NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Annual Report and Accounts

2021-2022

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Performance overview

Statement from Mark Brandreth, Interim Accountable Officer

In April 2021, NHS Shropshire Clinical Commissioning Group (CCG) and NHS Telford and Wrekin CCG came together to become a single commissioning organisation. This transition created opportunities to work more efficiently and effectively to reduce health inequalities and to ensure we commission value for money healthcare services when and where they are needed.

I would wish to thank Claire Skidmore who was the Interim Accountable Officer from April 2021 until I joined in September 2021 and worked so hard to lead the CCG during this period.

From when I started in post, I can see how hard our staff have worked to make the CCG work, to face the challenges in the local health and care system, to deal with the pressures of COVID-19 and to prepare for the formation of the Integrated Care Board (ICB). I would want to put on record my thanks to them, the Governing Body and our wider partners for the incredible work over what has been a difficult period.

We have continued to try and be guided by our mission to ensure that everyone in Shropshire, Telford and Wrekin has the best possible health and healthcare through our planning, buying and monitoring of services. To do this, we have been led by 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.

Subject to Parliament, the CCG will be dissolved at the end of June 2022 and the new Integrated Care Board (ICB) will be formed. We are working with our health and care partners building on the relationships formed over recent years and particularly during the initial COVID-19 outbreak. This year, we have continued to work closely with our partners across the NHS, other healthcare providers, local authorities, voluntary and community sector organisations.

Our local vaccination teams, alongside colleagues from the local authorities, have worked to take the COVID-19 vaccines out to those populations in our county with lower uptakes. This has included organising three vaccination buses to visit town market days, match-day football stadiums and faith centres. The vaccination team worked with local autism and learning disability charity, Bethphage, to encourage vaccination and a project was also set up to ensure people experiencing homelessness could access the vaccine, with regular pop-up clinics being held at local homeless centres.

This year we have further cemented our relationship with the voluntary sector. They play a huge role in ensuring our residents across Shropshire, Telford and Wrekin are able to access the support that they need, whether it's supporting them through long-term illness or helping them stay well at home for longer. Importantly though, they do so much more than this in terms of connecting residents and providing support. We are very grateful for their hard work.

In October 2021, the CCG signed a Memorandum of Understanding along with representatives from the voluntary, community and social enterprise (VCSE) sector to kickstart the process of working closer together. We are now in the process of establishing a VCSE Alliance that will include strategic representation from the sector plugged into the governance of the new ICB and will provide crucial representation within decision-making forums.

There have been concerns expressed nationally and locally in the last year about patients not being able to access their local GP surgery in a timely way, particularly regarding accessing face-to-face appointments. General practice has seen a 10 per cent increase in demand for appointments, and measures to prevent infection and keep patients and staff safe has resulted in a challenging experience for some patients. Despite this, the majority of patients are seen face-to-face, and we have increased the number of appointments at evenings and weekends to ensure patients can be seen according to clinical need. The use of convenient telephone, online and video consultations has increased rapidly.

In line with the national profile our area has seen a 12 per cent drop in full time equivalent GPs since 2015. There is little doubt we would like to see more GPs in our county, and we hope that the national work to increase the number of GPs in training will eventually help.

The national review led by Donna Ockenden, which reviewed cases of serious and potentially serious concern at The Shrewsbury and Telford Hospital NHS Trust, was published in March 2022. The findings of the review and the horrific experiences of the families involved are shocking. The whole NHS must learn from this and make sure this never happens again. The CCG, and subsequently the ICB as the successor body to the CCG, will be working hard to take all actions necessary to ensure women who use local maternity services receive safe care.

As a CCG, we have worked to improve the way we hear the experiences of women and families using maternity services and have also invested in funding for The Shrewsbury and Telford Hospital NHS Trust to support increases in maternity staffing levels. We are also working with our partners across the health and care system to ensure that further improvements are made in light of the report.

There is little doubt that the last period has been extremely challenging for the NHS. However, the Integrated Care Board, which will succeed the CCG, has strong local partnerships in place and fantastic staff right across health and care system working hard for the local population. I would want to take the opportunity to thank them for all they do.

Mark Brandreth
Interim Accountable Officer
NHS Shropshire, Telford and Wrekin CCG
15 June 2022

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 2021/22.

About us

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group (CCG) is a statutory body established under the Health and Social Care Act 2012.

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 our business is Halesfield 6, Telford, TF7 4BF.

The CCG is a membership organisation. During 2021/22, there were 51 GP practices in Shropshire, Telford and Wrekin and all are member practices of the CCG. As local GPs, we have regular contact with patients and know what health services are needed to support our local population.

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

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

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

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

- most of our local acute services come from The Shrewsbury and Telford Hospital NHS Trust (SaTH)
- 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 work closely with other organisations to ensure local health services are joined up. This includes 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 discharge the responsibility for commissioning primary care services in our area, on behalf of NHS England.

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

A governance structure chart is included on page 116 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 have identified five key priorities to help us deliver our mission statement. These priorities will guide 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 serve a total population of around 487,000 people across Shropshire, Telford and Wrekin, who live in a large and diverse landscape of urban and rural areas.

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

Currently, we have around 88,000 people living with a long-term illness – that's 18 per cent of our population.

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

In Telford and Wrekin we have a large, younger urban population, with some rural areas. Many of the people we serve live in deprived areas, with more than a quarter (27 per cent) of the borough's population living in the 20 per cent most deprived areas nationally, an increase of 24 per cent 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 are a significant consideration for the CCG in planning healthcare services for Shropshire residents. It is anticipated that the needs of this group of older people will increase significantly, with the potential for a particular impact on secondary care services.

As a result, tackling health inequalities is 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 ICS 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 continue 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 are

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 2021/22.

COVID-19

2021/22 has continued to be a very challenging year for the NHS nationally and locally due to the continuing global COVID-19 pandemic and the mass vaccination programme, on which the CCG led with partners.

Locally, this has continued to solidify strong partnership working on a vast scale to ensure 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 have been working together to support those suffering from COVID-19, and also to prevent the spread of the virus by encouraging everyone eligible to be vaccinated. This meant ensuring local people were 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)

Our Chair, Dr John Pepper, and Interim Accountable Officer, Mark Brandreth, sit 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

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

- reduce health inequalities
- increase healthy life expectancy.

The current strategy is available on Shropshire Council's website. A new strategy from 2022 will shortly be presented to the Board for approval.

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

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

Our interaction with the Joint Health Overview and Scrutiny Committee has continued to be significant during 2021/22. A number of service redesign projects have been discussed at the committee, as well as updates on the progress of meeting the COVID-19 challenge.

NHS Midlands and Lancashire Commissioning Support Unit

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

2021/22 financial position

The Shropshire, Telford and Wrekin system is part of the Recovery Support Programme – Level 4 of the NHS England and NHS Improvement 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 NHS England and NHS Improvement as required whilst the system remains in the Recovery Support Programme.

Due to the continued COVID-19 pandemic, the financial framework in operation during 2021/22 has been very different to previous years. The normal financial regime (including planning and contracting rounds) was paused in March/April 2020, and a temporary financial framework was put in place.

Each system was given a funding envelope to operate within for 2021/22, split into two halves of the year: H1 and H2. This funding envelope was significantly above traditional fair shares allocations and included funding specifically for COVID-19 services and elective recovery.

In 2021/22, the CCG is reporting a £4.1 million deficit against the NHS England and NHS Improvement requirement of break-even. This contributes to the system-wide deficit in 2021/22 of £6.3 million deficit. NHS England and NHS Improvement are involved in regular

meetings across the system and have oversight of the development and progression of the system financial recovery plan. As a result of the deficit, the external auditors made a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014.

COVID-19 expenditure

The CCG spent £12.3 million on COVID-19-related costs in 2021/22.

The breakdown of this is as follows:

Category	Total (£)	Outcomes
Acute services		
Nursing home recovery beds	35,090	Specific isolated provision for COVID-19 patients following discharge from hospital
Mental health services		
Section 117	356,612	Discharge costs associated with COVID-19 patients
Non-contracted activity	18,592	Specific isolated provision for COVID-19 patients following discharge from hospital
Community health services		
Primary care services		
General practice – community-based services	1,079,236	Specific allocations to support primary care in managing COVID-19 patients
Long COVID	253,000	
Other	18,137	Medicines Management staff additional hours to assist in the vaccination programme
Patient transport	69,044	Additional costs relating to segregated journeys, social distancing etc
System Vaccination Operations Centre (SVOC)	267,010	Dedicated vaccination team
Telford International Centre	100,911	Short-term provision December 2021 to January 2022 to facilitate booster roll out
Running costs	1,063	CCG staff additional hours to assist in the vaccination programme
Continuing care services		
Local authority commissioned	6,219,216	Discharge costs associated with COVID-19 patients
CCG directly commissioned	3,917,510	Discharge costs associated with COVID-19 patients
Total	**12,335,420**	

The majority of the CCG's 'general' COVID-19 allocation for the first half of the year (H1) and second half of the year (H2) 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.

That which remained with the CCG was fully utilised – as broken down below.

Category	Total (£)
Primary care COVID-19 expansion	1,027,695
Long COVID	339,000
System Vaccination Operations Centre (SVOC)	250,000
Telford International Centre	101,000
Additional vaccination programme costs	141,000
Total	**1,858,695**

In addition, a specific Hospital Discharge Programme allocation of £8.668 million was received to cover the majority of the 'continuing care services'.

Community health services

This expenditure was funded through the system COVID-19 allocation and a separate, non-recurrent funding stream in 2021/22 to support the hospital discharge programme.

The CCG was able to utilise these COVID-19-specific funds to implement several interventions to ensure patient safety and appropriate care continued to be delivered during this period of escalation.

Examples include the redeployment of staff, delivery of specialist infection prevention control support and advice and specific Hot Clinics, a COVID-19 Management Service in primary care, and designated COVID-19 beds in our community. These arrangements enabled the CCG to meet the COVID-19 response requirements set out in NHSE guidance, and also its emergency preparedness, resilience and response obligations.

EU exit funding

The CCG received no funding in 2021/22 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 financial year with an in-year deficit of £4m and a cumulative deficit position of £134m. This is in the context of a temporary financial framework being in operation in 2020/21 and 2021/22 due to COVID-19. In 2021/22 each healthcare system was given a funding envelope to operate within with a clear expectation that organisations would manage within this funding and report a break even position across the system. The Shropshire, Telford and Wrekin system has reported a £6.5m deficit in 2021/22.

The Health and Care Act 2022 was granted royal assent on the 28 April 2022 and the intention is that a Statutory Instrument will be issued under this Act. The Act enables the establishment of Integrated Care Boards (ICBs), across England and abolishes clinical commissioning groups, (CCGs) with effect from 1 July 2022. ICBs will take on the commissioning functions of CCGs and all of the CCG's assets and liabilities will transfer to the ICB, (NHS Shropshire, Telford and Wrekin Integrated ICB).

These changes, together with the ongoing impact of the COVID-19 pandemic, has required the CCG to review whether this creates material uncertainty regarding its going concern status.

At this time, it is judged that the going concern status of the organisation remains unchanged on the following basis:

- The formation of the new organisation (ICB), has been approved by NHS England and the services currently provided by the CCG will transfer entirely to the new organisation together with its assets and liabilities
- Government support is available to the NHS for all COVID-19 related costs and the CCG is fully participating in all financial returns and reviews
- The CCG have taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt are not materially impacted. These steps include securing remote access to financial systems for all finance staff and budget holders, and working with our third party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the low value of the CCG's aged debt and its continued high achievement against the Better Payment Practice Code.

Although the financial position of the CCG and the issue of a Section 30 referral letter to the Secretary of State for Health in relation to the CCG for 2021/22 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 has submitted its 2022/23 financial plan covering the 3 months that the CCG will still be in operation and the 9 months once the ICB has been established. This plan is based on the allocations notified by NHSEI for the full financial year of 2022/23.

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

The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

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 2021/22 continues to be significantly impacted by the need to deal with the COVID-19 emergency. This has meant continued reductions in some areas of planned and emergency activity and the cessation of reporting on some key indicators. There are a number of key performance measures and constitutional standards that have not been met nationally and local for 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.

In planned care, there has been a similar approach to unscheduled care in modelling and realising 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 restored and numbers waiting reduced as quickly as is possible whilst still maintaining an ability to respond to any future resurgence of COVID-19 demand.

The local health system has coped well with the COVID-19 emergency in 2021/22 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 year-end performance is shown on the next page.

This year we will see new challenges in the proposed changes to the constitutional standards for ambulance and NHS 111, urgent and emergency care and planned care. The system has started to capture such data.

NHS Constitution and related indicators – 2021/22

KPI	Q1		Q2			Q3			Q4			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
EB3: 18ww RTT: incomplete waits	59.3 %	61.0 %	62.1 %	62.8 %	62.4 %	60.4 %	60.3 %	61.7 %	59.7 %	51.5 %	59.3 %	60.0 %
EB3: 18ww RTT: incomplete waits beyond 52 weeks	4633	4354	3910	3984	3930	3844	3816	3701	3760	3832	3729	4083
EB4: Diagnostic waits	24.2 %	22.9 %	20.3 %	21.8 %	29.2 %	33.4 %	32.3 %	33.2 %	38.7 %	37.9 %	34.2 %	38.7 %
EB6: CWT - 2-week cancer waits	85.3 %	85.9 %	79.0 %	82.8 %	87.4 %	86.7 %	83.9 %	74.6 %	76.1 %	69.5 %	76.7 %	75.9 %
EB7: 2-week breast waits	5.4%	3.8%	10.7 %	35.4 %	82.8 %	90.3 %	63.8 %	17.2 %	6.8%	10.1 %	13.8 %	17.8 %
EB8: CWT - 31 days to cancer treatment	98.4 %	97.9 %	95.4 %	96.3 %	94.1 %	93.6 %	93.8 %	94.1 %	97.1 %	80.7 %	91.5 %	91.3 %
EB9: CWT - 31 days to treatment (surgery)	85.0 %	87.5 %	85.4 %	80.3 %	87.2 %	92.6 %	74.4 %	76.0 %	86.7 %	72.0 %	85.7 %	63.3 %
EB10: CWT - 31 days to treatment (drugs)	100 %	100 %	100 %	99.0 %	100 %	98.8 %	98.5 %	100 %	100 %	83.2 %	94.4 %	90.6 %
EB11: CWT - 31 days to treatment (radiotherapy)	95.4 %	98.8 %	100 %	97.2 %	96.2 %	97.2 %	96.3 %	92.9 %	100 %	90.5 %	81.5 %	69.9 %
EB12: CWT - 62 days from referral to treatment	**79.1 %**	**68.7 %**	**63.7 %**	**64.9 %**	**64.2 %**	**60.3 %**	**63.0 %**	**62.3 %**	**61.1 %**	**46.9 %**	**44.9 %**	**63.6 %**
EB13: CWT - 62 days to treatment after	**45.5 %**	**61.9 %**	**41.7 %**	**85.7 %**	**64.7 %**	**62.5 %**	**72.7 %**	**59.3 %**	**84.2 %**	**34.5 %**	**34.5 %**	**69.2 %**

referral from screening												
EB13: CWT - 62 days to treatment after consultant upgrade	89%	83%	93%	77%	75%	79%	70%	73%	78%	78%	72%	69%
EB13: CWT - 28 day diagnosis	72.5 %	74.0 %	72.9 %	72.0 %	70.2 %	66.1 %	**67.6 %**	**61.4 %**	**60.6 %**	**47.8 %**	**63.7 %**	**56.6 %**
EB13: A&E 4-hr waits for treatment / decision / discharge (SaTH)	**75.7 %**	**72.9 %**	**68.4 %**	**62.4 %**	**60.7 %**	**58.4 %**	**57.7 %**	**57.0 %**	**58.2 %**	**55.9 %**	**55.8 %**	**54.3 %**
EB13: A&E 12-hour waits for admission (SaTH)	**12**	**1**	**53**	**97**	**69**	**131**	**132**	**302**	**322**	**497**	**336**	**307**
EAS1: Dementia diagnosis rates	62.5 %	62.4 %	62.8 %	62.6 %	62.2 %	61.9 %	61.6 %	61.5 %	60.5 %	60.0 %	60.4 %	60.0 %
EA3: IAPT rollout YTD - based on MPFT reports	989	1653	2383	3038	3753	4565	5327	6160	6817	7597	8403	9145
EAS2: IAPT recovery rate	**51.6%**			**51.0%**			**44.0%**			**50.5%**		
EH1-A1: IAPT completion where RTT was within 6 weeks	**95.0%**			**95.0%**			**95.0%**			**99.6%**		
EH1-AS2: IAPT completion where RTT was within 18 weeks	**100%**			**100%**			**100%**			**93.9%**		
EH10: Routine Eating Disorders - seen within 4 weeks	98.4%			96.3%			88.9%			78.4%		

EH11: Urgent Eating Disorders - seen within 1 week	75.0%			68.8%			62.5%			58.3%		
EH13: SMI patients have Annual Health Checks (rolling year)	25.7%			26.1%			29.4%			39.5%		
EK1a: IP care in LD/autism (CCG responsible)	6	6	6	7	6	8	8	7	9	9	10	11
EK1b: IP care in LD/autism (NHSE responsible)	11	10	10	11	13	12	12	12	11	11	11	11
EK3: LD patients having Annual Health Checks (cumulative)	73			333			746			1560		
EO1: Wheelchair waits (children) within 18 weeks	not reported			100%			90.9%			90.0%		

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 March 2022, we achieved 60 per cent which has remained stable throughout 2021/22. Performance was impacted particularly at SaTH by the impact of COVID-19 and the loss of capacity for elective care and at RJAH by a pause in the elective admissions to allow staff to be seconded to SaTH to assist in critical care due to the COVID-19 surge. In addition, staff have been seconded to assist in the delivery of a successful local COVID-19 vaccination programme.
Number of 52-week RTT pathways (incompletes): Zero tolerance of over 52-week waits	At the end of March, published figures showed 4,083 Shropshire patients had been waiting over 52 weeks for treatment. Waiting list backlogs will be addressed taking full account of clinical priority to recover the numbers waiting. The plan is to have zero patients waiting 104 weeks for elective care by July 2022 and the national target is 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 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 theaatre 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 38.7 per cent in March. 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 increased in quarter 4 across the system as a result of targeted local actions.
A&E waits: Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	It's been a difficult year in managing the complexities of the COVID pandemic, the emergency departments have seen increased staff absences and a decreased flow through the hospital. There has also been a 58 per cent year-on-year increase in the number of patients self-presenting with no contact to NHS 111 or other services prior to arrival. Despite the increase we have maintained the performance for patients being dealt with less than four hours. Improvement plans at SaTH are 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.

