	607	0
Young	Zena	Executive Director of Nursing & Quality	0	87.5-90	35-40	250-255	1,219	-1,234	27	0

The benefits and related CETVs do not allow for a potential future adjustment for some eligible employees arising from the McCloud judgement.

Compensation on early retirement or for loss of office - Finance

Shropshire, Telford and Wrekin CCG does not have any to report during the three month period to 30th June 2022 (nil in 2021/22).

Expenditure on consultancy

The CCG spent £86,427 on consultancy services in the three months to 20th June 2022. The majority of this related to payments to a consultancy firm for continuing care and transforming care projects.

Payment to past members - AUDITED

Shropshire, Telford and Wrekin CCG does not have any to report during the three month period to 30th June 2022 (nil in 2021/22).

Pay ratio information

Percentage change in remuneration of highest paid director - AUDITED

2021/22	Salary and allowances	Performance pay and bonuses
Highest paid director: Percentage change compared to 2021/22	5.63%	N/A
All staff: Percentage change compared to 2021/22	6.29%	N/A

The increase in the highest paid director salary reflects the annual pay uplift.

The increase in all staff reflects the annual pay award and the recruitment to several higher banded posts which were previously vacant and covered by interim staff.

As at 30 June 2022, remuneration ranged from £12k to £185k (0% to 3% against 2021/22: £12k to £180k) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

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

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, CCGs must publish information on their highly paid and/or senior off-payroll engagements. The tables below show the existing arrangements as of 30 June 2022.

For all off-payroll engagements as of 30 June 2022, paying more than £245* per day, lasting longer than six months and are new

Number of existing engagements as of 30 June 2022	Number
Of which, number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

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

Shropshire, Telford and Wrekin CCG can confirm that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax.

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

Number of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	Number
Of which, number that have existed:	
Number not subject to off-payroll legislation(2)	0
Number subject to off-payroll legislation and determined as in-scope of IR35(2)	0
Number subject to off-payroll legislation and determined as out of scope of IR35(2)	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: Number of engagements that saw a change to IR35 status following review	0

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

Off-payroll engagements and senior official engagements

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

Number of off-payroll engagements	Number
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial period.(1)	0
Total no. of individuals on payroll and off-payroll that have been deemed 'Board members, and/or, senior officials with significant financial responsibility', during the financial period. This figure should include both on-payroll and off-payroll engagements.(2)	20

Staff costs

Remuneration of Shropshire, Telford and Wrekin CCG's staff – Audited

2021/22	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£23,949	£40,588	£59,041
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£23,949	£40,588	£59,041

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

The banded remuneration of the highest paid director/member in Shropshire, Telford and Wrekin CCG in the three month period to 30th June 2022 was £185k to £190k (+5.7% to + 5.6% against 2021/22: £175k to £180k) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio	75th percentile salary ratio
7.8	7.8	4.6	4.6	3.2	3.2

In the three month period to 30th June 2022, 0 (2021/22, 0) employees received remuneration in excess of the highest-paid director/member.

Staff Report

Exit packages and severance payments

Exit packages agreed in the three months to 30th June 2022 – Audited

Compulsory redundancies	Number	£
Less than £10,000	-	-
£10,001 to £25,000	-	-
£25,001 to £50,000	-	-
£50,001 to £100,000	-	-
£100,001 to £150,000	-	-
£150,001 to £200,000	-	-
Over £200,001	-	-
Total	**-**	**-**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook.

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

Staff costs

Employee benefits and staff numbers

Employee benefits 30th June 2022 – Audited

Employee benefits three months to 30th June 2022

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	2,174	620	**2,794**
Social security costs	254	-	**254**
Employer Contributions to NHS Pension scheme	417	-	**417**
Other pension costs	-	-	**-**
Apprenticeship Levy	8	-	**8**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	2,853	620	3,473
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	2,853	620	3,473
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	2,853	620	3,473

There are no Covid-19 related costs included in the above (2021-22: £122k)

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 2021/22 NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.4

Staff Analysis by Gender

	Headcount by Gender				% by Gender		
Staff Grouping	**Female**	**Male**	**Unknown***	**Totals**	**Female**	**Male**	**Unknown***
Governing Body	11	9	4	**24**	45.8%	37.5%	16.7%
Other Senior Management (Band 8C+)	20	10	0	**30**	66.7%	33.3%	0.0%
All Other Employees	177	40	0	**217**	81.6%	18.4%	0.0%
Grand Total	**208**	**59**	**4**	**271**	**76.75%**	**21.77%**	**1.48%**

*Unknown Gender pertains to Governing Body Members without an entry in the CCG Electronic Staff Record (ESR) system. This applies for all data sets hereafter.

Named Individuals categorised as Unknown are :-
Barry Parnaby
Lynn Cawley
Liz Noakes
Rachel Robinson

Senior Staff Analysis by Band

Pay Band	Headcount
Apprentice	0
Band 1	0
Band 2	1
Band 3	63
Band 4	33
Band 5	11
Band 6	31
Band 7	32
Band 8 - Range A	29
Band 8 - Range B	17
Band 8 - Range C	6
Band 8 - Range D	4
Band 9	2
Medical	20
VSM	18
Gov Body (off payroll)	4
Grand Total	**271**

Staff sickness absence

Staff sickness absence 2022	2022 Number
Total Days Lost	2174.10
Total Staff Years	219.57
Average Working Days Lost	9.90

The sickness absence data for the CCG in 2022 was whole time equivalent (WTE) days available of 49404.15 and WTE days lost to sickness absence of 2174.1 and average working days lost per employee was 9.9 which was managed through the absence management policy.