	Infection control measures, which were enhanced due to COVID-19, have begun 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. Recovery in breast screening continues to be of concern and we are working with NHS England to rapidly improve the position. There has been an increase in the number of patients being referred for breast pain. The system has responded by commissioning additional community-based services. The evidence would suggest that there is unknown demand that we are unable to quantify at this time as there are of patients that have not presented or presented late due to the pandemic. The CCG is actively reaching out to our local communities to encourage patients to contact their GP if at all concerned. 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 2021/22 in category 1 responses. For calls in categories 2 the performance deteriorated in the second part of the year as seasonal activity combined with staffing absences relating to COVID-19 impacted on ambulance waiting times. We have restoration plans to help recover Category 1 and 2 performance in 2022/23 to improve waiting times.
Mental health and primary care indicators	The restoration of services in primary care has seen an in-year increase of 24 per cent in face-to-face appointments with the addition of maintaining virtual appointments where appropriate. The CCG has an improving performance in achieving annual health checks for people with a learning disability and dementia assessment rates over 2021/22. Numbers of people presenting to the improving access to psychological therapies (IAPT) services has now restored to 2019/20 levels. The system is now responding to the demand in recovery of the services following the pandemic. In 2021/22 we have invested in improving services for children and young people in mental health crisis.

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), which are all linked to one of eight 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:

- **extended access**
- **structured medication reviews** supported by the CCG Medicines Management team
- **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 2020/21 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**

- **cardiovascular disease (CVD) prevention and diagnosis:** improve diagnosis of hypertension and the number of blood pressure checks delivered
- **tackling health inequalities:** by 28 February 2022, identify a population within the PCN who are experiencing inequality in health provision and/or outcomes and develop a plan to tackle their 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 this year, with over 120 ARRS-funded staff now in post.

The rollout of the COVID-19 booster vaccination programme from December 2021 became the main priority and focus for PCNs with general practice playing a vital role in this roll out. Our thanks go to all PCNs and their member practices for their huge efforts and hard work in relation to this.

Access to general practice

There has been media coverage nationally and locally in 2021/22 about 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 has seen an increase in the number of calls requesting appointments and the range and type of appointments offered. The levels of increased demand and the infection prevention and control restrictions resulting from the pandemic have created challenges for primary care locally and did impact detrimentally on some patients' experiences.

Overall demand for general practice has increased by more than 10 per cent and, despite this rise, almost six in 10 patients are being seen face-to-face. This is in line with the national direction of travel to have mixed appointment types according to clinical need. The use of online and video consultations has increased rapidly to meet new ways of working. In addition, the CCG has commissioned a new online GP locum booking platform which is helping practices to provide additional sessions.

The extended access service, offering clinical appointments to patients in the evenings and at weekends, has continued this year. In the 2021 National GP Survey, NHS Shropshire, Telford and Wrekin CCG practices scored an average satisfaction score of 69 per cent for ease of getting through to a GP practice on the telephone, compared to the national average of 68 per cent.

Further work to improve access was undertaken in October 2021 when NHS England released, '*Our plan for improving access for patients and supporting general practice*'. For the five months from November 2021 to March 2022, this provided access to a new national £250 million Winter Access Fund (WAF) to support patients with urgent care needs to be seen when needed, on the same day, considering their preferences, instead of going to a hospital.

Our local schemes included:

- additional GP locum doctors
- additional capacity in primary care from existing workforce including administrative staff
- a scheme to incentivise sign-up to the Community Pharmacy Consultation Service as an alternative to a GP practice consultation
- additional call handlers in the CCG Prescription Ordering Service
- a communications/media campaign
- support to practices to increase the efficiency of telephone systems, enable easier access for patients and ensure that call centre systems are operating as efficiently as possible
- a COVID-19 management service, including pulse oximetry at home, provided through Shropdoc.

This additional capacity is predicted to generate more than 25,000 additional appointments over the five months from November 2021 to March 2022. This is on top of the 15,700 additional primary care appointments generated from separate local system investment in primary care capacity through winter monies.

GP appointment data shows that the majority of our GP practices are back to pre-pandemic appointment levels.

Primary care workforce

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

- continued involvement in the system-wide vaccination workforce group, enabling over 300 practice staff, CCG staff and locums to join the STP workforce
- supporting 20 newly-qualified GPs and one newly-qualified general practice nurse on the NHS England and NHS Improvement funded Fellowship Programme across the Shropshire, Telford and Wrekin footprint
- seven 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.

Primary care estate

Over the last 12 months, three new-build premises were approved for Shawbirch, Whitchurch and Shifnal. The Whitchurch project is being delivered in partnership with Shropshire Council and Wrekin Housing Trust. A range of smaller but vital improvement projects have taken place in a further 14 practices, utilising Improvement Grant monies.

In addition to the above capital schemes, the CCG was also successful in submitting a bid to NHS England to become one of six pioneer projects across the country for the development of an integrated health and wellbeing hub in the south of Shrewsbury. The hub, which is

being designed to meet the 'PassivHaus' building standard (very low running costs, environmentally sustainable and energy saving), will see significant inward revenue and capital funding from NHS England.

The project is in the planning and design stage, due to open in 2025. A listening exercise with local communities was undertaken in 2021 and the outcome is being used to inform the future service model. Further communications and engagement activity is planned for spring/summer 2022.

Blood taking (phlebotomy) in primary care

The CCG has adapted its locally commissioned service contract for phlebotomy which was already in existence for Shropshire practices and opened it up to Telford and Wrekin practices. This incentivises more blood taking in primary care to avoid patients having to travel to one of the acute hospital sites, thus reducing demand for acute services.

This is an interim arrangement awaiting the outcome of the system phlebotomy redesign project in 2022/23, which aims to ensure consistent commissioning of phlebotomy across Shropshire, Telford and Wrekin for adults and children, reducing variation in service access and improving quality and patient experience.

In 2021/22, the redesign project developed a list of options for the new service delivery model on which a further patient/public engagement exercise is planned in 2022.

Cancer care co-ordination

A new project team, the Macmillan Community Care Coordination team, was set up in autumn 2021 to work with primary care. The aim of the project is to improve the number and quality of cancer care reviews completed by primary care within 12 months of cancer diagnosis, thereby enhancing the support available to patients. This is a pilot project ending in February 2023.

Home blood pressure monitoring

Home blood pressure monitoring has been identified as a priority for cardiovascular disease (CVD) management to ensure that patients who are vulnerable to becoming seriously ill with COVID-19 can manage their hypertension well and remotely, without the need to attend GP appointments.

Blood Pressure @home forms one part of a range of initiatives developed by NHS @home to provide better connected, more personalised care in people's homes including care homes, supported by technology where appropriate.

In autumn 2021, the CCG received 1,500 blood pressure monitors which have been distributed to general practice for clinical teams to target patients with poorly controlled hypertension, prioritising those most at risk of becoming seriously ill with COVID-19 or suffering heart attacks and strokes.

Veteran-friendly practices

The CCG is supporting our GP practices to adopt 'Veteran-friendly' status, which ensures a range of measures to support veterans and their families. We aim for all practices to be accredited by December 2022.

Digital

We have provided intensive support to practices to implement a range of digital projects to support operational improvements and efficiencies and ultimately improve patient care and access.

These include:

- moving practices to a new domain to improve operability
- rolling out the electronic prescription service to the vast majority of practices
- procuring online/video consultation solutions, remote patient monitoring in care homes and, most recently, a notes digitisation programme which, when complete, will release much-needed space in general practice for use as clinical space.

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 exceeded the annual target of at least 67 per cent of people on learning disability registers receiving an annual health check before the end of March 2021 by reaching a total of 77 per cent.

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 included recovery of existing waiting list backlogs and referral to treatment (RTT) performance for certain elective specialties, improved experiences and outcomes of services, 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.

Urgent and emergency care transformation

Integrated urgent and emergency care – NHS 111 First

Our ambition is to continue to ensure that our patients are provided with high quality services outside of hospital, a key area of work that is stringently linked to our system-wide Urgent and Emergency Care Improvement Plan 2022/23. One of our key focus areas is to ensure the availability of a range of community-based services including pharmacy, promotion of self-care, NHS 111, extended GP access joined up with hospital and community care services to offer an effective and inclusive service to patients.

We will be working collaboratively with our partners to ensure that patients have all the information that they need to make the right decision on which service to access first, when seeking advice or help for further care. This will help to ensure that patients with an urgent need will be able to quickly and safely be directed to an urgent care service and those with serious or life-threatening conditions will be assessed and treated in an emergency department.

NHS 111 can help if you need medical help quickly but are not in an emergency/life-threatening situation. NHS 111 will ensure that patients get to the right service first time. NHS 111 is available 24 hours a day, seven days a week, and 365 days of the year. The service is able to book the caller a time slot for the most appropriate service, such as a GP, minor injury unit, urgent treatment centre, or, if needed, A&E (emergency department) at the Royal Shrewsbury Hospital (RSH) or the Princess Royal Hospital (PRH) in Telford. We will ensure that the availability of booked appointments for NHS 111 to access and book appointments are available and optimised.

This will help the NHS manage the flow of patients when capacity in waiting rooms is much smaller than before the pandemic, to maintain distancing and reduce the risk of infection. This will also improve the patient experience as people will be seen and treated more quickly.

Data indicates that NHS 111 First is reducing the number of patients who self-present to A&E and increasing the uptake of booked appointments into urgent treatment centres and general practice.

In November and December 2021, Healthwatch Shropshire and Healthwatch Telford and Wrekin carried out a patient survey about NHS 111 on behalf of the ICS. We wanted to gather the views and experiences from people who have used NHS 111 to understand how they were helped to access services. The outcome and findings will help to inform our key focus areas of work that is required to improve patient/carer satisfaction and experience when using NHS 111 and getting the help and advice that they need.

Reducing delayed discharges

Although we are one of the best performing areas for delayed discharges, the extreme pressure on acute beds from the pandemic, and particularly in the second surge in the winter, sharpened our focus this winter on further improving our discharge processes to

support effective flow through the acute hospitals. Between December 2021 and February 2022 we carried out four Multi-Agency Discharge Events (MADE) to improve our processes even further.

The outcome of these events included:

- improving the number of discharges before midday
- enhancing the number of patients who access care directly through our new and improving the Same Day Emergency Care process rather than going into A&E first
- improving our Frailty Assessment at the front door of the hospitals so that we can avoid unnecessary admissions
- increasing the number of patients who are discharged on the day they become medically fit for discharge
- working with the Non-Emergency Patient Transport provider, EZEC Medical to ensure effective, timely and efficient hospital discharges for patients.

Early on in the pandemic, the system also worked together to develop a COVID-19 discharge pathway. It was clinically developed – based on national guidance, requirements and evidence and covers patients discharged from an acute hospital to a supported pathway in a community hospital, care home or in domiciliary care.

Through this COVID-impacted period, there has been additional focus on reducing delayed discharges from hospital. The national guidance has highlighted the need for further reducing delays in hospital discharges when medical fit to leave. It also required that those complex discharges who are COVID positive could only be transferred into a 'designated setting' – units separated from areas so that there is no risk of COVID-19 transmission during the period of their stay.

Care providers have supported personal care at home wherever possible with appropriate protective equipment to maintain the 'Home First' approach where people prefer care at home. There have been cycles of increased and reduced numbers of COVID-impacted discharges throughout the year, particularly through the winter period. COVID-19 has had, at times, delayed the timeliness of care provision due to the rates of community infection.

The approach of integrated planning, commissioning, working, and evaluating performance across health and social care to support discharges has ensured delays have been kept to a minimum despite the impact of COVID-19. These include:

- regular multi-agency learning events to improve proactive discharge planning
- co-located teams to improve communication and discharge planning
- targeted investments to maximise performance including admission avoidance, support to care homes
- close communication with key non-statutory partners
- monitoring of performance measures to understand the impact of key actions and initiatives.

Shropshire Community Health NHS Trust – urgent community response teams

The urgent community response teams are a critical component of the overall urgent and emergency system. These teams will respond within two hours to a patient who is in their own home and in crisis.

Feedback from patients who receive this service is extremely positive as they appreciate being able to receive a full package of support that can help them with all of the aspects of their life in their own home.

They can receive support with making meals, getting in and out of bed, their clinical condition will be carefully monitored by nurses who can prescribe medication and therapists are also available to provide equipment to allow people to function more safely and easily in their home whilst they are unwell.

People who receive this service tell the teams that they really valued being able to stay in their own home with their loved ones around them whilst they were unwell.

We are currently in the process of rolling out the full urgent care response service across Shropshire. This will ensure that there is the ability to respond to a national set of clinical conditions from 8am to 10pm, 365 days a year.

This service is currently in Telford, Shrewsbury and Southwest Shropshire and will be in Southeast and North Shropshire by the end of October 2022.

Royal Shrewsbury and Princess Royal Hospital – same day emergency care

Royal Shrewsbury and Princess Royal operate a Same Day Emergency Care Unit, which significantly improves their ability to safely assess, treat and discharge more patients on the same day as they attend the hospital.

This unit provides a better patient experience with much improved facilities and speedier discharge, frees-up much needed acute beds through reduced admissions and improves staff retention and recruitment, with better working environments and the ability to deliver better outcomes for patients.

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 or those living with a learning disability or who have autism.

During 2021/22, we have undertaken 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 now 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 country
- peer support for people discharged from the Redwoods Hospital where there are complex needs
- SMI physical health checks have been a priority, numbers are increasing and systems are working together to increase uptake.

This investment will grow again in 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 – these are specialist nurses who will support individuals living with dementia and their carers.

We have agreed our priories 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 have been refreshed in 2021. This report details an update since 2020, areas where improvements have been made and where services and plans are being developed to meet the actions.

Areas of improvement include:

- increase in early intervention mental health via programme such as Anna Freud across the county schools, the mental health trailblazer in school service
- both council websites contain improved communications and understanding of the mental health support 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 pathways that have 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. When they started, there were more than 300 on the waiting list across the county, they are now working through this list and all CYP will have started their assessment by the end of April 2022. 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 workstream has been developed. The key elements include:

- the development of a recovery, restoration and 'new normal' governance structure within the health and care system 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 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 in order to target interventions and prevent needs from escalating across the system
- share information effectively and efficiently with partner agencies
- develop an approach that supports the ethos of 'getting the right help at the right time', while taking into account the need for 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.

The services were reduced during COVID-19, but no services were stood down. Children were assessed and given a risk rating to decide what level and type of service they required. Services offered many children virtual consultations and will continue to offer this service where appropriate in future service provision.

During 2020/21, a number of service reviews began. Findings will be published during 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.

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.

The aim of the asthma project is to reduce the numbers of children who are admitted to secondary care service with an exacerbation of asthma. It was recognised that improved self-management of asthma as a long-term condition reduces the risk of exacerbation. The project group explored how this could be achieved through personalised care and identified an opportunity to utilise a digital health approach.

The Project Group selected an asthma app, which was shared for user feedback in schools and across the healthcare community. The app provides the user with educational materials around asthma, peak flow monitoring, reminders for medications, as well as the ability to share the Asthma Management Plan in a digital format. The app has subsequently been commissioned and will launch in June 2022. This will also support our plan to achieve the asthma standards in the Asthma Care Bundle.

The project team recognised the benefits of providing creative activities designed to support lung health and management of breathing for children with asthma. An Expression of Interest exercise took place which reached out into our creative communities to explore opportunities to expand evidence-based activities for children with a diagnosis of asthma across the region. A number of opportunities have been commissioned including group sports activities, a singing group and a creative approach delivered through local libraries for younger children which will not only support children with asthma, but could expand to support children's speech and language therapies.

Further to this, it was identified that our current demands on primary care time has impacted on the delivery of annual asthma reviews for children and young people. The personalised care budget was used to procure a 12-month support package from Shropshire Community Health NHS Trust to assist GP practices with annual asthma reviews. The new service will explore a personalised care approach to delivery of the asthma review which will highlight self-management, and enable additional advertising of the asthma app and the commissioned creative activities.

A mental health project was designed to support early help for children and young people who have been unable to access the BeeU Service due to demands on the service which have been created as a result of the impact of COVID-19 on children's mental health. The personalised care offer involved a collaboration with the National Centre for Creative Health, who supported a further Expressions of Interest process in the creative communities to support children and young people's mental health.

A range of innovative activities have been commissioned including clay pottery sessions, horse care, countryside activities, dancing and boxing. These activities will be launched in May 2022 through the BeeU Service. Further to this, the National Centre for Creative Health has been working with a group of children and young people with lived experience to support the BeeU Service through feedback and service improvement activities. One of these projects includes the co-production of a booklet which will be offered to children who require support with an eating disorder. The book will be developed by children who have experienced an eating disorder in collaboration with an artist facilitator who has been commissioned to support.

A Personalised Care and Support Plan (PCSP) has been co-produced with children and young people who access the Social Prescribing Link Worker Service in South West Shropshire. The PCSP will help children to identify what their personal goals are around their health and wellbeing, and will be shareable electronically with other service providers they may be in contact with in relation to their mental health.

Finally, two voluntary sector providers 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 in Telford and Shropshire Parent and Carer Council in Shrewsbury 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.

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.

SEND (Special Educational Needs and Disability)

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 27 and 31 January 2020. The final letter was published on 6 May 2020 and identified many strengths, including the positive education outcomes for Shropshire children and young people with an Education, Health and Care Plan (EHCP) that attend mainstream schools and colleges.

A number of concerns were identified by the inspection. 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.

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.

Elective care transformation and recovery

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

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 has recently 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 covers 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 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
- improved environment through reduced journeys to hospital therefore reduced CO2 emissions – 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 is complete with the aim of commencing this programme of work with engagement and involvement sessions from November 2021, although as a recovery requirement, patient-initiated follow-ups went live earlier in June 2021 for three specialties.

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 the last 12 months include:

- the continuation of the Strategic Cancer Board and development and delivery of the system Cancer Strategy. The Cancer Strategy itself is due for approval, but had to be paused as a result of the Omicron outbreak, winter pressures and staffing shortages
- the Macmillan Cancer Care Review (CCR) project commenced and work is ongoing to meet the objectives outlined within the project PID. Additional funding may need to be secured in due course to lengthen the period of this project from 18 months to three years
- work continues with restoration of 62-day performance and the delivery of the faster diagnosis standard

- the rollout of a non-site specific pathway has been delayed whilst a clinical lead is appointed, and the deadline for this is now 2024 (previously 2022)
- Living Well sessions continue virtually, and SaTH is developing a health and wellbeing app to help further support cancer patients in other ways
- rollout of Faecal Immunochemical Testing (FIT) for all colorectal urgent suspected cancer patients from 1 April 2022
- a project in its early stages, to develop a pilot for the use of tele-dermatology as a first step towards having this provision across the county. This would help with the effective and efficient triaging of suspected skin cancer referrals and significantly reduce the need for face-to-face appointments in the hospital
- Community Breast Pain Clinic established in November 2021 to provide care closer to home in a non-acute setting whilst protecting capacity for more urgent suspected cancer patients.