Staff Turnover

CCG Staff Turnover 2022-23	2022-23 Number
Average FTE Employed 2022-23	218.46
Total FTE Leavers 2022-23	19.76
Turnover Rate	9.04%

The CCG Staff Turnover Rate for 2022-23 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The CCG's Total FTE Leavers in year was 19.76. The CCG's Average FTE Staff in Post during the year was 218.46. The CCG Staff Turnover Rate for the year was 9.04%

Other employee matters

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

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

We were 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 and staff newsletters. We were part of our regional Joint Staff Consultative Committee, which provided a forum for trade union staff representatives to meet and contribute to service change and development and for issues to be discussed.

During the COVID-19 pandemic, where the majority of our staff were working from home, we ran weekly ‘huddle’ meetings via Microsoft Teams which we have continued to do post Covid. These were hosted by the Accountable Officer, directors and all staff to share information and receive updates on key areas of development with the pandemic and other priority areas. We also developed a Staff Health and Wellbeing Forum, where initiatives can be discussed and developed. This was supported by the CCG’s Health and Wellbeing Champion, who is one of the CCG’s lay members.

The CCG had a recruitment policy which was based on NHS best practice. We used the recruitment service of MLCSU to ensure that recruitment is carried out robustly and transparently in line with our policy and there is a clear audit trail of recruitment decisions

and employee checks. The CCG had a Training and Development Policy which sought to ensure that all staff have equal opportunity and access to training and development required by their role through identification with their managers in appraisals and regular one-to-one meetings.

Employees with a disability

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

The CCG's commitment to people with disabilities included:

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

Trade union facility time

For the period 1st April to 30th June 2022, we had no Trade Union officials within NHS Shropshire, Telford and Wrekin CCG.

Relevant union officials

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

Percentage of time spent on facility time

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

Percentage of pay bill spent on facility time

Percentage of pay bill spent on facility time	Figures
Provide the total cost of facility time	0
Provide the total pay bill	0
Provide the percentage of the total pay bill spent on facility time, calculated as:	0

(total cost of facility time ÷ total pay bill) x 100

Paid trade union activities

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

Health and safety

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

During the period 1st April – 30th June 2022, due to the lasting effects of the COVID-19 pandemic, the majority of CCG staff continued to work from home, but with a small number of staff having to work in the office environment due to the nature of their roles. In order to ensure that staff safety was paramount during the pandemic we assessed the risk to all staff having to work from the office and put mask wearing protocols and social distancing and cleaning processes in place to allow them to do so safely. Some staff were identified as having a greater risk and were either redeployed or provided with equipment to allow them to work from home.

We also developed a home workstation assessment checklist for all staff working from home to ensure they are working in an environment that supports their health and wellbeing.

There was one health and safety incident reported in the year, which was did not result in injury, but which is reportable as a RIDDOR incident which has been actioned by the CCG.

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, there is no relevant audit information of which the CCG's external auditor is unaware
- the member has taken all steps required as a member in order to make them aware of any relevant audit information and to ensure the CCG's auditor is aware of the information.

Parliamentary Accountability Report

The CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts and fees and charges are included as notes in the Financial Statements of this Annual Report at note 15 and note 23.

An audit certificate and report is also included in this Annual Report at page 173.

Annual Accounts

Please find a full version of our annual accounts appended following this page.

Simon Whitehouse
Accountable Officer
29th June 2023

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the period ended 30th June 2022	2
Statement of Financial Position as at 30th June 2022	3
Statement of Changes in Taxpayers' Equity for the period ended 30th June 2022	4
Statement of Cash Flows for the period ended 30th June 2022	5

Notes to the Accounts

Accounting policies	6-11
Other operating revenue	12
Contract Revenue	12
Employee benefits and staff numbers	13-15
Operating expenses	16
Better payment practice code	17
Finance costs	18
Net gain/(loss) on transfer by absorption	18
Property, plant and equipment	19
Right of Use Assets and Leases	20-21
Trade and other receivables	22
Cash and cash equivalents	23
Trade and other payables	24
Provisions	25
Contingencies	26
Financial instruments	27
Operating segments	27
Joint arrangements - interests in joint operations	28
Related party transactions	29
Events after the end of the reporting period	30
Financial performance targets	30
Analysis of charitable reserves	30
Losses and special payments	30

Statement of Comprehensive Net Expenditure for the three month period ended 30 Jun 2022

	Note	Three month period ended 30 June 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	(0)	(0)
Other operating income	2	(255)	(1,014)
Total operating income		**(256)**	**(1,015)**
Staff costs	4	3,473	12,810
Purchase of goods and services	5	241,809	973,194
Depreciation and impairment charges	5	65	-
Provision expense	5	(36)	426
Other Operating Expenditure	5	112	381
Total operating expenditure		**245,424**	**986,810**
Net Operating Expenditure		**245,168**	**985,796**
Finance income		-	-
Finance expense	7	2	-
Net expenditure for the Period		**245,171**	**985,796**
Net (Gain)/Loss on Transfer by Absorption	8	-	72,994
Total Net Expenditure for the Financial Period		**245,171**	**1,058,790**
Total other comprehensive net expenditure		**-**	**-**
Comprehensive Expenditure for the period		**245,171**	**1,058,790**