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 of outpatients transformation it aims to improve referral processes and information sharing, shared decision-making, and reduction in 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 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 and NHS Improvement 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.

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
- Phase 2 (Years 2 and 3) – Optimisation of orthopaedics
    - outpatients improvement project (aligned to the transformation programme)
    - 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 by quarter 4 2021/22 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 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 meant more than ever working together as one cohesive system as a combined force with the same aims and objectives and accelerating 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

- 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 more fully engage with our communities
- In regard to prevention and healthy lifestyles, the local authority has launched the ‘Year of Wellbeing’. The CCG has launched an NHS England and NHS Improvement 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, during 2021/22 there has been a programme of work to introduce NHS-funded tobacco prevention in acute inpatient settings and further development of the tobacco prevention model in maternity. 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 have opened the independent living smart house to showcase technology that supports people at home as well as support skills and means of digital access

- COVID-19 has impacted on the scale of the transformation planned within respiratory and diabetes services as clinicians' input has been reduced due to operational pressures, however during 2021/22 the respiratory services have developed and refined their models of in reach and duty nurse role to assist more individuals receive care in their own homes
- The Integrated Health and Social care team have continued to provide a valued service over 2021/22 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
- TWIPP have also contributed to the development of the system-wide Dementia Strategy and reviewed how mental health can connect more closely into the TWIPP work as we develop our governance structure as part of the transition to an integrated care system
- 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. This will build on the learning from the vaccination programme and will be in partnership with our primary care colleagues
- Working with our partners in the voluntary and community organisations, a programme of work has commenced 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 objectives and outcomes, not organisations. 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, 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

In regard to social prescribing, we had 1,901 referrals for 2021/22 with the data showing a demonstrable significant improvement in wellbeing.

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.

As part of our developing Children and Young People's 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.

To help tackle health inequalities, 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.

Local care transformation programme

Working in collaboration with the CCG and local providers, the local care transformation programme is led by Shropshire Community Health NHS Trust.

During 2021, the programme continued with the rollout of rapid response across the county and, despite difficulties in recruiting teams to cover the more rural areas of the county, the aspiration is to have a regional wide service over the next few months.

A sustainable model of support for care homes was established seeing a multidisciplinary team working with care homes and GP practices to enable more residents to discuss their future wishes and future care needs with a personalised advance care plan.

The programme also completed phase one of the respiratory transformation programme which sees the community services team working more closely with the hospital team to support early hospital discharge and to avoid unnecessary admission to hospital.

This ambitious three-year programme has used the learning and some of the progress made from the previous Care Closer to Home programme to support integration of services at a neighbourhood level with the development of new models of community-based care to include:

- ageing well
- anticipatory care
- integrated therapies
- virtual Wards.

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 in this year, 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.

One of the key objectives of the review was to work in collaboration with people that had experience of the care for someone at the end of life, patient representatives and other key stakeholders to include NHS and care providers, local hospices, care homes and Healthwatch.

The outputs and recommendations of this review have been incorporated into the Shropshire Telford and Wrekin Integrated Palliative and End of Life Care Strategy (Adults) 2022-25. The strategy will be launched in May 2022 and a number of priorities have been identified to be progressed throughout the 2022/23.

Shrewsbury Admission Avoidance / Rapid Response Team

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

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

The running of the service over the winter of 2020/21 demonstrated the need for an aligned community-based Rapid Response offer across Shropshire, Telford and Wrekin as a whole, and funding was secured as part of the Alternatives to Hospital Admission (A2HA) investment case.

The funding enabled:

- enhancement of the model in Telford and Wrekin
- roll out of the Rapid Response model of care across Shropshire
- a crisis response (within two hours) from a multi-disciplinary health and social care team
- supporting people with an urgent care need to remain well/recover in their usual place of residence and avoid hospital admission.

We are now rolling out the Admission Avoidance pilot to a whole-county community-based Rapid Response service. Governance is managed at a local level within Shropshire Community Health NHS Trust, Telford and Wrekin Council, Shropshire Council, and feeds into the local care programme and system structures.

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 within it 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 will be monitored throughout 2022 prior to a 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 is also underway to commence 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, 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.

COVID-19 response

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

Medicines optimisation clinical projects

Despite the continued impact of COVID-19, the team has seen a number of key achievements in clinical projects during 2021/22:

Wound care

A wound care management formulary was finalised for use across the local health economy in quarter 3 of 2021/22 and formally launched in April 2022, following a short delay in the launch event due to redeployment and the COVID-19 vaccination booster programme.

The medicines management team supported the implementation and roll out of this formulary along with the development of a wide range of supporting clinical pathways to ensure appropriate use of wound care products, including use of antimicrobial pathways and negative wound pressure therapy (NWPT).

Respiratory

Working with clinicians in SaTH and Shropshire Community Health NHS Trust, the 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. This was particularly important during COVID-19 to keep patients out of hospital and reduce the need for GP practice visits.

Cardiovascular disease (lipid management and atrial fibrillation)

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

- a cardiovascular focus project was conducted across primary care, focusing on 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 CVD events
- guidance and searches were developed by the team (alongside secondary care) to support these projects, along with a training programme run in conjunction with local clinicians and the WMAHSN
- the medicines management team has also established 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.

Self-care/drugs of limited clinical value

Nationally it has been recognised that self-care and low-priority prescribing is an increasingly challenging area to address, with the more complex medicines remaining to be addressed. The medicines management team worked closely with secondary care to develop comprehensive guidance, with a consistent message across the system for primary care to address some of the more complex areas of prescribing:

- vitamin D
- dry eyes
- vitamin B.

Medicines optimisation in care homes

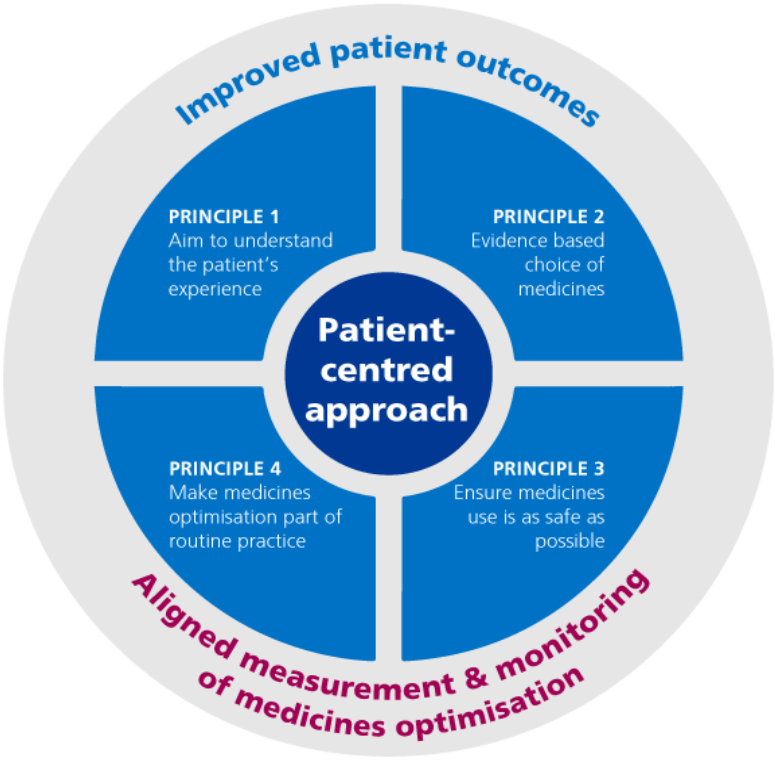
The care home medicines optimisation team collaboratively work with care homes, GP practices, community pharmacies and the local authorities to provide support, education and guidance to ensure safe and effective use of medicines and to support the delivery of quality, personalised and safe care. The 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 in Shropshire and Optimise Rx in Telford)

Scriptswitch, since its inception in Shropshire in 2015 and Optimise Rx in Telford since 2019, have been continually developing to ensure that safety and savings messages remain current, strengthening engagement with practices. This year has been no exception, with savings of £424,000 for Scriptswitch and £274,000 for Optimise Rx exceeding both the planned target figures. Information and safety messages have been

updated, which has been key to respond to COVID-19 developments.

This year a procurement process following the SBS framework, has taken place to move to one prescribing support system. An evaluation panel assessed the two current systems used across the CCG and have made the decision that Scriptswitch will continue their contract and cover all practices from 1 June 2022. Scriptswitch already has more than 9,000 messages on the system with weekly updates which will be 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.

At the 2020/21 National Eclipse awards ceremony, NHS Shropshire, Telford and Wrekin CCG achieved national recognition – winning three awards for High-Risk Drug monitoring (Azathioprine, Methotrexate and Warfarin).

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. It will not only reduce bed occupancy in hospitals; 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 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.

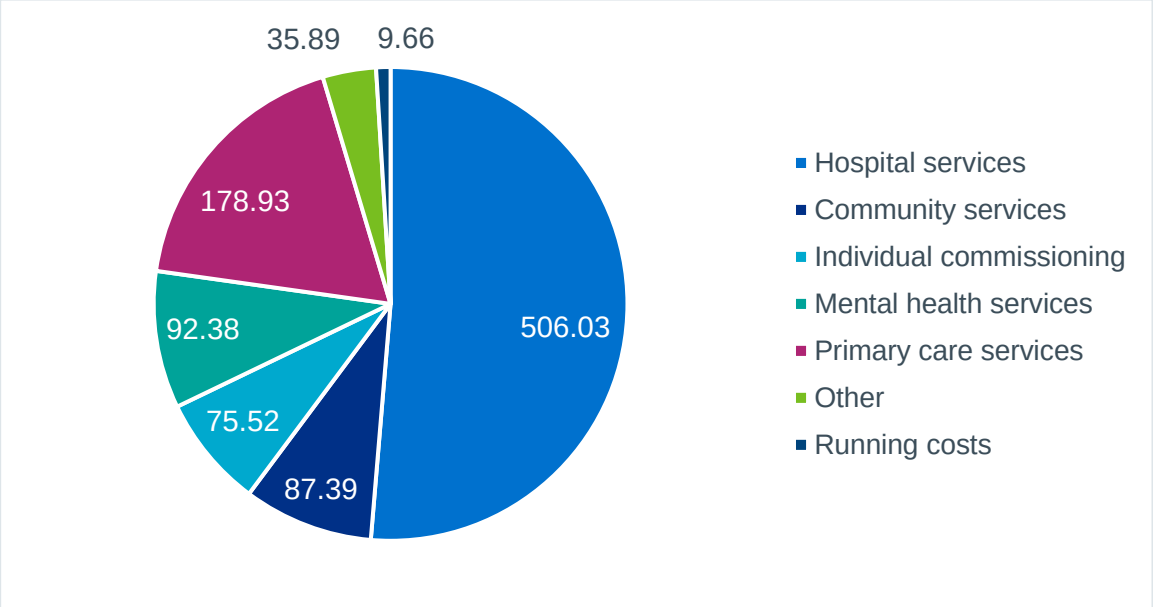
Working collaboratively with our local hospitals and community provider

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 2021/22 the CCG received a total allocation of £982 million to spend on the healthcare of its residents. The chart below shows a breakdown of the CCG's expenditure for 2021/22 by spend type:

Expenditure 2021/22 (£986 million)



Further analysis of expenditure, by type

2021/22	Total (£'000)
Pay	12,810
Purchase of goods and services	
Services from other CCGs and NHS England	6,782
Services from foundation trusts	152,028
Services from other NHS trusts	482,301
Purchase of healthcare from non-NHS bodies	144,817
Prescribing costs	83,553
General Ophthalmic services	496
GPMS/APMS and PCTMS	84,353
Supplies and services – clinical	2,462
Supplies and services – general	10,338
Consultancy services	989
Establishment	1,944
Transport	182
Premises	1,043
Audit fees	126
Other non-statutory audit expenditure	

Other services	8
Other professional fees	1,501
Legal fees	136
Education, training and conferences	134
Total Purchase of goods and services	**973,194**
Provision expense	
Provisions	426
Total Provision expense	**426**
Other Operating Expenditure	
Chair and Non-Executive Members	350
Grants to Other bodies	32
Expected credit loss on receivables	(2)
Other expenditure	1
Total Other Operating Expenditure	**381**
Total Expenditure	**986,811**

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

Statement of Financial Position as at 31 March 2022	2021/22 (£'000)	2020/21 (£'000)
Current assets		
Trade and other receivables	3,618	5,758
Cash and cash equivalents	375	201
Total current assets	**3,993**	**5,959**
Total assets	**3,993**	**5,959**
Current liabilities		
Trade and other payables	(64,902)	(76,274)
Provisions	(2,406)	(2,679)
Total current liabilities	**(67,309)**	**(78,953)**
Non-Current Assets plus/less Net Current Assets/Liabilities	**(63,316)**	**(72,994)**
Assets less Liabilities	**(63,316)**	**(72,994)**
Financed by Taxpayers' Equity		
General fund	(63,316)	(72,994)
Total taxpayers' equity	**(63,316)**	**(72,994)**

Sustainable development

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

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

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint. We had planned to develop a Sustainability Policy during 2021/22 but due to capacity constraints resulting from the pandemic we have been prevented from completing this work. However, we have appointed a board-level Sustainability Champion.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the 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 ICS 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, NHS Shropshire CCG at William Farr House and NHS 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.

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 the 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 year's 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.

Utilities costs 2020/21 and 2021/22

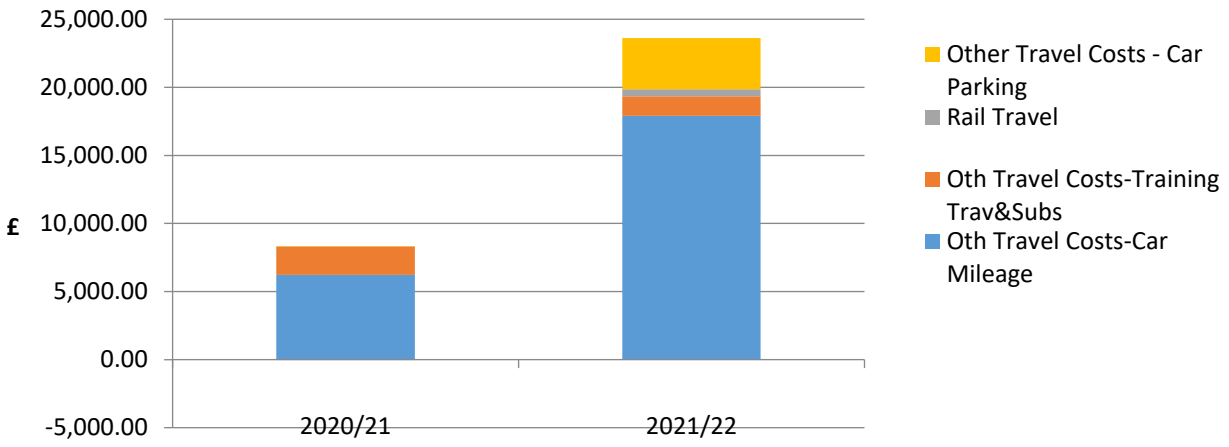
* Data energy usage is not available for the Ptarmigan House site to calculate our position against our benchmark.

Travel

The graph below shows an increase of travel costs from 2020/21 which reflects the relaxing of COVID-19 restrictions nationally, but is significantly less than the accumulated travel costs reported in the annual reports of NHS Shropshire CCG and NHS Telford and Wrekin CCG for the year 2019/20. To support staff, the CCG 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 CCG does not own, hire or lease car fleets and none of our travel costs include any flights, either international or internal within the UK.

Travel costs 2020/21 and 2021/22



Consumables and waste management

During 2021/22 the CCG used a total of 217 reams of paper, but we are unable to provide a comparison to last year's consumption as this was not reported. 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 uses to contract for its services.

Efficiency programme

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

During 2021/22, delivery of these plans was challenging due to the impact of the pandemic. Block contracts remained in place with our main providers and some efficiency programmes were suspended as staff were redeployed to other departments. However, the CCG was still able to deliver £7.2 million of savings which were predominantly within the medicines management and individual commissioning teams.

As part of the development of the system financial sustainability plan, the aim is that in 2022/23 all system organisations will work to deliver a 1.6 per cent internal efficiency target. For the CCG, this equates to a £7.3 million efficiency target. On top of this, the CCG will also be working with healthcare system partners on the system transformation programme.

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 must continue 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.

We commission 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 12 months, we have worked with providers to identify several quality areas which required further in-depth analysis and understanding. CCGs hold the responsibility for the performance management of the Serious Incidents (SIs) reported by commissioned services. We ensure that all incidents are investigated, and we develop action plans which we then monitor to completion. Any 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

The most significant quality risk during 2021/22 continues to be with SaTH, which has a history of challenges, including quality. SaTH is placed in NHS England and NHS Improvement System Oversight Framework (SOF) 4 (Recovery Support Programme).

In November 2021, a CQC inspection was undertaken at the Trust with a focus on:

- urgent and emergency services
- medical care
- end-of-life services
- maternity services.

In addition, a well-led inspection took place.

CQC acknowledged that the Trust has made progress but remains rated as inadequate overall, with ‘requires improvement’ for the ‘effective’ and ‘well-led’ categories.

CQC did find some progress which, if sustained, would lay the foundations to improving patient care considerably. At the time of writing, SaTH awaits a decision from CQC on their review of conditions applied to the Trust's registration.

Maternity services in our system are under external review relating to concerns raised about standards of safety and care and compassion over a longer period of time (the Ockenden Report). As of February 2022, the Trust, under the supervision of the Local Maternity and Neonatal Services (LMNS), has made good progress, with the achievement of more than 80 per cent of the first recommendations. Many of the remaining elements sit outside the sole responsibility of the Trust to deliver and are the responsibility of the wider system.

The second Ockenden Report has now been published and we are waiting for the Trust to respond to the recommendations. The focus is on four key pillars for improvement:

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

The report identifies 66 Local Actions for Learning (LAFLs) and 15 Immediate and Essential Actions for Learning (IEAs) which will be supported and monitored by the LMNS.

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

Our pathways and facilities for children and young people in need of a mental health assessment needed reconsideration to meet national standards. We are undertaking a range of improvement work and developing different models of care delivery. 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.

We strengthened our infection prevention and control (IPC) measures since the COVID-19 pandemic by working in partnership with local authority public health colleagues. We continue to work in partnership to deliver support, expertise and training, as well as maintain an oversight role where infection outbreaks occur.

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

Emergency Preparedness Resilience and Response (EPRR)

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

Further to the challenges presented by the COVID-19 pandemic in 2020/21, the 2021/22 year has been no less challenging. 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 the year.