Statement of Financial Position as at
30 June 2022

	Note	30 June 2022 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment	9	-	-
Right-of-use assets	10	1,044	-
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		1,044	-
Current assets:			
Inventories		-	-
Trade and other receivables	11	2,910	3,618
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	12	104	375
Total current assets		**3,014**	3,993
Non-current assets held for sale		-	-
Total current assets		**3,014**	3,993
Total assets		**4,059**	3,993
Current liabilities			
Trade and other payables	13	(61,172)	(64,902)
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	10.2	(1,046)	-
Borrowings		-	-
Provisions	14	(2,219)	(2,406)
Total current liabilities		**(64,437)**	(67,309)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(60,378)**	(63,316)
Total non-current liabilities		-	-
Assets less Liabilities		**(60,378)**	(63,316)
Financed by Taxpayers' Equity			
General fund		(60,378)	(63,316)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(60,378)**	(63,316)

The notes on pages 6 to 30 form part of this statement

The financial statements on pages 2 to 30 were approved by the Governing Body on 28th June 2023 and signed on its behalf by:

Simon Whitehouse
Accountable Officer

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for the Three month period ended 30 June 2022				
Balance at 01 April 2022	(63,316)	0	0	**(63,316)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for the Three month period ended 30 June 2022				
Net operating expenditure for the financial period	(245,171)			**(245,171)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Period	**(245,171)**	**0**	**0**	**(245,171)**
Net funding	248,108	0	0	**248,108**
Balance at 30 June 2022	**(60,378)**	**0**	**0**	**(60,378)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(72,994)	0	0	**(72,994)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating costs for the financial period	(985,796)			(985,796)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Period	**(985,796)**	**0**	**0**	**(985,796)**
Net funding	995,474	0	0	995,474
Balance at 31 March 2022	**(63,316)**	**0**	**0**	**(63,316)**

The notes on pages 6 to 30 form part of this statement

Statement of Cash Flows for the three month period ended 30 June 2022

	Note	**Three month period ended 30 June 2022 £'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(245,171)	(985,796)
Depreciation and amortisation	5	65	0
Interest paid		2	0
(Increase)/decrease in trade & other receivables	11	708	2,140
Increase/(decrease) in trade & other payables	13	(3,731)	(11,372)
Provisions utilised	14	(152)	(699)
Increase/(decrease) in provisions	5	(36)	426
Net Cash Inflow (Outflow) from Operating Activities		**(248,313)**	(995,300)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		248,108	995,474
Repayment of lease liabilities		(66)	0
Net Cash Inflow (Outflow) from Financing Activities		**248,042**	995,474
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(271)**	174
Cash & Cash Equivalents at the Beginning of the Financial Period		**375**	201
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**104**	375

The notes on pages 6 to 30 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury.
Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2022-23, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.
Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

The accounts are prepared for a three month period to 30th June 2022 due to the cessation of the CCG. Prior year comparatives for 21/22 are for a 12 month period.

1.1 **Going Concern**

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

The CCG ended the three month period to 30th June 2022 in a breakeven position and a cumulative deficit position of £134m. The Shropshire, Telford and Wrekin System reported a £10.1m deficit in the three month period to 30th June 2022.

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

This change required the CCG to review whether this creates material uncertainty regarding its going concern status.

At the time, it was judged that the going concern status of the organisation remains unchanged on the following basis:

•The formation of the new organisation (ICB), has been approved by NHS England (NHSE) and the services provided by the CCG transfer entirely to the new organisation together with its assets and liabilities;
•The CCG has taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt are not materially impacted. These steps include securing remote access to financial systems for all finance staff and budget holders, and working with our third party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the low value of the CCG's aged debt and its continued high achievement against the Better Payment Practice Code.
•There is a presumption that CCGs are deemed to be a going concern because there is a statutory requirement to perform the commissioning function by a public body – and this determines the requirement to apply the going concern principle – not whether the specific CCG will be doing the function in future.

Although the financial position of the CCG and the issue of a Section 30 report by the Secretary of State for Health indicates some uncertainty over the CCG's ability to continue as a going concern, the Governing Body, having made appropriate enquiries, have reasonable expectations that the CCG will have adequate resources to continue in operational existence for the foreseeable future both as a CCG and as its successor organisation, the ICB .

Further, the CCG submitted its 2022/23 financial plan covering the 3 months that the CCG was still in operation and the 9 month period for the ICB. This plan is based on the allocations notified by NHSE for the full financial year of 2022/23. The ICB has also submitted its draft plan for 2023/24 based on the allocations notified by NHSE for the full financial year 2023/24.

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

1.2 **Accounting Convention**

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

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

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

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

1.4 **Pooled Budgets**

The clinical commissioning group has entered into a pooled budget arrangement with Telford and Wrekin Local Authority [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for Better Care Fund (BCF), and the Transforming Care Programme (TCP). The TCP pool is hosted by the Local Authority and the BCF pool is jointly hosted.

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

The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of these pooled budgets, identified in accordance with the pooled budget agreements. Note 18 to the accounts provides details of the income and expenditure for these arrangements.

1.5 **Operating Segments**

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

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

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

Payment terms are standard reflecting cross government principles.