NHS Shropshire, Telford and Wrekin CCG has led the multi-agency system response to the pandemic, ensuring a responsive, multi-agency approach to a complex, demanding and evolving incident. As we have remained in a national Level 4 incident for much of the year, we have been guided by the incident management instructions from NHS England.

Throughout 2021/22, we have seen a number of COVID-19 ‘waves’ driven by the emergence of variants of the virus. This has had a significant impact on service delivery and our workforce, with March seeing COVID-19-related admissions to hospital reaching some of the highest levels seen throughout the whole pandemic. In addition, March saw some of the highest COVID-19-related staff sickness levels throughout the whole pandemic.

This context of managing the specific service requirements and impact of COVID-19 (for instance on bed spacing; a wide range of infection, prevention and control measures; patient streaming and testing) along with significantly reduced staffing and the focus on restoring services has presented a significant challenge.

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

We have rolled out our local vaccination service at pace, seeing some of the best performance and vaccination uptake in the country alongside continued communication with our residents regarding how to protect themselves and their families. This has helped to provide the best defence against the virus for our population.

Further details regarding our vaccination programme can be found under ‘Engagement activities’ and ‘Reducing health inequalities’ sections of this report.

EPRR self-assessment

Following a departure from the usual assessment process in the preceding year, NHS England re-instated the self-assessment process during 2021/22 – albeit with additional focus on learning following the pandemic. On this basis, all areas across the country were given additional actions to focus on to address their learning. Shropshire, Telford and Wrekin received a rating of ‘substantial assurance’.

During the year, we have maintained our 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 and NHS Improvement
- 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 been in place for 2021/22.

Safeguarding

The Safeguarding team (designated nurses for children and looked-after children, designated lead professional for adults, named GPs) continues to offer advice, guidance, support and training across the health economy to professionals including dentists, pharmacists and GPs. As part of the merger to a single CCG organisation, we have strengthened the leadership capacity and organisation of our safeguarding team.

We remain as committed as ever 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 2021/22 included:

- 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 hospital 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.

As well as continuing the above areas of activity, for 2022/23 we will be maintaining a focus on:

- enacting any changes in requirements for adult safeguarding statutory legislation, including the awaited changes to Mental Capacity Act/Deprivation of Liberty safeguards (MCA/DOLs) and Liberty Protection safeguards when these are published
- 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.

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.

Next steps for LeDeR across the Shropshire, Telford and Wrekin system include:

- implementing our LeDeR policy and the three-year LeDeR strategy that will build on our successes

- further strengthening 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 2020/21.

ICS quality developments

In collaboration with our partners, over the next year we are leading the development of a system Quality Strategy, which reflects the changing priorities of the ICS from July 2022. The Quality Strategy describes improved opportunity for co-production of quality improvements and partnership-working at the organisational and system level, with service users and patient representatives, and enables us to ensure that improving quality is at the heart of everything we do.

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.

We have developed a Patient Safety and Quality Committee in Common to provide strategic leadership and oversight for quality across the ICS during the transition period. We are also implementing quality governance and assurance mechanisms across the system to focus on improvement and sustainability:

- there will be an ICS approach to risk management and escalation
- a quality monitoring dashboard is being developed
- 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
- **maternity transformation** and improvement priorities
- **learning from deaths:** including the new requirements of the LeDeR programme
- **patient experience:** with a focus on co-production as a principle of shared working

- **quality improvement** approaches.

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

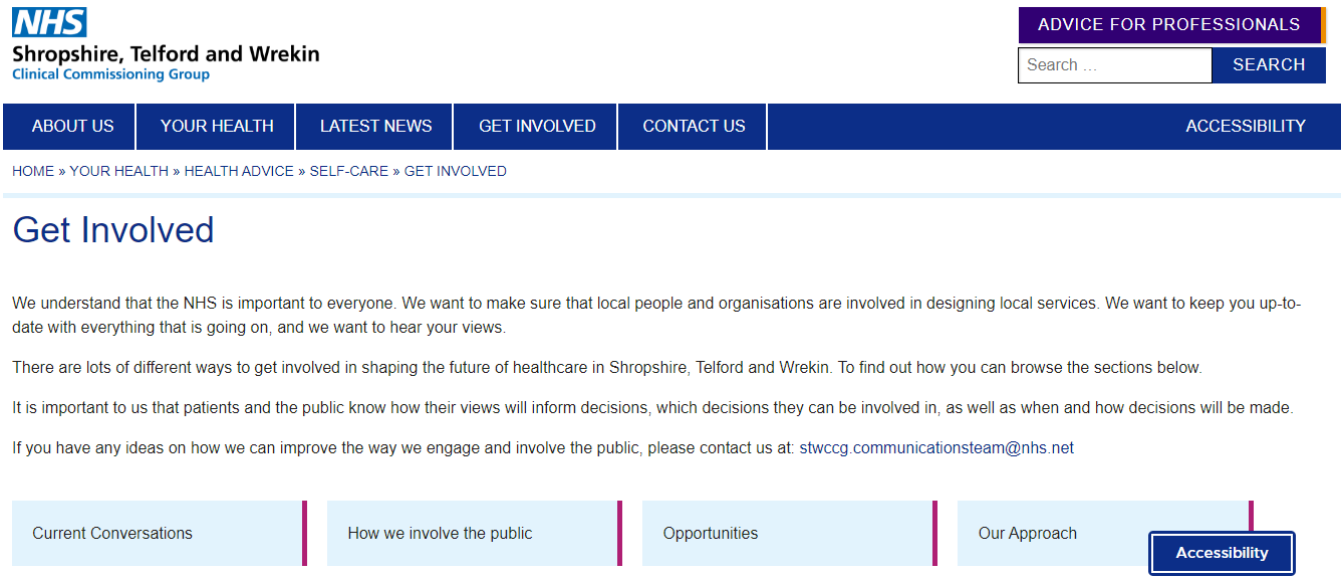
As a commissioning organisation, we have a legal duty under the National Health Service Act 2006 (as amended) to involve the public in the commissioning of services for NHS patients ('the public involvement duty'). For NHS Shropshire, Telford and Wrekin CCG, this duty is outlined in Section 14Z2 of the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

We are always keen to hear the views of and provide opportunities for local people to be involved in the work of the CCG. There are numerous ways for people to share their views on local health services and discover ways to be 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 exists 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 receives 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 comprises 10 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 is 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 ensures 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 are 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.

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.

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

Impact of involving people

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

Some examples are highlighted on the next page.

Feedback from people and communities	Action taken in response	Change
Patient representatives provided feedback on a patient letter to help manage expectations and reassure around waiting times	Responses from patient representatives were collated, commenting on the tone, content and wording.	The letter was amended in light of the feedback from patient representatives.
Members from Polish communities shared that they had identified COVID-19 vaccine hesitancy through their networks	The Engagement team worked with them to understand their hesitancy, identify questions and the most effective channels to reach them.	A video and Q&A were created where a local Polish GP answered questions put forward by the community. These were shared directly through their networks and formed part of a toolkit that was distributed to businesses.
Patient Participation Groups shared the experiences of patients struggling to get GP appointments during the pandemic	A meeting was facilitated between the patient groups and primary care to discuss the challenges experienced.	This provided an opportunity for primary care to share the pressures they and their staff face. The patient groups involved penned a letter of support to practices which was shared with support from the Communications team.
Young people aged 18 to 29 provided feedback about their views on COVID-19 vaccination and where/how they access information	This feedback was collated and themed by the Engagement team.	Findings were shared with the vaccine programme and helped shape communications with young adults and inform the communications channels used.

Engagement activities

Community diagnostic centres

The CCG Communications team provided support with engagement work following the successful bid for more than £6 million to run a pilot community diagnostic centre in Telford.

A comprehensive survey was launched with support from a research company, Influential, to help us understand what our populations think about the plans for dedicated elective diagnostic centres and what else they want the centre to provide.

The engagement targeted specific demographics to ensure we heard from people with protected characteristics and people living in areas experiencing the greatest health inequalities. The analysis of this survey helped us shape the development of the centre, which is due to open this year and will also provide insight to support the development of future centres across the county.

Musculoskeletal transformation programme

The musculoskeletal transformation programme is about strengthening community provision over the next five years to improve care.

A communications and engagement plan has been developed to ensure stakeholders are kept informed of progress and are aware of the ways in which they can be involved.

Engagement has included analysis of existing intelligence and insight captures through the Patient Advice and Liaison Service (PALS), Healthwatch partners, clinician and public surveys and outreach work with interested groups.

This is ongoing and the insight and learning continues to be fed into the programme as it develops.

High intensity users service

The CCG carried out a review of the high intensity users (HIU) services in the county to develop a new model based on the views and experiences of patients and health and care staff.

As part of the review, we looked at the stories of people who had been supported by the services, as well as asking HIU staff, stakeholders and service users for their views to find out what they thought worked well, what could be improved and how.

One of the key insights suggested that the name ‘High Intensity Users Service’ could be negatively perceived by the person being supported, suggesting they over-use certain services, creating a sense of burden and guilt. In reality, we know the reasons they use services such as A&E, 999 or NHS 111 frequently are often beyond their control because the root cause of their care needs is not being addressed. We pulled together several

alternative names for the service with the help of patient representatives and those involved in the review, and asked people to vote for their preferred option.

Based on the outcome of the vote, the future version of the service will be called the Positive Lives Service.

We are now using what we have learnt from the review to develop the new Positive Lives Service model which will be launched next year following a procurement process.

Voluntary, community and social enterprise sector Memorandum of Understanding

Following a successful collaboration workshop with voluntary, community and social enterprise (VCSE) sector colleagues across Shropshire, Telford and Wrekin in May, an MoU is now in place between the ICS and the VCSE sector.

The MoU sets out the role of both in improving health, social care and wellbeing in the area and explains why a partnership is being created on shared ambitions. These ambitions include improving health outcomes and reducing health inequalities, maximising value from financial resources, building successful partnerships and effectively engaging with people and communities in Shropshire, Telford and Wrekin.

The MoU was co-produced between the ICS and the chairs of Shropshire and Telford and Wrekin VCSE, and co-signed at the annual general meeting.

Encouraging uptake of the COVID-19 vaccine

The Shropshire, Telford and Wrekin (STW) COVID-19 Vaccination Service has been very successful in ensuring good uptake across the system and has regularly been one of the best performing systems both regionally and nationally. The programme has been effective in reducing the number of people getting severely ill and dying from COVID-19. Our work amongst our underserved communities and those with health inequalities has been used as an exemplar in regional briefings. The service has successfully worked with all system partners to achieve this success.

STW COVID-19 Vaccination Service use a balance of providers PCNs, community pharmacies , hospital hubs (HH+s), vaccination centres located across the county. These sites are focused around population centres, with a focus on being ‘local’ to our communities for accessibility and convenience.

Geographical site locations have been stable for the vast majority of the programme, with only minor adjustments – now well established and well known.

PCNs, whilst using their designated local vaccination service sites (all from medical practice locations), are additionally delivering clinics from the majority of their component GP practices. This further ensures ease of access and familiarity for patients.

Hospital Hub+ sites are primarily focused on vaccinating health and social care workers, and providing specialist clinics such as for immunosuppressed patients or people with allergies. They also provide an inpatient service for eligible patients requiring vaccination prior to discharge into residential or care home settings.

Consideration of ensuring a maximum drive to a vaccination clinic of 30 minutes has been assured. Where there are limited public transport options, additional bespoke transport is available for eligible individuals, through our local authority partners.

Our mobile (buses) and pop-up services are operating out of local fire stations, local community centres, interfaith buildings, larger employer workplace locations, local authority retail outlets and car parks. These supplement the static locations both in respect to geographical location as well as expanding the days and times available. This delivery model also supplements care home and housebound vaccinations if/when a PCN requires support. The mobile and pop-up services have a key focus on reducing vaccination inequalities, with locations chosen according to lower uptake data.

The main objectives for the Shropshire, Telford and Wrekin COVID-19 vaccination communication and engagement programme have been to:

- build confidence in the COVID-19 vaccine
- manage expectations about when people will receive it
- increase uptake, particularly in priority communities, by listening to and understanding local concerns and providing information in a factual and unbiased way
- support health and care frontline staff with their operational communication around delivering vaccinations.

Despite high uptake of COVID-19 vaccines overall, there is variation in uptake between different groups of Shropshire, Telford and Wrekin's population. A smaller proportion of younger people, those living in the most deprived areas and people from some ethnic groups have been vaccinated.

A system-wide equalities group including the CCG, local authorities, community leaders, health professionals and equality and inclusion leads have come together to identify barriers to the uptake of COVID-19 vaccination and share information. The shared aim is to increase uptake and reduce vaccine hesitancy.

A communications and engagement plan has been developed to involve local communities, health and care staff, stakeholders, partners and the media (including social and digital platforms) to increase uptake and reduce hesitancy through a variety of methods, such as:

- reviewing data to better identify trends of vaccine hesitancy such as deprivation or ethnicity
- working with organisations, clinical leads, community leaders and faith leaders to tailor messaging for young people and those with ethnic minority backgrounds
- improving accessibility of information such as information, leaflets, videos and toolkits in different languages or formats where appropriate
- delivering outreach work to target groups that are less likely to come forward, such as the homeless, those in Gypsy, Roma and Irish Traveller communities, asylum seekers and migrant workers.

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 meet 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 communicative and 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 continue to work closely with them in relation to our plans, particularly with regard to Place. We use 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 work closely with our patient participation group (PPG) networks, which bring together PPGs from across the county. The meetings provide a forum to share good practice, keep informed and engaged with national and local NHS developments and provide opportunities to get involved. PPG networks are also key in helping 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 continues to be an important partner for the CCG. They are regularly involved in formal and informal meetings including Governing Body and service transformation programmes. They attend the QPC 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, for example for the Children and Young People's Mental Health Services. These reports are a valuable source of information for service reviews.

Patient Advice and Liaison Service

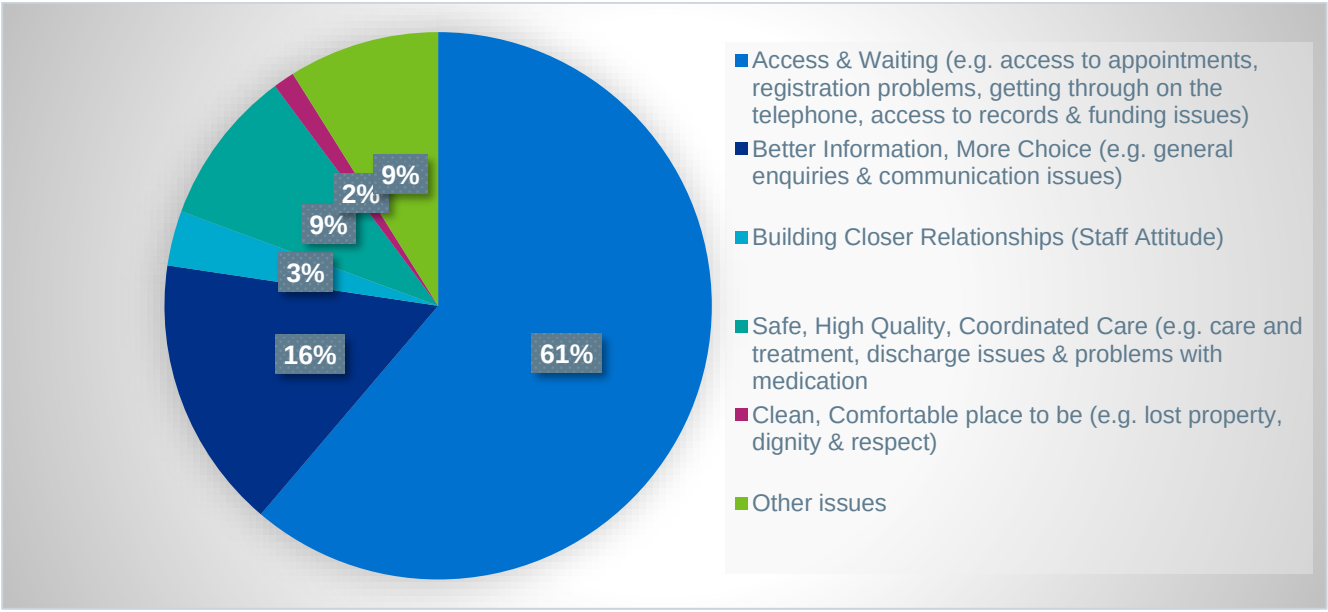
PALS is integral to the commitment of NHS Shropshire, Telford and Wrekin CCG to working closely with patients and staff to improve services. It is an informal and impartial way to resolve the concerns of patients, relatives, carers and members of the public.

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

During 2021/22, 876 PALS enquiries were received via NHS Shropshire, Telford and Wrekin CCG Patient Services team. This is a decrease on the 1,060 enquiries received during 2020/21.

The chart below illustrates the 'domains of patient experience' the PALS enquiries related to during 2021/22.

Subject area of PALS concerns 2021/22



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

Of the enquiries received, 277 related to GP practices and a high proportion of these were around accessing appointments.

There were 102 enquiries relating to hospital services. Just over half were around access to appointments and included delays with dates for surgery and routine review appointments.

354 enquiries related to CCG services, with 204 of these being around COVID-19 and access.

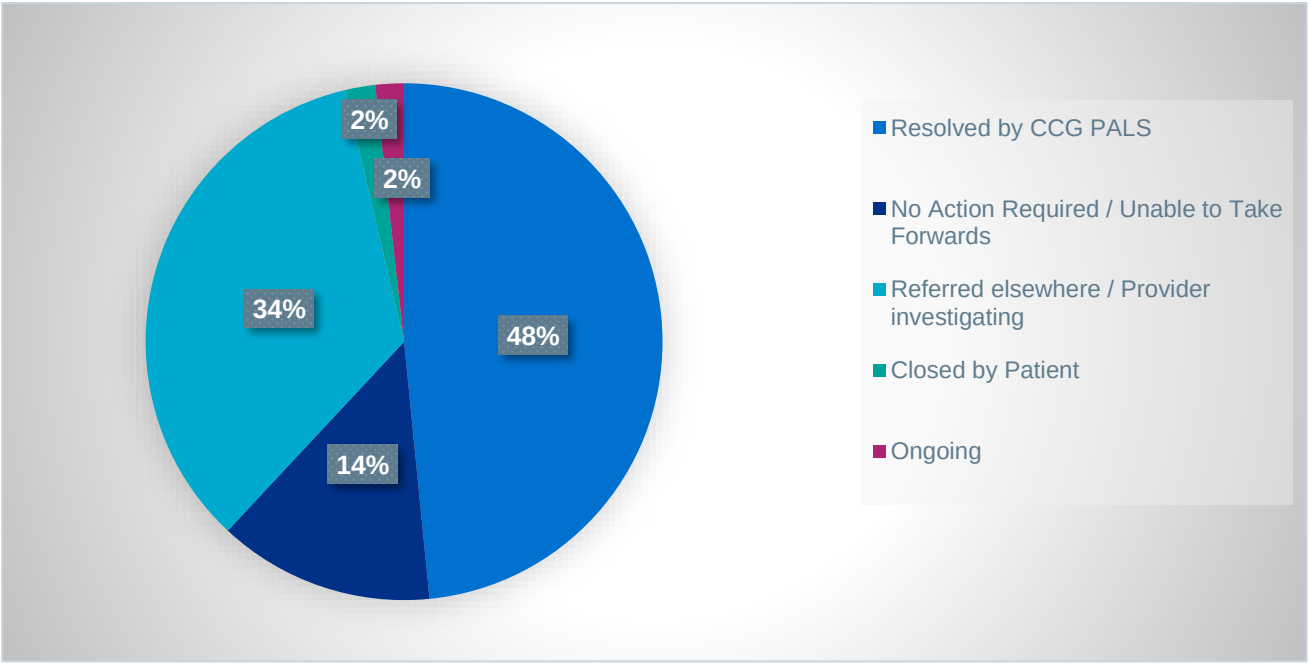
24 enquiries related to the Prescription Ordering Department and were around access or problems with prescriptions once they had been ordered.