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

Notes to the financial statements

1.7.2 **Retirement Benefit Costs**

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

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

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

1.8 **Other Expenses**

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

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

1.9.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each period end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

Notes to the financial statements

1.10. **Leases**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 Leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the Standard have been employed. These are as follows;

The CCG has applied the practical expedient offered in the Standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 Leases and IFRIC 4 Determining whether an Arrangement contains a Lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application the CCG has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the Standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10(c) of IFRS 16.

Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.

There are further expedients or election that have been employed by the CCG in applying IFRS 16. These include;

The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.

The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

The CCG will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.14 instead.HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The CCG is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the CCG has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

The CCG is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value.

These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.10.1 **The Clinical Commissioning Group as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Notes to the financial statements

1.10.1 **The Clinical Commissioning Group as Lessee cont'd**
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

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

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

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

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 3.51% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 3.0% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

A restructuring provision is recognised when the 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 and the CCG has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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

1.16.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 **Financial assets at fair value through other comprehensive income**
Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

The CCG did not hold any such assets as at 30th June 2022.

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

The CCG did not hold any such assets as at 30th June 2022.

Notes to the financial statements

1.16.4 **Impairment**

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

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 **Financial Liabilities**

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

1.17.1 **Financial Guarantee Contract Liabilities**

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

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

The CCG did not take financial guarantee contracts in the period to 30th June 2022.

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

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

The CCG did not hold any financial liabilities at fair value through profit and loss during the period to 30th June 2022.

1.17.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 **Value Added Tax**

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

1.19 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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 the 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.

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.

Accruals - Prescribing: The CCG recognises the cost of drug prescribing based on data received from the NHS Business Services Authority (NHSBSA). Reports are received on a monthly basis, but reflect charges up to the end of February only. June costs are estimated using historical levels of expenditure. The NHSBSA uses a methodology for forecasting prescribing expenditure that is based on national averages and does not necessarily reflect local issues. Therefore consideration is given to the use of local knowledge to determine the appropriate level of expenditure to be included in the accounts. This review is undertaken and full disclosure of any proposed adjustments shared with the auditors.

1.21 **Gifts**

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

Notes to the financial statements

1.22 **Adoption of new standards**

On 1 April 2022, the clinical commissioning group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the CCG will recognise a right-of-use asset representing the CCG's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the CCG will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The CCG has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the CCG recognised £1.1m of right-of-use assets and lease liabilities of £1.1m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was a nil impact to tax payers' equity.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

The following table reconciles the CCG's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	(789)
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	7
Operating lease commitments discounted used weighted average IBR	(782)
Add: Finance lease liabilities at 31 March 2022	0
Add: Peppercorn leases revalued to existing value in use	0
Add: Residual value guarantees	0
Add: Rentals associated with extension options reasonably certain to be exercised	0
Less: Short term leases (including those with <12 months at application date)	(328)
Less: Low value leases	0
Less: Variable payments not included in the valuation of the lease liabilities	0
Lease liability at 1 April 2022	**(1,110)**

1.23 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted. The impact on the CCG has not yet been assessed.

2 Other Operating Revenue

	Three month period ended 30 June 2022 Admin	Three month period ended 30 June 2022 Programme	Three month period ended 30 June 2022 Total	2021-22 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Education, training and research	-	-	**-**	-
Non-patient care services to other bodies	-	-	**-**	-
Patient transport services	-	-	**-**	-
Prescription fees and charges	-	-	**-**	-
Dental fees and charges	-	-	**-**	-
Income generation	-	-	**-**	-
Other Contract income	-	0	**0**	0
Recoveries in respect of employee benefits	-	-	**-**	-
Total Income from sale of goods and services	**-**	**0**	**0**	**0**
Other operating income				
Rental revenue from finance leases	-	-	**-**	-
Rental revenue from operating leases	-	-	**-**	-
Charitable and other contributions to revenue expenditure: NHS	-	-	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-	**-**	-
Receipt of donations (capital/cash)	-	-	**-**	-
Receipt of Government grants for capital acquisitions	-	-	**-**	-
Continuing Health Care risk pool contributions	-	-	**-**	-
Non cash apprenticeship training grants revenue	-	-	**-**	-
Other non contract revenue	-	255	**255**	1,014
Total Other operating income	**-**	**255**	**255**	**1,014**
Total Operating Income	**-**	**256**	**256**	**1,015**

3 Contract Revenue

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

The CCG did not receive any income in the period to 30th June 2022 from the sale of goods and services (contracts).

3.2 Transaction price to remaining contract performance obligations

The CCG did not have any contract revenue in the period to 30th June 2022 expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	Total Permanent Employees £'000	Other £'000	Three month period ended 30 June 2022 Total £'000
Employee Benefits			
Salaries and wages	**2,174**	**620**	**2,794**
Social security costs	**254**	**-**	**254**
Employer Contributions to NHS Pension scheme	**417**	**-**	**417**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**8**	**-**	**8**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	**2,853**	**620**	**3,473**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**2,853**	**620**	**3,473**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**2,853**	**620**	**3,473**

	Total Permanent Employees £'000	Other £'000	2021-22 Total £'000
Employee Benefits			
Salaries and wages	9,099	1,174	10,273
Social security costs	920	-	920
Employer Contributions to NHS Pension scheme	1,582	-	1,582
Other pension costs	-	-	-
Apprenticeship Levy	34	-	34
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	11,635	1,174	12,810
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	11,635	1,174	12,810
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	11,635	1,174	12,810

There are no Covid-19 related costs included in the above (2021-22: £122k)

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 2021/22 NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.4

4.1.2 Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in the period to 30th June 2022.