23 related to the Individual Commissioning team and were around delays with continuing healthcare assessments and poor communication around the delays.

The rest of the enquiries received were around a variety of services including community services, mental health services, ambulance services, council services, pharmacies and dentists. However, the numbers for all these services were fairly low compared with the services mentioned above.

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

PALS enquiries outcomes 2021/22



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

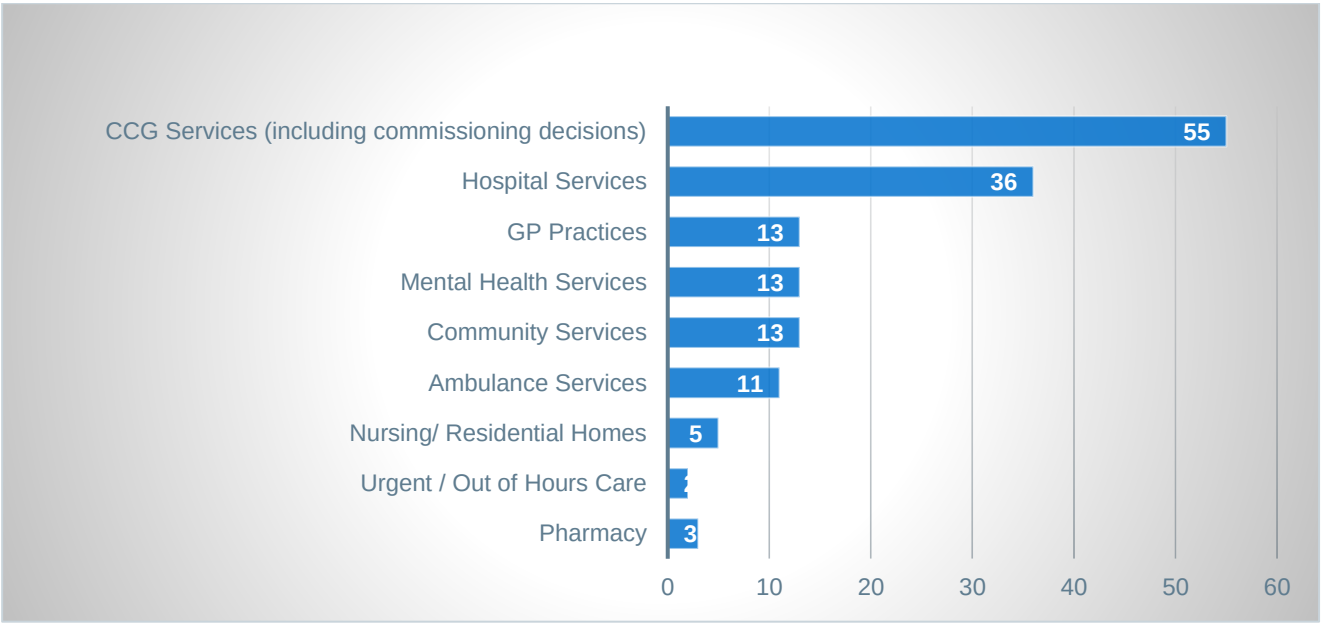
Complaints

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

The CCG's complaint policy can be viewed on the CCG website.

During 2021/22, the CCG received 135 complaints, which is a slight increase on the number received in 2020/21. 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.

Services complaints related to 2021/22

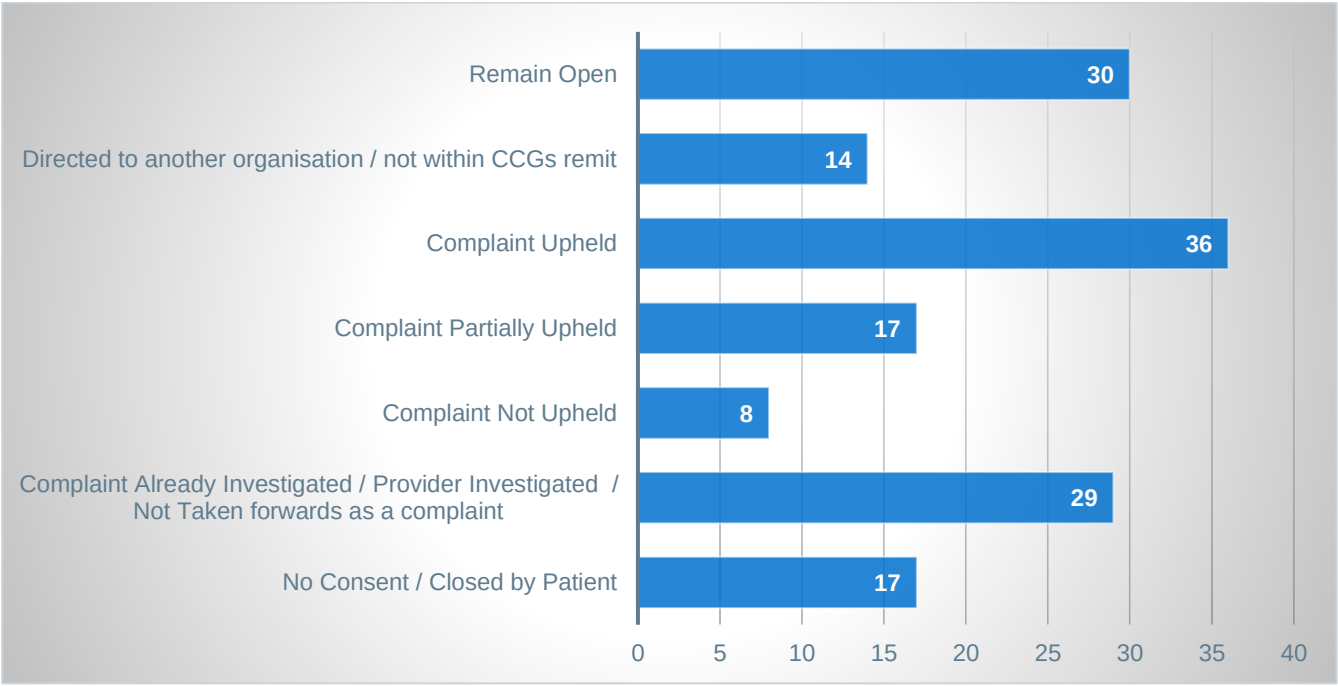


Of the complaints received, 52 related to CCG services. 17 of these related to the Individual Commissioning team and were around delays with the continuing healthcare assessment process and poor communication from the team around these delays.

15 related to medicines management, 11 of which were around the Prescription Ordering Service and getting through to the service or issues with the medication order once the order had been placed.

Of the 135 complaints received, 17 are ongoing. The graph below shows the outcomes for complaints where the process has been completed during 2021/22.

Complaint outcomes 2021/22



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 not received any requests from the PHSO for review of complaint cases during 2021/22, following them being contacted by a member of the public, and therefore the CCG did not investigate any PHSO complaint cases during this period. As there were no requests from members of the public received from the PHSO, the CCG did not have any recommendations to comply with.

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

Member of Parliament letters

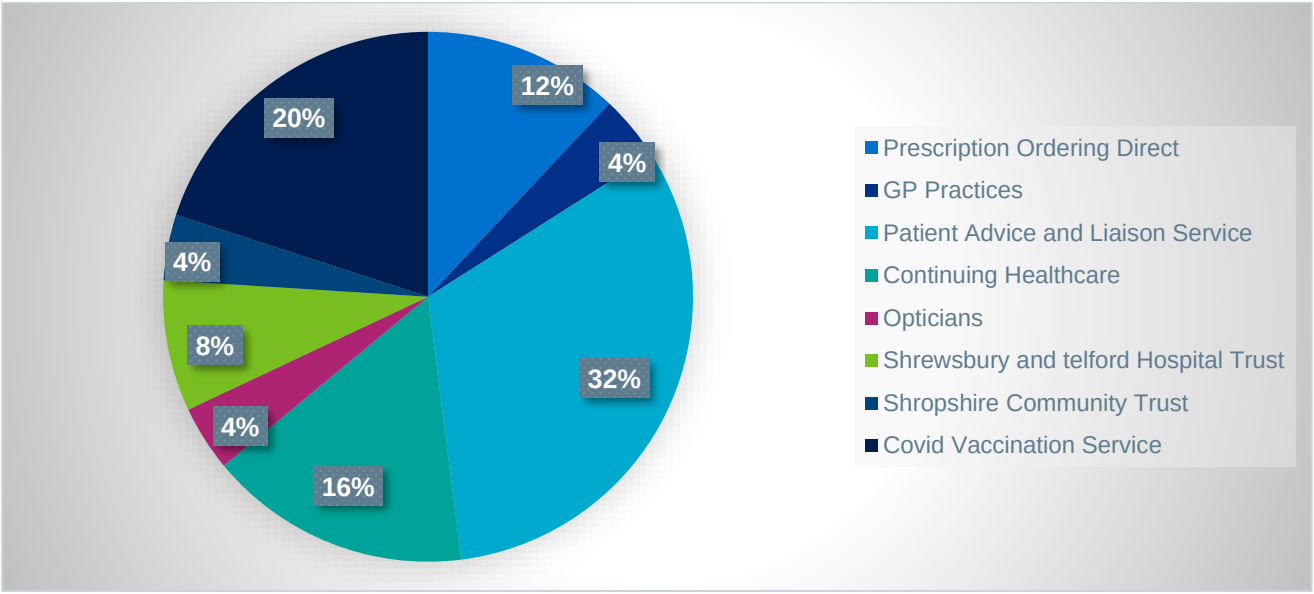
During 2021/22, the CCG received 88 letters or emails from local Members of Parliament relating to the healthcare of their constituents. 70 of these enquiries related to access to services, 22 related to COVID-19 and were mainly around accessing the vaccine, and 20 enquiries related to GP services and included getting through on the telephone, accessing appointments and changes to appointment systems due to the pandemic.

The remaining enquiries related to a variety of services and there were no other themes in relation to individual services.

Compliments

In addition to dealing with complaints, concerns and enquiries, the CCG also receives positive feedback in the form of compliments. A total of 23 compliments were received during 2021/22. The chart below highlights the services these compliments related to.

Services compliments related to 2021/22



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.

Examples of changes made following patient feedback are shown on the next page.

What we heard	What has happened
A patient contacted the service as she was struggling with rheumatoid arthritis	The CCG contacted the service that the patient had been referred to and was able to bring her appointment forward. The CCG also contacted the patient's GP and arranged for an appointment with her GP. They also sought permission to share her details with the local rheumatoid arthritis support group who agreed to contact the patient
Several concerns have been raised around trying to get through to the local phlebotomy service	This was due to changes to the service relating to COVID-19 and increased demand. In responding to these concerns, the CCG expedited a new online booking system that was originally planned for delivery later in the year
A number of enquiries were received from patients who were struggling to access their second COVID-19 vaccination	The CCG's Insight team proactively liaised with the patients' individual GP practices and the vaccination team to ensure that the patient was able to book in for their second dose
Complaint received to highlight the difficulties in accessing the Minor Eye Condition Service (MECS)	The CCG worked with the MECS to improve accessibility, particularly in relation to patient advice, triage processes and effective and timely appointment availability. They also ensured appropriate advice is provided by the hospital when referring patients to MECS, particularly out of hours, and that patients with certain conditions are aware of the referral route in the event of any exacerbation of their condition. The patient concerned was also invited to be involved in the Transformation of Ophthalmology Services programme

What we heard	What has happened
Patient complained that, due to the CCG Value Based Commissioning (VBC), it would not be possible to access laparoscopic surgery for an inguinal hernia repair	It was agreed that the patient could be offered the treatment as the VBC policy was in the process of being updated to reflect authorisation for such procedures to be undertaken laparoscopically based on clinical opinion
Concerns were raised about hospital discharge processes	The hospital apologised that their discharge processes were not followed, and that the requisite equipment was not provided to ensure safe continuity of care. In addition, the hospital has noted the need to provide a catheter pack with information about where to obtain further supplies, and will ensure that all staff adhere to the discharge checklist to avoid any future such omissions in the continuity of care

Equality, Diversity and Human Rights Report

We believe that equality and inclusion involve 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.

Following the creation of the single strategic commissioner in 2021 and moving towards the Integrated Care Board (ICB) in July 2022, we have aimed to strengthen our relationships with key stakeholders across both the Shropshire and Telford and Wrekin areas. We have in the last year developed a wide-ranging programme of engagement which enables measurable involvement and ensures that the CCG listens to the views and experiences of our population to influence commissioning decisions.

We continue to engage regularly with a multitude of key partners and stakeholders, including voluntary and community groups, as well as patient groups and both Healthwatch organisations. We have also introduced new roles to include increased capacity for continued, meaningful 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.

The following are examples of our activity to engage meaningfully with groups who make up the nine protected characteristics:

- patient representatives provided feedback on a patient letter to help manage people's expectations and provide reassurance around waiting times. Responses were collated on

tone, content and wording and the letter was subsequently amended in light of the feedback

- members from Polish communities shared that they had identified COVID-19 vaccine hesitancy through their networks. The CCG's engagement team worked to understand the nature of the hesitance and provided a video and Q&A where a local Polish GP answered questions put forward by the community
- Patient Participation Groups (PPGs) shared experiences of patients' struggling to get GP appointments during the pandemic. A meeting was facilitated between the PPGs and primary care to discuss the challenges, providing an opportunity for primary care to share the pressures faced in practices. As a result, the patient groups wrote a letter of support to practices which was shared via the Communications team
- young people aged between 18 and 29 provided feedback on the COVID-19 vaccination and where/how they access information. This feedback was collated, themed and findings shared with the vaccine programme helping to shape communications with young adults and inform the communication channels used
- similar to this work, and as part of the opportunities afforded by the new Integrated Care Board (ICB), the CCG is working to embed the county's voluntary, community and social enterprise (VCSE) sector within the ICB.

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 ICB wishes to work in partnership with the VCSE on shared ambitions and how we aim to achieve this over the coming years.

As next steps, we are now in the process of 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 CCG is also fortunate to have been able to have recruited two new Learning Disability and Autism Champions. They are working closely with local organisations to understand the challenges faced by individuals with a learning disability and/or autism and to raise awareness of the needs of this group throughout our local services.

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 10 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.

Over the course of 2021, CCG officers were asked to attend the Committee to update on the programme or scheme that they are working on, including an update on the communications and engagement strategy in place for that specific piece of work. This approach provides oversight and opportunities for the Committee to provide constructive guidance.

Over the course of 2021, the AIC 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.

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 link 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. Along with partners, the CCG has created the ICS System BAME Network for staff to come together from across various system partner organisations and raise awareness of key issues.

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

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

A total of 28 forms were returned during 2021/22, with most complainants being White British and heterosexual. However, we did receive several complaints from patients who are considered to have protected characteristics.

Historically, the complaints team has attended engagement activities to promote the complaints process to various groups in order to ensure equality of access. We hope this will be more of a possibility as we continue to move out of the coronavirus pandemic.

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

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

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

The Workplace Race Equality Standard (WRES) requires us to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive 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 recognises that unfair discrimination is unacceptable and, in this respect, has made a statement of policy on equal opportunities in employment through its Equality and Diversity Policy. This ensures that no potential or actual employee receives less favourable treatment on the grounds of age, disability, sex, sexual orientation, race, nationality, religion or belief, national or ethnic origins, gender reassignment, pregnancy or maternity, marriage or civil partnership or trade union membership.

In our policy on equal opportunities, we recognise that everyone in the organisation has a role in ensuring fairness towards people with any disability. Emphasis will be placed on the

individual's ability, rather than disability, and we will endeavour to support disabled employees and prospective employees in the workplace with reasonable adjustments.

We remain committed to ensuring that staff receive up-to-date and relevant equalities and inclusion training, which is described in the 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 covers 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 2021/22, 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 is 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

The priorities in the Shropshire Joint Health and Wellbeing Strategy 2020/21 were:

- prevention and self-care promotion
- promoting independence at home
- promoting easy-to-access and joined-up care.

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 2021/22.

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.

Joint Health and Wellbeing Strategy

At the Shropshire Health and Wellbeing Board meeting in July 2021, the draft Joint Health and Wellbeing Strategy (JHWBS) was agreed for further public and stakeholder consultation.

Between September and November 2021, feedback was gathered through a public and stakeholder online survey and through Partnership Boards, meetings and focus groups. View the report of findings.

In March 2022, Shropshire Health and Wellbeing Board approved a new 2022-27 Joint Health and Wellbeing Strategy.

Strategic priorities for 2022-27 are:

- reducing inequalities
- improving population health
- working with and building strong and vibrant communities
- joined-up working.

Key areas of focus are:

- mental health
- children and young people, including Adverse Childhood Experiences (ACEs) and Trauma
- healthy weight and physical activity
- workforce.

Other areas of focus are:

- social prescribing
- drugs and alcohol
- domestic abuse
- county lines
- smoking in pregnancy
- food poverty
- housing
- suicide prevention
- killed and seriously injured on roads
- air quality.

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.

NHS Shropshire Telford and Wrekin CCG has provided assurance to both HWBBs in regard to the work being undertaken across primary care to address public concerns around access to primary care appointments over the pandemic period in addition to updates on the work being undertaken by the Local Maternity and Neonatal programme, mental health transformation, actions to address pressures in the urgent care system and the progression of the Hospital Transformation Programme (previously known as Future Fit).

There have been regular updates with regard to the progression of the formation of the Integrated Care Board ICB which will replace the CCG in July 2022.