4.2 Average number of people employed

	Three month period ended 30 June 2022			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**218.46**	**28.63**	**247.09**	**213.73**	**44.47**	**258.20**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial period

	Three month period ended 30 June 2022 Compulsory redundancies		Three month period ended 30 June 2022 Other agreed departures		Three month period ended 30 June 2022 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	4,495	-	-	1	4,495
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	72,622	-	-	1	72,622
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**77,117**	**-**	**-**	**2**	**77,117**

	Three month period ended 30 June 2022 Departures where special payments have been made		2021-22 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	Three month period ended 30 June 2022 Other agreed departures		2021-22 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**-**	**-**

These tables report the number and value of exit packages agreed in the financial period. The expense associated with these departures may have been recognised in part or in full in a previous period.
Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms & Conditions of Service Handbook.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the period of departure.
Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

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

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating expenses

	Three month period ended 30 June 2022 Admin £'000	Three month period ended 30 June 2022 Programme £'000	Three month period ended 30 June 2022 Total £'000	2021-22 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	581	1,040	1,621	6,782
Services from foundation trusts	-	36,853	36,853	152,028
Services from other NHS trusts	-	120,108	120,108	482,301
Provider Sustainability Fund	-	-	-	-
Services from Other WGA bodies	-	-	-	-
Purchase of healthcare from non-NHS bodies	-	35,268	35,268	144,817
Purchase of social care	-	-	-	-
General Dental services and personal dental services	-	-	-	-
Prescribing costs	-	21,145	21,145	83,553
Pharmaceutical services	-	-	-	-
General Ophthalmic services	-	177	177	496
GPMS/APMS and PCTMS	-	22,835	22,835	84,353
Supplies and services – clinical	-	409	409	2,462
Supplies and services – general	16	2,439	2,455	10,338
Consultancy services	6	80	86	989
Establishment	(218)	429	211	1,944
Transport	1	80	81	182
Premises	64	132	196	1,043
Audit fees	100	-	100	126
Other non statutory audit expenditure				
· Internal audit services	-	-	-	-
· Other services	-	6	6	8
Other professional fees	12	294	306	1,501
Legal fees	7	1	8	136
Education, training and conferences	3	(58)	(55)	134
Funding to group bodies	-	-	-	-
CHC Risk Pool contributions	-	-	-	-
Non cash apprenticeship training grants	-	-	-	-
Total Purchase of goods and services	**573**	**241,236**	**241,809**	**973,194**
Depreciation and impairment charges				
Depreciation	33	32	65	-
Amortisation	-	-	-	-
Impairments and reversals of property, plant and equipment	-	-	-	-
Impairments and reversals of right-of-use assets			-	-
Impairments and reversals of intangible assets	-	-	-	-
Impairments and reversals of financial assets	-	-	-	-
· Assets carried at amortised cost	-	-	-	-
· Assets carried at cost	-	-	-	-
· Available for sale financial assets	-	-	-	-
Impairments and reversals of non-current assets held for sale	-	-	-	-
Impairments and reversals of investment properties	-	-	-	-
Total Depreciation and impairment charges	**33**	**32**	**65**	**-**
Provision expense				
Change in discount rate	-	-	-	-
Provisions	-	-	(36)	426
Total Provision expense	**-**	**-**	**(36)**	**426**
Other Operating Expenditure				
Chair and Non Executive Members	110	-	110	350
Grants to Other bodies	-	8	8	32
Clinical negligence	-	-	-	-
Research and development (excluding staff costs)	-	-	-	-
Expected credit loss on receivables	-	(6)	(6)	(2)
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-	-	-
Inventories written down	-	-	-	-
Inventories consumed	-	-	-	-
Other expenditure	-	-	-	1
Total Other Operating Expenditure	**110**	**2**	**112**	**381**
Total operating expenditure	**716**	**241,270**	**241,950**	**974,001**

The above includes expenditure dealt with under pooled budget arrangements as set out in Note 18.

COVID-19 costs included in the above figures total £1,126k (2021-22: £12,335k). The majority of these costs fall under Services from other NHS Trusts and Purchase of Healthcare from non-NHS bodies. COVID-19 pay costs are shown in Note 4.1.

External Audit Fees are inclusive of VAT and include the following:
Statutory audit fees for the period to 30th June 2022 is £100k (2021-22: £101k, plus £25k for prior year CCG fees)

The auditor's liability for external audit work carried out for the period to 30th June 2022 is limited to £1million (2021/22: £1 million).

The full year fee paid to external auditors disclosed within Other Services (review of MHIS compliance statement) was £20k plus VAT.

Internal audit and counter fraud services are provided by CW Audit who are part of a Foundation Trust. The cost of these services was £10k in the period to 30th June 2022 (2021/22: £40k), and is included within other professional fees.

6.1 Better Payment Practice Code

Measure of compliance	Three month period ended 30 June 2022 Number	Three month period ended 30 June 2022 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Period	13,704	71,846	43,288	266,235
Total Non-NHS Trade Invoices paid within target	13,607	70,159	42,886	262,527
Percentage of Non-NHS Trade invoices paid within target	**99.29%**	**97.65%**	**99.07%**	**98.61%**
NHS Payables				
Total NHS Trade Invoices Paid in the Period	175	155,284	549	650,339
Total NHS Trade Invoices Paid within target	170	155,193	539	649,408
Percentage of NHS Trade Invoices paid within target	**97.14%**	**99.94%**	**98.18%**	**99.86%**

The Better Payment Practice Code requires the clinical commissioning group to pay valid invoices by their due date or within 30 days of receipt of the invoices, whichever is the later.