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 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. Questions asked relate to the nine protected characteristics.

Working with our partners across the system, 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 is 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 meet to conduct business as the CCG, this is known as the CCG Membership Forum.

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

The member practices are outlined below:

Practice name	Address
Albrighton Medical Practice	Shaw Lane, Albrighton, Wolverhampton, WV7 3DT
Alveley Medical Practice	Village Road, Alveley, Bridgnorth, WV15 6NG
The Beeches Medical Practice	1 Beeches Road, Bayston Hill, Shrewsbury, SY3 0PF
Belvidere Medical Practice	23 Belvidere Road, Shrewsbury, SY2 5LS
Bishop's Castle Medical Practice	Schoolhouse Lane, Bishop's Castle, SY9 5BP
Bridgnorth Medical Practice	Northgate Health Centre, Northgate, Bridgnorth, WV16 4EN
Broseley Medical Centre	Bridgnorth Road, Broseley, TF12 5EL
Brown Clee Medical Practice	Ditton Priors, Bridgnorth, WV16 6SS
Cambrian Surgery	Oswestry Health Centre, Thomas Savin Road, Oswestry, SY11 1GA
The Caxton Surgery	Oswald Road, Oswestry, SY11 1RD
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 discharges the day-to-day decision-making for the CCG as a whole and is made up of a number of different clinical and non-clinical professionals and lay members.

CCG Governing Body composition during 2021/22 is 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
Mrs Fiona Smith (voting) to 1 August 2021	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)
Mrs Claire Skidmore (voting) from 1 April 2021 and to 31 August 2021	Interim Accountable Officer
Mr Mark Brandreth (voting) from 1 September 2021	Interim Accountable Officer
Mrs Claire Skidmore (voting) from 1 September to 31 March 2021	Executive Director of Finance
Mrs Laura Clare (voting) from 1 April 2021 to 31 August 2021	Interim Executive Director of Finance
Mrs Zena Young (voting)	Executive Director of Nursing and Quality
Professor Steven Trenchard (voting) to 30 November 2021	Interim Executive Director of Transformation
Dr Julie Garside (voting) from 1 December 2021	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
Dr Julie Garside (non-voting) from 1 April to 30 November 2021	Director of Performance
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
Marion Kelly (non-voting) to 31 July 2021	General Manager – Healthwatch Telford and Wrekin
Barry Parnaby (non-voting) from 1 November 2021	Chair – Healthwatch Telford and Wrekin

Committee(s) including Audit Committee

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

The Composition of the Audit Committee is 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 10 incidents during 2021/22. 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 support the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis

- state whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health and Social Care have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis.

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.

Mark Brandreth
Interim Accountable Officer
NHS Shropshire, Telford and Wrekin CCG
15 June 2022

Governance Statement 2021/22

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 sets 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 1 April 2021, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

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 2021/22 has continued to see an unprecedented emergency response from the NHS to the COVID-19 global pandemic. There has been a continuing impact on the CCG, in that staff and resources have been redeployed to support frontline services and the mass COVID-19 vaccination programme. The governance processes for the CCG have, in line

with national guidance, also needed to change temporarily to fit this emergency situation. Some committees of the Governing Body and membership have stood down or are meeting 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 during 2021/22.

In addition to the response to COVID-19, in April 2021 the two previous CCGs, NHS Shropshire CCG and NHS Telford and Wrekin CCG, were dissolved to make way for NHS Shropshire, Telford and Wrekin, a new CCG across both geographical areas. As a consequence, the CCG adopted a new Constitution with a new governance structure, outlined in the following pages.

The systems have been in place for the year under review and up to the date of approval of the annual report and accounts.

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 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:

Name	Title	Medical Practice	Attendance
Tracey Wilcox	Practice Manager	Baschurch	6
Dr T W Lyttle	General Practitioner	Churchmere Medical Group	1

Dr Nick Von Hirschberg (substitute for Dr TW Lyttle)	General Practitioner	Churchmere Medical Group	1
Ms Jenny Davies	Practice Manager	Churchmere Medical Group	3
Dr A Schur	General Practitioner	Clive	6
Mrs Zoe Bishop	Practice Manager	Clive	0
Dr J Mehta	General Practitioner	Hodnet	6
Mrs Rosemary Mehta	Practice Manager	Hodnet	6
Dr J Davies	General Practitioner	Knockin	4
Mrs Mary Herbert	Practice Manager	Knockin	5
Dr Michael Matthee	General Practitioner	Market Drayton	6
Mrs Michele Matthee	Practice Manager	Market Drayton	5
Dr S Eslava	General Practitioner	Oswestry - Cambrian	0
Mr Kevin Morris (retired)	Practice Manager	Oswestry - Cambrian	1
Ms Nicola James	Practice Manager	Oswestry - Cambrian	1
Dr S Lachowicz	General Practitioner	Oswestry - Caxton	2
Mr James Bradbury	Practice Manager	Oswestry - Caxton	5
Dr Y Seenan	General Practitioner	Oswestry - Plas Ffynnon	4
Mr Nicolas Storey	Practice Manager	Oswestry - Plas Ffynnon	5
Dr A C W Clark	General Practitioner	Shawbury	2
Ms Kirsty Arkinstall	Practice Manager	Shawbury	1
Dr C Rogers	General Practitioner	Wem and Prees	6
Ms Caroline Morris	Practice Manager	Wem and Prees	5
Dr K Lewis (Chair)	General Practitioner	Westbury	6
Mrs Helen Bowkett	Practice Manager	Westbury	0

The Forum met six times in the year and a summary of the areas discussed at the Forum are outlined below:

- new maternity IT system
- respiratory service
- Macmillan project
- proxy ordering in care homes (Medicines Management)
- low risk diabetic foot screening
- NHS 111 and winter
- end of life care pathway
- new Breast Pain Community service
- cancer Strategy, pulse oximetry, outpatient transformation, two-week brain tumour pathway
- connect Pain Management Solutions – review of service provision
- phlebotomy
- mental health
- integrated care record update

- musculoskeletal (MSK) transformation
- community services
- community pharmacist consultation service
- Lantum staff bank
- end of Life Care Business Case
- pathology 'Getting it right first time' initiative for blood test requests
- SaTH referrals – learning.

Telford and Wrekin Locality Forum

Name	Title	Medical Practice	Attendance
Dr D Sharp	General Practitioner	Charlton Medical Practice	6
Anne Thorpe	Practice Manager	Charlton Medical Practice	1
Dr Teresa McDonnell	General Practitioner	Court Street	8
Maria Humphries	Practice Manager	Court Street	4
Dr H Bufton	General Practitioner	Dawley Medical Practice	7
Nicki Mott / Denise Hallett	Practice Manager	Dawley Medical Practice	7
Dr J Hudson	General Practitioner	Donnington Medical Practice	7
Angela Crompton / Bernadette McCormick	Practice Manager	Donnington Medical Practice	4
Dr R Mishra	General Practitioner	Hollinswood / Priorslee MP	9
Mala Mishra	Practice Manager	Hollinswood / Priorslee MP	0
Dr M Garland / Dr S Eli	General Practitioner	Ironbridge Medical Practice	6
Helen Lippitt	Practice Manager	Ironbridge Medical Practice	8
Dr S Waldendorf	General Practitioner	Linden Hall, Newport	7
Karen Sloan	Practice Manager	Linden Hall, Newport	4
Dr C Freeman / Dr P Coventry / Dr C Garrington / Dr P Davies/ Dr E Steedman / Dr C McDermott	General Practitioner	Shawbirch Medical Practice	7
Ruth Waldendorf	Practice Manager	Shawbirch Medical Practice	8
Dr M Innes / Dr N Gureja	General Practitioner	Stirchley Medical Practice	9
Tracie Craddock	Practice Manager	Stirchley Medical Practice	9
Dr I Chan (Chair)	General Practitioner	Teldoc	8
Dr D Ebenezer / Dr N Singh	General Practitioner	Wellington Medical Practice	2

Dr K Douglas	General Practitioner	Wellington Road, Newport	7
Lynn Kupiec	Practice Manager	Wellington Road, Newport	4
Dr M Thompson	General Practitioner	Woodside Medical Practice	9
Teresa Beasley	Practice Manager	Woodside Medical Practice	5
Poonam Mehta	General Practitioner	Ironbridge Medical Practice	1
Dr A Pringle	General Practitioner	Lawley Medical Practice	2
Anna Rogers	Practice Manager	Ironbridge Medical Practice	4
Charlotte Garrington	General Practitioner	Shawbirch Medical Practice	1
Jason Shelley	Practice Manager	Donnington Medical Practice	3
Jane Hope	Deputy Practice Manager	Donnington Medical Practice	1

The Forum met nine times in the year. A summary of the areas discussed at the Forum are outlined below:

- update on CCG matters
- GP Practice Forum Chair's update
- practice managers' update
- mental Health service update
- COVID-19 and vaccinations update
- sexual health services
- locality meetings – ICR
- West Midlands upper GI EAG recommended two-week wait form
- MSK transformation
- Macmillan project
- diabetic foot screening
- phlebotomy
- primary care breast pain clinic
- community diagnostic hubs
- utilisation of NHS 111 direct booking slots
- summary care records update
- primary care blood test requests
- new sexual health service contract
- maternity mental health
- breast pain community clinic and Cancer Strategy update
- primary care role in the ICS
- CCG/ICS/ICB update
- primary care representation at ICS/ICB
- agreement on two-week wait proforma
- new pathway for referrals into urology
- agreement on the future of locality meetings
- asthma – personalised care for children and young people
- community service update.

The Shrewsbury and Atcham Locality Forum

Name	Title	Medical Practice	Attendance
Dr B Teelucksingh	General Practitioner	Belvidere	4
Ms Caroline Davis	Practice Manager	Belvidere	3
Dr M Fallon	General Practitioner	Claremont Bank	2
Ms Jane Read	Practice Manager	Claremont Bank	5
Dr E Baines (Chair)	General Practitioner	Marden	5
Mrs Zoe George	Practice Manager	Marden	6
Dr J Visick	General Practitioner	Marysville	1
Mrs Izzy Culliss	Practice Manager	Marysville	6
Dr S Watton	General Practitioner	Mytton Oak	2
Ms Susan Lewis (up to September 2021)	Practice Manager	Mytton Oak	3 of 3
Vacancy	Practice Manager	Mytton Oak	0
Dr A Adams	General Practitioner	Pontesbury and Worthen	4
Ms Annie Hill (up to September 2021)	Practice Manager	Pontesbury and Worthen	3 of 3
Mr T Bellett (up to September 2021)	Practice Manager	Pontesbury and Worthen	3 of 3
Dr C Hart	General Practitioner	Radbrook Green	3
Dr H Bale	General Practitioner	Radbrook Green	2
Dr Benjamin Roberts	General Practitioner	Radbrook Green	4
Ms Angela Treherne	Practice Manager	Radbrook Green	4
Dr P Rwezaura	General Practitioner	Riverside	4
Ms Amanda Lloyd	Practice Manager	Riverside	4
Dr D Martin	General Practitioner	Severn Fields	0
Ms S Griffiths	Practice Manager	Severn Fields	5
Dr L Davis	General Practitioner	South Hermitage	2
Mrs Caroline Brown	Practice Manager	South Hermitage	6
Dr E Jutsum	General Practitioner	The Beeches, Bayston Hill	3
Ms N Perks	Practice Manager	The Beeches, Bayston Hill	1

The Forum met six times in the year. A summary of the areas discussed at the Forum are outlined below:

- Chair update
- partnerships update
- mental health update
- respiratory update
- integrated care records
- phlebotomy
- end of life care pathway
- macmillan project
- outpatient transformation programme
- diabetic foot screening and phlebotomy

- new Breast Pain Community Service
- Community Pharmacy Consultation Scheme
- Shrewsbury Rapid Response team
- CCG/ICS/ICB update
- Integrated Cancer Strategy
- end of life care.

The South Shropshire Locality Forum

Name	Title	Medical Practice	Attendance
Dr Matthew Bird (Chair)	General Practitioner	Albrighton	6
Ms Val Eastup	Practice Manager	Albrighton	6
Dr D Abbotts	General Practitioner	Alveley	0
Mrs Lindsey Clark/Theresa Dolman	Practice Manager	Alveley	3
Dr A Penney / Dr P Gardner	General Practitioner	Bishops Castle	2
Ms Sarah Bevan/Thomas Davies	Practice Manager	Bishops Castle	1
Dr G Potter	General Practitioner	Bridgnorth	5
Ms Dude Newell (started attending March 2021)	Practice Manager	Bridgnorth	5
Dr M Babu	General Practitioner	Broseley	4
Ms Nina Wakenell	Practice Manager	Broseley	6
Dr W Bassett	General Practitioner	Brown Clee	1
Ms Vicki Brassington	Practice Manager	Brown Clee	0
Dr A Chamberlain	General Practitioner	Church Stretton	3
Ms Emma Kay	Practice Manager	Church Stretton	5
Dr P Thompson	General Practitioner	Cleobury Mortimer	5
Mr Mark Dodds/Cate Tolley	Practice Manager	Cleobury Mortimer	5
Dr J Bennett	General Practitioner	Clun	3
Mr Peter Allen	Practice Manager	Clun	1
Dr D Appleby / Dr M Carter	General Practitioner	Craven Arms	2
Mrs Susan Mellor-Palmer	Practice Manager	Craven Arms	6
Dr S Allen	General Practitioner	Highley	2
Mr S Consul	Practice Manager	Highley	3
Dr C Beanland / Dr C Targett	General Practitioner	Ludlow – Portcullis	5
Mrs Rachel Shields	Practice Manager	Ludlow – Portcullis	5

Dr G Cook	General Practitioner	Ludlow – Station Drive	0
Ms Jodie Billinge	Practice Manager	Ludlow – Station Drive	2
Dr J Wentel	General Practitioner	Much Wenlock and Cressage	2
Mrs Sarah Hope / Ms M Jones	Practice Manager	Much Wenlock and Cressage	4
Dr R Shore / Dr P Leigh	General Practitioner	Shifnal and Priorslee	3
Ms Hayley Breese	Practice Manager	Shifnal and Priorslee	0

The Forum met six times in the year. A summary of the areas discussed at the Forum are outlined below:

- CCG Chair report
- locality Chair update
- partnership update
- breast Pain Community Service
- MSK update
- integrated Cancer Strategy 2021-26
- low-risk diabetic foot screening
- medicines management.

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 seven times during the year in total. The names of members and their attendance are listed below:

Governing Body members up to 31 March 2022	Board Role	Meetings attended during 2021/22
Dr John Pepper (voting)	GP Chair	7
Dr Mike Matthee (voting)	GP/Healthcare Professional Member	7
Mrs Rachael Bryceland (voting)	GP/Healthcare Professional Member	7
Mrs Fiona Smith (voting) to 1 August 2021	GP/Healthcare Professional Member	1 of 2
Dr Mary Ilesanmi (voting)	GP/Healthcare Professional Member	6

Dr Adam Pringle (voting)	GP/Healthcare Professional Member	7
Dr Martin Allen (voting)	Secondary Doctor Member	6
Mrs Audrey Warren (voting)	Independent Nurse Member	7
Mr Geoff Braden (voting)	Lay Member – Governance	7
Mr Meredith Vivian (voting)	Lay Member – Patient Public Involvement (PPI)	7
Mrs Donna McArthur (voting)	Lay Member – Primary Care	7
Mr Ash Ahmed	Lay Member – Patient Public Involvement (PPI) – Equality, Diversity and Inclusion (EDI)	7
Mrs Claire Skidmore (voting) from 1 April 2021 and to 31 August 2021	Interim Accountable Officer	2 of 2
Mr Mark Brandreth (voting) from 1 September 2021	Interim Accountable Officer	5 of 5
Mrs Claire Skidmore (voting) from 1 September to 31 March 2021	Executive Director of Finance	5 of 5
Mrs Laura Clare (voting) from 1 April 2021 to 31 August 2021	Interim Executive Director of Finance	2 of 2
Mrs Zena Young (voting)	Executive Director of Nursing and Quality	6
Professor Steven Trenchard (voting) to 30 November 2021	Interim Executive Director of Transformation	5
Dr Julie Garside (voting) from 1 December 2021	Director of Performance responsible for the Executive Director of Transformation portfolio	3 of 3
Ms Claire Parker (non-voting)	Director of Partnerships	6
Miss Alison Smith (non-voting)	Director of Corporate Affairs	6
Dr Julie Garside (non-voting) from 1 April to 30 November 2021	Director of Performance	4 of 4
Mrs Sam Tilley (non-voting)	Director of Planning	7
Dr Deborah Shepherd (non-voting)	Medical Director	5
Dr Stephen James (non-voting)	Interim Chief Clinical Information Officer	7
Rachel Robinson (non-voting)	Director of Public Health for Shropshire Council	5
Liz Noakes (non-voting)	Director of Public Health for Telford and Wrekin Council	5
Lynn Cawley (non-voting)	Chief Officer – Healthwatch Shropshire	7
Marion Kelly (non-voting) to 31 July 2021	General Manager – Healthwatch Telford and Wrekin	2 of 3
Barry Parnaby (non-voting) from 1 November 2021	Chair – Healthwatch Telford and Wrekin	4 of 4

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 eight times during 2021/22, which is included in the attendance table below.

Audit Committee members	Meetings attended during 2021/22
Mr Geoff Braden – Lay Member for Governance (Chair)	8
Mr Meredith Vivian – Lay Member PPI	6
Mrs Donna MacArthur – Lay Member Primary Care	7
Mr Ash Ahmed – Lay Member PPI – EDI	6

The major areas of focus for the Committee have been:

- focus on managing and mitigating the key risks held in Board Assurance Framework and Directorate Risk Registers against a backdrop of COVID-19
- needing to ensure that actions are concluded on key areas identified by Audit committee workplan to given Board assurance including areas such as Internal Audit, for example safeguarding
- oversight of due diligence of transition from NHS Shropshire, Telford and Wrekin CCG to Integrated Care Board.

Throughout the year, the Committee has received regular reports on the following:

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

Remuneration Committee

The Remuneration Committee recommends to the Board appropriate salaries, payments and terms and conditions of employment. The Remuneration Committee has met five times as required during 2021/22.

Remuneration Committee members up to 1 August 2020	Meetings attended during 2021/22
Mrs Donna MacArthur – Lay Member Primary Care (Chair)	5
Mr Meredith Vivian – Lay Member PPI	5
Mr Ash Ahmed – Lay Member PPI – EDI	3

The major areas of focus for the Committee have been

- implementation of national guidance in relation to pay awards. This included enacting the pay freeze in 2021/22 for CCG staff engaged as Very Senior Managers as notified to the CCG by the Cabinet Office
- 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.