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

7. Finance costs

	Three month period ended 30 June 2022 £'000	2021-22 £'000
Interest		
Interest on loans and overdrafts	-	-
Interest on lease liabilities	2	-
Interest on late payment of commercial debt	-	-
Other interest expense	-	-
Total interest	**2**	**-**
Other finance costs	-	-
Provisions: unwinding of discount	-	-
Total finance costs	**2**	**-**

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

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

	Three month period ended 30 June 2022 £'000	2021-22 £'000
Transfer of property plant and equipment	-	-
Transfer of intangibles	-	-
Transfer of cash and cash equivalents	-	201
Transfer of receivables	-	5,758
Transfer of payables	-	(76,274)
Transfer of provisions	-	(2,679)
Net loss on transfers by absorption	**-**	**(72,994)**

9 Property, plant and equipment

30 June 2022	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-	-	-	0	-	361	39	400
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	(166)	-	(166)
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 30 June 2022	**-**	**-**	**-**	**-**	**0**	**-**	**195**	**39**	**234**
Depreciation 01 April 2022	-	-	-	-	0	-	361	39	400
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	(166)	-	(166)
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the period	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 30 June 2022	**-**	**-**	**-**	**-**	**0**	**-**	**195**	**39**	**234**
Net Book Value at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Purchased	-	-	-	-	-	-	(0)	-	(0)
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**
Asset financing:									
Owned	-	-	-	-	-	-	(0)	-	(0)
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2022	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

10.1 Right-of-use assets

30 June 2022	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-	-	-	-	-	-	-	-
IFRS 16 Transition Adjustment	-	1,110	-	-	-	-	-	-	1,110
Addition of assets under construction and payments on account	-	-	-	-	-	-	-	-	-
Additions	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Lease remeasurement	-	-	-	-	-	-	-	-	-
Modifications	-	-	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-
Derecognition for early terminations	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-
Cost/Valuation at 30 June 2022	**-**	**1,110**	**-**	**-**	**-**	**-**	**-**	**-**	**1,110**
Depreciation 01 April 2022	-	-	-	-	-	-	-	-	-
Charged during the period	-	65	-	-	-	-	-	-	65
Reclassifications	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-
Derecognition for early terminations	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body									
Depreciation at 30 June 2022	**-**	**65**	**-**	**-**	**-**	**-**	**-**	**-**	**65**
Net Book Value at 30 June 2022	**-**	**1,044**	**-**	**-**	**-**	**-**	**-**	**-**	**1,044**

Revaluation Reserve Balance for right-of-use assets

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2022	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

10. Leases cont'd

10.2 Lease liabilities

	30 June 2022	2021-22
	£'000	£'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	1,110	-
Addition of Assets under Construction & Payments on Account	-	-
Additions purchased	-	-
Reclassifications	-	-
Interest expense relating to lease liabilities	2	-
Repayment of lease liabilities (including interest)	(66)	-
Lease remeasurement	-	-
Modifications	-	-
Disposals on expiry of lease term	-	-
Derecognition for early terminations	-	-
Transfer (to) from other public sector body	-	-
Other	-	-
Lease liabilities at 30 June 2022	**1,046**	-

10.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	30 June 2022	2021-22
	£'000	£'000
Within one year	(266)	-
Between one and five years	(798)	-
After five years	-	-
Balance at 30 June 2022	**(1,064)**	**-**
Effect of discounting	18	-
Included in:		
Current lease liabilities	(1,046)	-
Non-current lease liabilities	-	-
Balance at 30 June 2022	**(1,046)**	**-**

10.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	Three month period ended 30 June 2022	2021-22
	£'000	£'000
Depreciation expense on right-of-use assets	65	-
Interest expense on lease liabilities	2	-

10.5 Amounts recognised in Statement of Cash Flows

	Three month period ended 30 June 2022	2021-22
	£'000	£'000
Total cash outflow on leases under IFRS 16	(66)	-
Total cash outflow for lease payments not included within the measurement of lease liabilities	-	-
Total cash inflows from sale and leaseback transactions	-	-

11 Trade and other receivables	**Current 30 June 2022 £'000**	**Non-current 30 June 2022 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS receivables: Revenue	78	-	608	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	4	-	-	-
NHS accrued income	1,791	-	600	-
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	362	-	1,496	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	126	-	485	-
Non-NHS and Other WGA accrued income	279	-	142	-
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	(21)	-	(23)	-
VAT	282	-	295	-
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	8	-	16	-
Total Trade & other receivables	**2,910**	**-**	**3,618**	**-**
Total current and non current	**2,910**		**3,618**	
Included above:				
Prepaid pensions contributions	-		-	

11.1 Receivables past their due date but not impaired

	30 June 2022 DHSC Group Bodies £'000	**30 June 2022 Non DHSC Group Bodies £'000**	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	(11)	212	318	9
By three to six months	6	-	-	-
By more than six months	-	9	-	1
Total	**(5)**	**221**	**318**	**9**

11.2 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies**	**Other financial assets**	**Total**
	£'000	**£'000**	**£'000**
Balance at 01 April 2022	(23)	-	**(23)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	2	-	**2**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	-	-	**-**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	-	-	**-**
Total	**(21)**	**-**	**(21)**

12 Cash and cash equivalents

	30 June 2022	2021-22
	£'000	£'000
Balance at 01 April 2022	375	201
Net change in period	(271)	174
Balance at 30 June 2022	**104**	**375**
Made up of:		
Cash with the Government Banking Service	104	375
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**104**	**375**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2022	**104**	**375**
Patients' money held by the clinical commissioning group, not included above	-	-

The CCG does not hold any significant cash and cash equivalent balances that are not available for use by the organisation.