Throughout the year, the Committee has received regular reports on:

- review and recommendation on remuneration policies
- review of return and retire business cases
- review of performance related remuneration for Very Senior Managers (VSM) and policy development.

Quality and Performance Committee

The QPC Committee oversees and provides assurance on performance and quality of commissioned services. The committee met 10 times during the year. The Committee continued to meet during COVID-19 as its planned schedule but had a reduced agenda focussing on key areas of quality and performance.

Quality and Performance Committee members	Meetings attended during 2021/22
Mr Meredith Vivian – Lay Member PPI (Chair)	10
Mrs Audrey Warren – Registered Nurse	9
Mrs Rachael Bryceland – GP/Healthcare Professional	9
Dr Martin Allen – Secondary Care Doctor	8

The major areas of focus for the Committee have been:

- seeking assurance that the CQC inspection reports and imposed actions, relating to The Shrewsbury and Telford Hospital NHS Trust (SaTH), have been robustly addressed with a focus on learning and service improvement. The Committee has received regular

reports from the SaTH Safety and Oversight Assurance Group (SOAG) to provide detailed assurance
- regular examination of reports of current provision of maternity services with reports being received from the Local Maternity and Neonatal System Committee (LMNS). It has been noted throughout the year that there has been a significant shortfall in availability of workforce across the maternity system
- the partnership arrangements, training and monitoring undertaken to safeguard children and looked-after children have been scrutinised with particular attention as the numbers of children at risk, and the nature of risk, have been exacerbated by the pandemic
- arrangements for training, monitoring and assurance of infection prevention and control have been reported regularly to the Committee to provide certainty that the increased pressure in this area, brought about by the pandemic, has been appropriately responded to across the system.

Throughout the year, the Committee has also received regular reports on:

- Quality and Performance Exception Reports for all system providers
- Patient Experience Insight Reports, covering information on complaints, feedback through PALS, from MPs, and other data sources
- Adult safeguarding reports
- Special Educational Needs and Autism (SEND) updates
- Individual Commissioning (including Continuing Healthcare) updates
- Quarterly harms reports
- Serious incidents updates
- Quarterly Primary Care Quality Reports
- Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) updates
- Learning disabilities and autism updates with a focus on annual health checks in primary care
- Healthwatch updates
- Policies and information for approval.

Finance Committee

The Finance Committee oversees and provides assurance on the financial delivery of commissioned services. The committee met 11 times during 2021/22 which included one informal meeting.

The Committee continued to meet during COVID-19 as its planned schedule but had a reduced agenda focussing on key areas of financial assurance.

Finance Committee members	Meetings attended during 2021/22
Mr Geoff Braden – Lay Member Governance (Chair)	11
Mr Ash Ahmed – Lay Member PPI – EDI	9
Dr John Pepper – GP Chair	7
Dr Mike Matthee – GP / Healthcare Professional	11
Dr Martin Allen – Secondary Care Doctor	10

The major areas of focus for the Committee have been:

- financial performance for 2021/22 and the focus on the key risks and opportunities
- value for money, progress with 2021/22 plans and programmes
- impact of COVID-19 and the wider health economy pressures on financial performance of the CCG.

Throughout the year, the Committee has also received regular reports on:

- 2021/22 Finance Plan and 2022/23 Finance Plan
- Value for Money / QIPP Plan including from the Sustainability Working Group
- Board Assurance Framework and Directorate Risk Register
- CCG Monthly Finance Report – months 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11
- Elective Recovery Fund
- ICB Transition – Finance – Due diligence process.

The Strategic Commissioning Committee

The Strategic Commissioning Committee oversees and provides assurance on the commissioning of services. The Committee has met 11 times during 2021/22 which is included in the attendance table below.

Strategic Commissioning Committee members	Meetings attended during 2021/22
Mrs Audrey Warren – Registered Nurse (Chair)	9
Mr Ash Ahmed – Lay Member PPI – EDI	9
Mrs Donna MacArthur – Lay Member Primary Care	9
Dr John Pepper – GP/Healthcare Professional from 1 September 2021	8 of 10
Mrs Fiona Smith – GP/Healthcare Professional to 1 August 2021	2 of 4
Mr Mary Ilesanmi – GP/Healthcare Professional	10

The major areas of focus for the Committee have been:

- Flash glucose monitoring system update – associated with improved diabetes control and an audit has demonstrated improved outcomes in HbA1C and reductions in test strip and lancet usage which in turn have led to cost savings. Policy to reflect the single commissioning organisation on the use of flash glucose monitoring systems was approved in January 2022
- Outpatients parenteral antibiotics therapy (OPAT) – the Committee approved a Project Initiation Document (PID) and supported the ongoing development of a detailed business case for the design of a system-wide OPAT service. The service would provide a way of ensuring safe and cost-effective delivery of intravenous antibiotics which would promote avoidance of hospital admission and facilitate early discharge
- Single Point of Access (SPA) – the service aim was to increase the number of referrals from unplanned care back to a managed process, reducing the footfall on the emergency department, improve quality of care and patient experience. Initial data and findings

showed an increase in the use of alternatives pathways for patients which resulted in an extension of the SPA for a further 12 months.

Throughout the year the Committee has also received regular reports on:

- IVF Policy
- enhanced health in care homes and community support
- elective care
- Board Assurance Framework and Directorate Risk Register
- local care transformation
- medicines management
- ADHD
- dementia care
- Flash glucose monitoring
- integrated urgent care out of hours.

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 bi-monthly as scheduled during 2021/22 and some additional extraordinary meetings have been convened mainly to consider time-critical estates issues.

Primary Care Commissioning Committee members	Meetings attended during 2021/22
Mrs Donna MacArthur – Lay Member Primary Care (Chair)	8
Mr Meredith Vivian – Lay Member PPI	8
Dr Andy Watts – Independent GP to 31 December 2021	5 of 6
Mrs Claire Skidmore – Interim Accountable Officer from 1 April 2021 to 31 August 2021	2 of 4
Mr Mark Brandreth – Interim Accountable Officer from 1 September 2021	1 of 4
Mrs Claire Skidmore – Executive Director Finance from 1 September 2021 to 31 March 2022	2 of 4
Mrs Laura Clare – Interim Executive Director for Finance from 1 April 2021 to 31 August 2021	3 of 4
Mrs Zena Young – Executive Director of Nursing and Quality	7
Professor Steve Trenchard – Executive Director Transformation to 30 November 2021	2 of 5
Claire Parker – Director of Partnerships	7
Dr Julie Garside – Director of Planning with responsibility for the Transformation portfolio from 1 December 2021	3 of 3

The major areas of focus for the Committee have been:

- comprehensive review of primary care estates issues including support for the Shifnal business case
- quality visits review
- support for the General Practice Nursing Strategy
- review of the Primary Care Training Hub.

Throughout the year, the Committee has also received regular reports on:

- quality performance
- bi-monthly scrutiny of primary care budgets and financial commitments
- review of the GP patient survey results for 2020/21 with recommendations and a plan for support to individual practices
- updates and review of CQC practice ratings and inspections with discussions of support to be offered to practices as required
- review of practice performance on completing annual health checks
- estates
- primary care workforce
- Winter Access Funding review and review of patient access issues
- reviewing the primary care risk registers
- updating on Primary Care Network (PCN) development.

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 met five times during the year 2021/22.

IFR stage one screening panel members	Meetings attended during 2021/22
Gabriel Agboado – Consultant in Public Health Medicine	5
Michele Rowland-Jones – Senior Pharmaceutical Advisor	5

Between 1 April 2021 and 31 March 2022, 10 cases were taken to the IFR stage one panel for consideration and zero cases were passed to a stage two Individual Funding Committee. Therefore no reviews took place and no decisions were made.

Individual Funding Committee members (stage two)	Meetings attended during 2021/22
Barrie Reis-Seymour – Head of Transformation and System Commissioning – Elective Care	0
Tracey Jones – Deputy Director of Partnerships	0
Deborah Shepherd – GP	0
Kay Holland – Deputy Director Contracting	0

Meryl Flaherty – Contracts Business Partner	0
Gordon Kochane – Public Health Consultant	0
Francis Sutherland – Head of Transformation and Commissioning – Mental Health, Learning Disabilities and Autism	0
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 2021 and 31 March 2022, zero cases were taken to the IFR stage three (appeal) review panel for consideration.

IFR stage three review panel members	Meetings attended during 2021/22
Dr John Pepper – GP	0
Zena Young – Executive Director of Nursing and Quality	0

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 six times during the year.

Assuring Involvement Committee members	Meetings attended during 2021/22
Mr John Wardle (Chair)	6
Mr Ash Ahmed – Lay Member PPI – EDI	5
Mr Meredith Vivian – Lay Member PPI	6
Mrs Beverley Ashton – Assuring Involvement Committee Member	6
Mr Karl Bailey – Assuring Involvement Committee Member	5
Mrs Sherrel Fikeis – Assuring Involvement Committee Member	3
Mrs Valerie Graham – Assuring Involvement Committee Member	4
Mrs Rosemary Hooper – Vice Chair and Assuring Involvement Committee Member	2
Mrs Jackie Jones – Assuring Involvement Committee Member	5
Mr Patrick Spreadbury – Assuring Involvement Committee Member	6
Mrs Dawn Yapp-Altinsoy – Assuring Involvement Committee Member	5

The major areas of focus for the Committee have been:

- focus on the planned communications and engagement supporting the development of the Shrewsbury Health and wellbeing Hub has been significant over the year as this is a

key primary care development which will affect a number of practices and patients in Shrewsbury
- communications and engagement plan for the forthcoming five-year transformation of MSK services is also a key strategic development for the Shropshire, Telford and Wrekin system and which has attracted significant amount of public interest.

Throughout the year, the Committee has also received regular reports on:

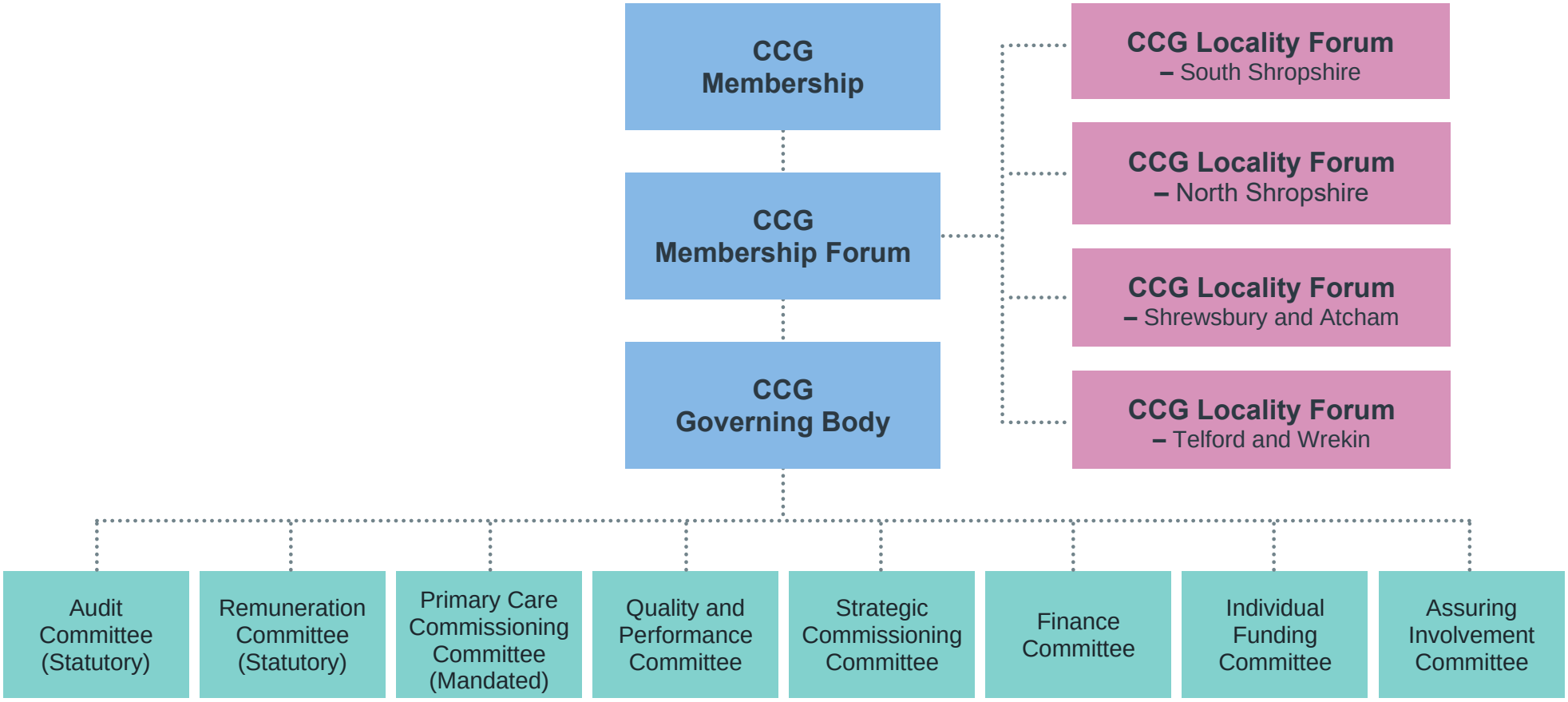
- communications and engagement related to the planned development of the Shrewsbury Health and Wellbeing Hub
- recruitment of patient representatives to steering and project groups
- communications and engagement related to the refresh of the Integrated Cancer Strategy for 2021-26
- communications and engagement related to the revision of the Dementia Vision (recommenced in 2021 following delays due to COVID-19) and three-year model for delivery
- communications and engagement plan for the forthcoming five-year transformation of MSK services which had been paused during the pandemic
- involvement in the review and redesign of the High Intensity Users Service planned for implementation in spring 2022
- engagement to date in the review of end of life care
- engagement plan for proposed changes to The Shrewsbury and Telford Hospital NHS Trust Renal Dialysis services provided at Princess Royal Hospital
- engagement to date re temporary changes to The Shrewsbury and Telford Hospital NHS Trust cardiology inpatient services in early 2022
- development of the new ICS Involvement Strategy for People and Communities
- communications and engagement plan for the Eye-Care Transformation programme launched in February 2022
- plans for a Healthier Minds engagement event in Telford in May 2022 focussed on local BAME communities and intended to raise awareness of mental health services and broader community-based support.

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 2021/22. The outcomes of these are 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 2021/22 on the Board Assurance Framework to assist it in navigating a very challenging environment and conserving valuable staff resources.

The CCG received a level 'A' assessment from its Internal Auditors which reflects that an Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement, and provides reasonable assurance that there is an effective system of internal control in place to manage the principal risks identified by the organisation.

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 are being action in quarter 1 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, IG 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 principle 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 year 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 2021/22	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.	1. Interim Communications and Engagement Strategy for STW CCG approved by Governing Body. 2. Communications and Engagement teams working jointly across CCG, ICS and providers providing more capacity and expertise in planning and delivery. 3. Reports to governing bodies/committees require section completing on Patient involvement. 4. Substantive ICS Director of Communications and Engagement now appointed and overseeing both ICS and CCG functions. 5. Presence of Healthwatch for both areas at Governing Body meetings and Quality and Performance Committee. 6. 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. 7. Assuring Involvement Committee in place as part of CCG Governance. 8. Communications and Engagement teams are working jointly across the CCG, ICS and system partners	1. The Interim Director and Assistant Director have established processes with their new-look team and are now developing a forward plan of activity. 2. Directors of Communications and Engagement and Corporate Governance will seek clarify where the Assuring Involvement Committee function will sit in ICB March 2022.

	providing more capacity and expertise in planning and delivery. 9. 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.	1. Governing Body members taking lead roles in ICS governance and delivery functions. 2. CCG Directors have dual roles with CCG and ICS. 3. Joint CCG/ICS management team meetings. 4. Transition steering group meetings taking place ICS Director, ICS Workforce, CCG Director of Corporate Affairs. 5. ICS has been authorised by NHS England and NHS Improvement. 6. Project lead identified by ICS. 7. National guidance has now been released. 8. ICS and CCG have now appointed an interim CEO for ICS. 9. Transition group overseeing transition plan and due diligence via fortnightly meetings. 10. Work is being shared between ICS/CCG and providers, with key leads being identified 11. CS Transition Group involves CCG Executive Director for Finance, Executive Director for Quality and Nursing, Director of Partnerships and Director of Corporate Affairs. 12. Transition Plan in place with PMO support. 13. Due Diligence plan approved and work is ongoing with identified PMO lead.	1. Guidance on model constitution and place and ICB structures has been released and ICB is leading more work on place-based arrangement for 1 July 2022.
3. CCG workforce capacity There is a risk that due to the number of secondments, staff	1. Work has been done to ensure that there a no duplication between the CCG and ICB meetings. 2. A reduced rhythm of CCG governance meetings has been	1. Capacity issues in directorates to be captured in the Directorate Risk Register.

vacancies, recruitment freeze and staff sickness levels that the capacity, capability and resilience of our workforce is unable to meet the demands of ongoing requirements.	agreed with the CCG Governing Body. 3. HR are collecting information on secondments/temporary staffing as part of due diligence process. 4. Effective prioritisation of workload to system Big 6 priorities and other quality and safety priorities is ongoing. 5. CCG is participating in collective mutual aid with system to support level 4 incident management Jan - Mar 2022 through an internal coordination overseen by Executive Director of Quality and Director of Corporate Affairs. December 2021 to March 2022.	
4. Financial sustainability There is a risk of failure to deliver the CCG element of the system financial sustainability plan.	1. Detailed year-to-date and forecasting information provided at both organisation and system level. 2. Regular CCG budget holder meetings and budget holder training programme in place. 3. PMO function set up within Finance directorate to help leads to develop efficiency programme and accurately monitor progress and delivery.	Controls: 1. Sustainability working group action plan agreed in January 2022 and actions being monitored through the group and reported to Finance Committee. 2. Progress on development of efficiency programmes across organisations to be reported through to the Integrated Delivery Board. 3. Risk score following mitigation increased to reflect lack of progress with efficiency programme. 4. Staff resource mapping to internal and system plans ongoing – gaps identified and

		added to Directorate and system risk registers (JD November 2021). 5. CCG Executive Director of Finance part of regional discussions regarding recurrent funding solutions for West Midlands Ambulance Service pressures. Assurance: 1. Business case documentation has been requested from all leads by the end of February. (Efficiency programme leads February 2022).
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 and NHS Improvement approval. As well as delivering the CCG element of the	1. Risk management framework in place across the system as part of development of system sustainability plan. 2. System governance arrangements in place through sustainability committee and investment panel to ensure that new investments are not made unless recurrent resource is available.	1. Significant work underway across system to model long-term plan. Modelling task and finish group assembled and reviewing system wide financial model available from NHS England and NHS Improvement. Future years of plan presented to the system in September – including a 10-year plan showing agreed high level assumptions. This was supported by system partners.