13 Trade and other payables	**Current 30 June 2022 £'000**	**Non-current 30 June 2022 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	2,046	-	2,084	-
NHS payables: Capital	-	-	-	-
NHS accruals	6,643	-	1,881	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	14,469	-	13,644	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	28,842	-	17,228	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	159	-	146	-
VAT	-	-	-	-
Tax	125	-	124	-
Payments received on account	-	-	-	-
Other payables and accruals	8,887	-	29,795	-
Total Trade & Other Payables	**61,172**	**-**	**64,902**	**-**
Total current and non-current	**61,172**		**64,902**	

Other payables include £902k outstanding pension contributions at 30 June 2022

14 Provisions

	Current 30 June 2022 £'000	**Non-current 30 June 2022 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	0	-	0	-
Redundancy	359	-	407	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	349	-	352	-
Continuing care	1,511	-	1,648	-
Other	0	-	0	-
Total	**2,219**	**-**	**2,406**	**-**
Total current and non-current	**2,219**		**2,406**	

	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 2022	**-**	**-**	**0**	**407**	**-**	**-**	**352**	**1,648**	**0**	**2,406**
Arising during the period	-	-	-	39	-	-	68	-	-	**107**
Utilised during the period	-	-	-	-	-	-	(70)	(82)	-	**(152)**
Reversed unused	-	-	-	(87)	-	-	-	(55)	-	**(142)**
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 30 June 2022	**-**	**-**	**0**	**359**	**-**	**-**	**349**	**1,511**	**0**	**2,219**
Expected timing of cash flows:										
Within one year	-	-	0	359	-	-	349	1,511	0	**2,219**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 30 June 2022	**-**	**-**	**0**	**359**	**-**	**-**	**349**	**1,511**	**0**	**2,219**

The redundancy provision reflects the potential impact on senior roles within the CCG as the senior team is restructured in preparation for the CCG's planned transition into an Integrated Care Board on the 1st July 2022. This transition is subject to passage through Parliament but it is expected that this restructuring process will be concluded early in the new financial year.

The legal claims provision relates to ongoing legal cases outstanding at 30th June 2022, with the estimated costs to conclusion provided by the CCG's legal advisors. The CCG has no claims currently lodged with NHS Resolution.

A continuing care provision has been created which reflects the estimated cost of continuing care appeals currently awaiting processing. The provision is based on the number of appeals outstanding at the 30th June 2022 and these are expected to be processed within the new financial year.

15 Contingencies

The CCG has no contingent assets or liabilities to disclose.

16 Financial instruments

16.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because 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.

16.1.1 Currency risk

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

16.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

16.1.3 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 period are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 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.

16.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 30 June 2022 £'000	Equity Instruments designated at FVOCI 30 June 2022 £'000	Total 30 June 2022 £'000
Equity investment in group bodies	-	-	-
Equity investment in external bodies	-	-	-
Loans receivable with group bodies	-	-	-
Loans receivable with external bodies	-	-	-
Trade and other receivables with NHSE bodies	1,157	-	1,157
Trade and other receivables with other DHSC group bodies	992	-	992
Trade and other receivables with external bodies	370	-	370
Other financial assets	-	-	-
Cash and cash equivalents	104	-	104
Total at 30 June 2022	**2,623**	**-**	**2,623**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 30 June 2022 £'000	Other 30 June 2022 £'000	Total 30 June 2022 £'000
Loans with group bodies	-	-	**-**
Loans with external bodies	-	-	**-**
Trade and other payables with NHSE bodies	1,190	-	**1,190**
Trade and other payables with other DHSC group bodies	7,831	-	**7,831**
Trade and other payables with external bodies	52,912	-	**52,912**
Other financial liabilities	-	-	**-**
Private Finance Initiative and finance lease obligations	-	-	**-**
Total at 30 June 2022	**61,933**	**-**	**61,933**

17 Operating segments

As stated in IFRS8, the "Chief Operating Decision Maker" is responsible for allocating resources to and assessing the performance of the operating segments of an entity. At Shropshire, Telford and Wrekin clinical commissioning group this function is performed by the Governing Body. The clinical commissioning group considers it has a single operating segment; commissioning of healthcare services. Hence finance and performance information is reported to the Governing Body as one segment. These Statements are produced in accordance with this position.

The values relating to this operating segment can be found in the SoCNE (page 2), and SoFP (page 3), and are summarised in the table below:

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Shropshire, Telford & Wrekin CCG	245,359	(255)	245,104	4,059	(64,437)	(60,378)
Total	**245,359**	**(255)**	**245,104**	**4,059**	**(64,437)**	**(60,378)**

17.1 Reconciliation between Operating Segments and SoCNE

	Three month period ended 30 June 2022 £'000
Total net expenditure reported for operating segments	245,104
Reconciling items:	
Depreciation & Amortisation	65
Finance costs	2
Total net expenditure per the Statement of Comprehensive Net Expenditure	245,171

18 Joint arrangements - interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY Three month period ended 30 June 2022				Amounts recognised in Entities books ONLY 2021-22			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin CCG and Shropshire LA	Commissioning of health and social care services under better care fund	-	-	-	2,080	-	-	-	24,522
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin CCG and Telford & Wrekin LA	Better care fund promoting integrated working	-	-	-	2,064	-	-	-	14,315
Transforming care programme S75 arrangement	Shropshire, Telford & Wrekin CCG and Telford & Wrekin LA	The transforming care programme for people with learning disabilities	-	-	-	408	-	-	-	1,947

18.1 Pooled budgets under the Better Care Fund

The total value of these pooled budgets in 2021/22 was £69m, £39m of this being the CCG's contribution. The partners determine the nature of the programmes of work making up the Fund and in particular whether joint control is in operation for each programme for the purposes of IFRS 11.

A summary of the schemes with each local authority is given below:

Shropshire Local Authority	Three month period ended 30 June 2022 £'000	2021-22 £'000
Assistive Technologies	153	1,799
Care navigation/Co-ordination	163	1,927
Enablers for Integration	348	4,100
Healthcare Services to Care Homes	18	216
Integrated Care Planning	302	3,566
Intermediate Care Services	296	3,487
Personalised Healthcare at Home	30	348
L A Schemes	770	9,078
Total	**2,080**	**24,522**

Telford & Wrekin Local Authority	Three month period ended 30 June 2022 £'000	2021-22 £'000
Rehabilitation and Reablement	858	5,950
Assistive Technologies	99	683
Preventative Services	19	130
Carers	32	223
Management Charges	9	65
Shropshire Community Health Trust	566	3,925
Shrewsbury and Telford Hospital	274	1,899
Maintaining Eligibility	131	910
Care Act Implementation	76	530
Total	**2,064**	**14,315**

19 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Adam Pringle (GP/Healthcare Professional) - Sessional work for Shropshire Doctors Co Operative Ltd (Shropdoc)	280	0	0	0
Mark Brandreth - Robert Jones & Agnes Hunt Orthopaedic Hospital	11,319	0	0	0

The Department of Health and Social Care is regarded as a related party. During the period the clinical commissioning group has had material transactions with entities for which the Department is regarded as the parent Department. These include:

NHS Business Services Authority

NHS England

NHS Midlands & Lancashire CSU

NHS Property Services Limited

Midlands Partnership NHS Foundation Trust

Shrewsbury & Telford Hospitals NHS Trust

Shropshire Community Health NHS Trust

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

University Hospital of North Midlands NHS Trust

West Midlands Ambulance Service NHS Trust

In addition, the clinical commissioning group has had a number of transactions with other government departments and other central and local government bodies. The majority of these transactions have been with Shropshire Council, Telford & Wrekin Council and Welsh Government Bodies.

Payments were also made to GP practices in 2022/23 in respect of GMS/PMS/APMS and enhanced services. Some of the general practitioners within these practices are also members of the clinical commissioning group's governing body.

20 Events after the end of the reporting period

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

21 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:

	Three month period ended 30 June 2022 Target	**Three month period ended 30 June 2022 Performance**	2021-22 Target	2021-22 Performance
Expenditure not to exceed income	245,427	245,427	982,397	986,724
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	245,171	245,171	981,468	985,796
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	2,347	2,347	9,685	9,656

22 Analysis of charitable reserves

	Three month period ended 30 June 2022 £'000	2021-22 £'000
Unrestricted funds	-	-
Restricted funds	-	1
Endowment funds	-	-
Total	**-**	**1**

The clinical commissioning group no longer holds any charitable reserves.

23 Losses and special payments

The CCG did not incur any losses or special payments in the three month period to 30th June 2022.

Independent auditor's report to the members of the Governing Body of NHS Shropshire, Telford and Wrekin Integrated Care Board in respect of NHS Shropshire, Telford and Wrekin Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Shropshire, Telford and Wrekin CCG (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure for the 3 months ended 30 June 2022, the Statement of Financial Position as at 30 June 2022, the Statement of Changes in Taxpayers Equity for the 3 months ended 30 June 2022, the Statement of Cash Flows for the 3 months ended 30 June 2022 and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Shropshire, Telford and Wrekin CCG transferred to NHS Shropshire, Telford and Wrekin ICB on 1 July 2022. When NHS Shropshire, Telford and Wrekin CCG ceased to exist on 1 July 2022, its services continued to be provided by NHS Shropshire, Telford and Wrekin ICB.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.
-

Opinion on regularity of income and expenditure 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

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

In preparing the financial statements, the Accountable Officer is responsible for assessing the 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.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

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

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - journal entries that improved the CCG's financial performance for the year; and
  - the reasonableness of the assumptions used in determining accounting estimates for accruals within trade and other payables.
- Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- journal entry testing, with a focus on significant journals which impacted on the CCG's financial performance;
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals; and
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to expenditure accruals and the prescribing accrual.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

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 was responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources were operating effectively during the three month period ended 30 June 2022..

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of NHS Shropshire, Telford and Wrekin CCG 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 NHS Shropshire, Telford and Wrekin ICB, as a body, in respect of the CCG, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of NHS Shropshire, Telford and Wrekin ICB those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Shropshire, Telford and Wrekin ICB and the CCG and the members of the Governing Bodies of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Andrew Smith, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

29 June 2023