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.		2022/23 plan now to be further refined following release of the planning guidance. ICS prioritisation session took place on 23 February 2022 to confirm system priorities and provide focus to financial, workforce and capacity modelling. Sustainability committee on 28 February 2022 to collectively review and agree the 2022/23 financial plan position, this will include delivery of Big 6 transformational projects. (CS February 2022) 2. System-wide development of Big 6 underway with SRO assigned to each, further work on modelling underway to align to system financial plan. Progress Review planned for February IDB meeting, focus on mobilisation plans. (Cherry West February 2022). 3. System risk management framework shared with sustainability committee and system CEOs in September 2021.

		Refinement ongoing to ensure non-financial risk is adequately captured. (CS February 2022).
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.	1. Development of an ICS Quality and Safety Strategy, co-produced with system health and social care partners and patient representative groups. Approved by ICS Board June 2021. 2. Establishment of our ICS governance structure including Quality and Safety Committee (a sub-committee of the ICS Board) and System Quality Group (SQG) which provides quality surveillance and improvement. 3. STW LMNS function is developing to encompass the new responsibilities for Perinatal Quality Surveillance Group (PNQSG) and Terms of Reference and risk register have been revised in light of this requirement. 4. SaTH Safety Oversight and Assurance Group (SOAG) in place, co-chaired by NHSE/ICS lead and with system membership. 5. Serious incident (SI) reporting in accordance with NHS SI Framework, monthly SI review meetings between commissioner and provider in place. 6. Patient Safety Group in place with remit to ensure the NHS Patient Safety strategy is delivered across system. 7. System-wide IPC forum in place providing oversight and peer support. 8. Vaccination quality governance forum in place to oversee COVID-19 delivery programme. 9. CCG/ICS quality and safety monitoring and reporting	1. Further develop and embed the system-wide revised approach to quality governance during 2021/22, including quality governance at ‘place'. Identify senior resource (DDoN) to lead this work. (quarter 3). 2. Continue to monitor quality risks and workforce plans at provider level through existing mechanisms including a presence at SaTH internal quality governance fora. (Note: Workforce reported to ICS People Board which has agreed key priority areas for action). (Ongoing). 3. Maintain a schedule of quality assurance visits, with triangulation of data from a variety of sources, including increased inclusion of patient experience elements. (Ongoing).

	arrangements will run in parallel during 2021/22.	4. SaTH undertaking a programme of Quality Improvement with UHB as their Improvement Alliance partner – Getting to Good Programme – reported monthly to SOAG for oversight and scrutiny. SOAG is co-chaired by ICS and NHS England and NHS Improvement directors. 5. Further develop the maternity metrics dashboard at LMNS level. (November 2021). 6. Negotiate access to SaTH real-time (unvalidated) data submissions to MBRRACE-UK. (October 2021). 7. Support to SaTH to further develop the content and accuracy of their internal maternity dashboard and improve exception reporting. (October 2021). 8. SaTH implementing the Badgernet electronic maternity records system from in a phased roll out programme which over time will improve

		confidence in audit information. (August 2021 onwards). 9. CCG Quality Lead to join SaTH Maternity Safety Champion programme of clinical quality assurance. (October 2021). 10. Continue to monitor Maternity service closure and impact, ensuring appropriate escalation process are followed in each occurrence. (Ongoing). 11. Targeted quality improvement work relating to CYP MH. (Ongoing). 12. Oversight of Safeguarding and LAC risks via system safeguarding assurance mechanisms. (Ongoing). 13. Continue to monitor looked after children (LAC) standards (which are improving), supporting with revised referral processes. (Ongoing). 14. Implement recommendations of CCG internal audit of Safeguarding Adult

		and Child processes. (October 2021). 15. Implement new statutory requirements for Liberty Protection Safeguards when national timelines and details are published. (Governing Body development event October 2021). 16. Review CCG Quality team staffing plans as part of budget setting (quarter 4 2021/22).
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.	1. Demand and Capacity Modelling. 2. System Clinical prioritisation and approach to harm policy in place. 3. Big 6 ticket items. 4. Development of digital and virtual capabilities. 5. Developing system infrastructure. 6. H1 Plan. 7. People Plan and workforce planning.	1. Elective Recovery trajectories set out in H1 plan. Big 6 items addressing key elements of sustainability and transformation. 2. Demand and capacity and performance monitoring ongoing to track progress and allow for early mitigation if deviation from plan is evident. 3. Work ongoing on implementation of People Plan. 4. Ongoing dialogue with NHSE regarding equipment and estate.
8. Population Health Needs There is a risk that the	1. Inequalities sits within the portfolio for Director of Planning and Partnerships.	1. First phase review of capacity and capacity completed. Analyst

CCG fails to understand its population health needs and how this contributes to health inequalities across the footprint resulting in widening health inequalities.	2. Population Health Management sits within the portfolio of the Director of Planning. 3. JSNA work led by councils.	network in place to support sharing skills and expertise and supporting a system approach. Two PHM posts (joint with local authorities) recruited to. 2. Refresh of Public Health Strategy required to ensure system BI capacity is wrapping around the correct priorities. 3. PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. Need for appropriate data sharing arrangements to be finalised to support this work. 4. Further momentum needed in relation to digital developments. 5. Engagement strategies being developed with the Shropshire Care Closer to Home (SCCtH) and Telford and Wrekin Integrated Place Partnership (TWIPP) boards. Joint posts with local authority to develop partnership and place-based working to deliver

		the needs of the population. 6. PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. 7. 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.	1. Robust safeguarding governance infrastructures for the two system local authorities, which is well attended by all statutory partners. 2. Regional safeguarding governance infrastructure which is well attended by CCG. 3. Experienced team members and good professional links between providers and commissioners of services across Shropshire, Telford and Wrekin.	1. Maintain attendance of designated and named professionals at safeguarding and LAC governance fora. 2. Continue to triangulate information and outcomes and address areas of concern. 3. Continue to undertake quality assurance visits. 4. Scope out development of a proactive/reactive support offer to CYP care homes with system partners. 5. Continue to support commissioners and providers in implementing new models of care.
10. Risk of sustained urgent and emergency care (UEC) pressure	1. Daily Silver Call. 2. Weekly Gold Call. 3. UEC Improvement Plan in place.	1. Several improvement workstreams in place but capacity to deliver change

There is a risk that demand for urgent and emergency care consistently outstrips capacity and that this will result in patients suffering harm.		has been limited due to the level of system pressure. There are signs that this is now beginning to ease. 2. Learning from our current UEC Improvement Plan and the approach to recent pressures needs to be consolidated and mapped into the current re-drafting of our UEC Plan from April 2022. 3. Significant collaboration between partners agencies, including our local authorities in addressing current pressures has shown benefits. 4. Winter Communications Plan in place, Winter Plan and specific winter schemes in place. 5. CCG UEC staffing resource structure developed and requires further discussion at Exec level regarding potential to implement. 6. Specific development in place regarding discharge and attendance avoidance.

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 year 2021/22 and up to the date of approval of the Annual Report and accounts.

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

Our Risk Management 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 and the audit provided moderate assurance, with some recommendations for further action. The key areas that required management action were to:

- ensure that up to date declarations are held for the remaining Governing Body members, senior management team and practice members
- address the shortfalls in Conflicts of Interest Module 1 mandatory training.

All recommendations have been fully accepted by the CCG and mandatory training is due to be up to date by 30 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 have been escalated.

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

Data quality

The Board relies on the data quality elements in its contracts with providers that requires them to quality assure their data prior to submission. The CCG also uses NHS Midlands and Lancashire Commissioning Support Unit (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 2021/22 and submitted by the end of March 2022, ahead of the 30 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 10 incidents during 2021/22 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.

There have been no limited findings from this year's reports which would require remedial action.

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 year 2021/22. 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 have materialised during 2021/22 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 and NHS Improvement System Oversight Framework. The system and CCG is therefore subject to significant scrutiny around finances and financial decisions. In 2021/22 the CCG (and the wider system) is reporting a deficit against the NHS England and NHS Improvement 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 and NHS Improvement 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.

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.

3. Urgent and emergency care

Urgent and emergency care remains very challenged and does 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 have now been set with the provider 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, continues 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 contract value was £80k, excluding VAT. The contract included 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 Protect in order to combat economic crime within the NHS. The CCG complies with the NHS Protect 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.

Head of Internal Audit (HOIA) Opinion

This opinion should be taken in its entirety for the Annual Governance Statement and any other purposes for which it is repeated. The purpose of my Head of Internal Audit Opinion (HOIAO) 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.

The HOIAO informs the Governing Body in the completion of its Annual Governance Statement. I have set out a summary of my opinion below with detailed supporting information below.

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

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

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

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

The design and operation of the Assurance Framework and associated processes

I have reviewed the overall arrangements the Governing Body has in place to conduct its review of the system of internal control. This has entailed reviewing the way in which the Governing Body has identified the principal risks to achieving its objectives, the identification of controls in operation to mitigate against these risks and the degree to which the organisation has received assurances that these risks are being effectively managed.

I have approached this by examining the Assurance Framework documents that you have in place and also by giving consideration to the wider reporting to the Governing Body that informs the Governing Body's assessment of the effectiveness of the organisation's system of internal control. Whilst broader control arrangements were in place, the BAF was not always fully updated and we noted some improvements required. We have raised a recommendation to address this.

It is my view that an Assurance Framework has been established which is designed and is broadly operating to meet the requirements of the 2022/23 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. Updates for the BAF should be maintained.

The system of internal control based on internal audit work undertaken

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

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

 Full Assurance	• Financial governance (planning guidance) • Financial ledger
 Significant Assurance	• Financial systems (payroll, debtors, accounts payable)
 Moderate Assurance	• Adult safeguarding • Complaints • Conflict of interest • Individual commissioning – funded nursing costs*
 Limited Assurance	• Child safeguarding

**Draft at time of providing opinion*

Details of the reviews where limited/moderate assurance was provided are set out below:

Limited assurance review

Child safeguarding

The review noted positive feedback from system partners and we were provided with some good examples of system working despite the pressure that the service is under. A key theme throughout the review had been the improvements required in terms of the reporting and assurances that need to be provided throughout the governance structure of the CCG.

We were concerned that at the time of review there were no plans to develop a prospective schedule of proactive safeguarding quality assurance visits. The CCG was unable to identify a service-level agreement with the Designated Doctor. We found some enhancements that could be made to policies.

Since the time of review, the CCG has been working through their action plan for this area.

Moderate assurance reviews

Adult safeguarding

The review noted positive feedback from system partners and throughout the review we were provided with some good examples of system working despite the pressure that the service is under. A key theme throughout the review has been the improvements required in terms of the reporting and assurances that need to be provided throughout the governance structure of the CCG.

We found that the job description for the Designated Professional did not fully align to the guidance as well as some enhancements that could be made to policies.

Since the time of review, the CCG has been working through their action plan for this area.

Complaints

The CCG has a hard-working and dedicated Patient Services team. Unfortunately, because of delays in responding fully to complaints, we were unable to conclude the process was fully effective. We are aware of ongoing capacity issues within the Patient Services team and at some provider organisations which has impacted on the timely investigation and response to complaints in some instances. The CCG continues to closely monitor open cases and engagement with the providers' and the CCG's investigating departments was beginning to increase in order to drive forwards completion.

The CCG were able to effectively demonstrate the identification and reporting of lessons learned from complaints although there is scope to enhance the wider learning from complaints through triangulation and the Complaints Service Evaluation Form. The monitoring of actions arising from complaints could also be strengthened to ensure these are being completed in line with final response letters.

Conflicts of interest

The effective management of conflicts of interest within an organisation plays a pivotal role in providing assurances over governance arrangements and in particular transparency with key decision making. The CCG had a hard-working team, and despite a range of controls in operation, it was noted that declarations held for the majority of Governing Body members and Senior Management Team had just lapsed the 12-month period at the time of our review. Mandatory training compliance for conflicts of interest required improvement.

Monitoring of GP practice member declarations also required enhancement in order to provide clearer audit trail around who was required to complete declarations and their status, and to ensure all of those required to declare interests are being captured and reminded where necessary.

Individual commissioning – funding nursing costs (FNC)

Review of FNC cases at three months is not routinely carried out (as based on best practice). This is due to current operational issues for the Individual Commissioning team – mainly team capacity and changed priorities in response to system escalation and patient flow. In addition, as at February 2022 there was a significant number of FNC cases which have not been reviewed within 12 months. This backlog of outstanding referrals is in the process of being cleared by the CCG's dedicated interim team.

There still remains significant vacancies and sickness levels within the Clinical Staffing team which means that individual commissioning assessments and reviews (including FNC) are

not carried out as quickly as planned. An active ongoing recruitment process is in place to help address establishment shortfalls.

The CCG continues to work towards implementing a consistent approach of the FNC framework across Shropshire, with plans in place to operate one version of the Broadcare system across both former CCG areas.

Provider serious incidents

Having in place robust incident management arrangements within healthcare organisations is fundamental to ensure that lessons are learned and areas for improvement are identified when things go wrong. It had been a challenge for the team working with significant staffing changes at providers and under transition arrangements. We had been advised the team is working towards advanced styles of quality governance and findings from the review are going to be used to inform these future plans.

Information in respect of provider Serious Incidents (SIs) is reported, although the timeliness of this could be improved. The review also noted the need for enhancement of reporting in particular turnaround performance of Root Cause Analysis (RCA) investigations by providers. Whilst narrative is provided outlining the number of open cases, it does not provide details of how long these cases have remained open. It should be noted that nationally, deadlines around SI reporting had been suspended since the start of the pandemic.

Sample testing identified some delays with providers reporting incidents within Strategic Executive Information Systems (StEIS) in line with the previous, but now suspended, two working day requirement. We also noted a lack of evidence to support compliance with Duty of Candour (DoC) requirements (at providers) where it was not evident this had been identified through the CCG process.

The CCG's Serious Incident Policy had been updated in the move to one strategic commissioning organisation in April 2021 – although documented arrangements for the sharing of lessons learnt was not currently in line with current practice with innovative approaches being introduced. We attended two meetings held between the CCG and its main providers. Our observations noted a sufficient level of scrutiny and challenge being applied by the CCG during these as part of RCA and action plan reviews.

Other

Transition to Integrated Care Board

The establishment of the new NHS statutory body, the Integrated Care Board (ICB) scheduled to be in place from July 2022 will significantly impact how the NHS plans, commissions, and delivers services. With a new role and new statutory duties and responsibilities the ICB, whilst inheriting the duties of the CCG, will have significantly changed strategic direction and objectives. This will necessitate a fresh assessment of the organisation's risk profile, the controls established by management for mitigation and the

mapping of assurances to ensure the Board is properly sighted on known and emerging risks.

This year, we have attended CCG transition overview group (Scrutiny panel) and provided constructive challenge. We have updated the Internal Audit Plan in year to recognise emerging risks and provided updates in our progress report. Through our work, we observed the transition is also impacting on capacity of key staff.

Financial position

Whilst a favourable position against the forecast deficit occurred this year, we understand that this is primarily due to a release of system non-recurrent allocations from additional late income and revenue underspends due in part to recruitment issues. Financial longer term system challenges remain. The underlying position against the Sustainability Plan remains the key focus across the system.

The noted control total for 2021/22 was a £9.984 million deficit. The actual position (pre external audit) against this at month 12 was a deficit of £4.073 million, and therefore favourable variance of £5.911 million. The underspends on non-recurrent allocations and non-recurrent prior year benefits are offsetting individual commissioning and mental health overspend.

The Control Total target has therefore been met, and the CCG delivered their element of the system plan – but the statutory breakeven duty was not met.

Following up of actions arising from our work

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

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

Reliance on third-party assurances

Midlands and Lancashire Commissioning Support Unit (MLCSU) report on Internal Controls Type II Finance and Payroll Service Auditor Report for the period 1 April 2021 to 31 March 2022 was received and reviewed. The report provides Reasonable Assurance overall and we can confirm that there are no issues or concerns we wish to highlight within this opinion.

We wish to highlight that the NHS SBS Employee Services – Service Auditor Report on Internal Controls Type II identified four qualifications out of 14 control objectives. We have concluded that this does not impact on our overall assurance level for the CCG.

There are a number of significant and persistent quality challenges. These have included amongst others urgent and emergency care performance, referral to treatment, cancer waiting times, and lack of staff in key areas at the main provider.

COVID-19 has compounded issues further as the system looks to restoration. In November 2021, the Care Quality Commission (CQC) published their latest report on The Shrewsbury and Telford Hospital NHS Trust (SaTH). The 'inadequate' rating was assessed as remaining in place. The final Ockenden Report (Independent Review of Maternity Services at SaTH) has been issued which highlighted serious and persistent failings with maternity services with tragic impacts on patient care and outcomes.

The report stated that: "Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures this message was lost in a wider healthcare system which was struggling with other significant concerns". The report includes immediate and essential actions.

During the year, Internal Audit issued the following audit reports:

- The review noted positive feedback from system partners and some good examples of system working despite the pressure that the service is under were provided
- A key theme throughout the review had been the improvements required in terms of the reporting and assurances that need to be provided throughout the governance structure of the CCG
- There were concerns that at the time of review there were no plans to develop a prospective schedule of proactive safeguarding quality assurance visits
- The CCG was unable to identify a service-level agreement with the Designated Doctor
- Some enhancements were also found that could be made to policies
- Since the time of review, the CCG has been working through their action plan for this area.

An Action Plan was agreed in quarter 2, which includes actions to address the following areas:

- To develop a programme of quality assurance visits
- To improve reporting and also to report internal safeguarding performance against key measurables
- To align the training and safeguarding supervision policies with the Intercollegiate guidance (2019)
- To strengthen learning from outcomes following local authority reviews
- The majority of these actions have been addressed in year with some still to be fully completed.

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. These challenges continue to be evident in 2021/22 coupled with those posed by the continued need to respond to the COVID-19 pandemic.

However, during the year, progress has been made to address these challenges. This Annual Report highlights many of our achievements during this period and our Internal Audit opinion reflects the efforts by CCG staff to make the required improvements. Despite this progress, significant issues still remain and NHS Shropshire, Telford and Wrekin CCG will continue to build on the work we have commenced to address these ongoing challenges. In doing so we will continue to utilise the assurance methods available to us which are outlined above, but will strive to enhance and build on these foundations in order to ensure a robust transition of the CCG's internal system of control to the new Integrated Care Board (ICB) in 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 maintains a generally sound system of internal control designed to meet the organisation's objectives, and controls are generally being applied consistently. Accepting the control issues identified above, and the actions that are being taken to address these and the results of the internal audit reviews undertaken during the year, I am confident that the organisation has appropriate mechanisms in place to deliver good governance.

Mark Brandreth
Interim Accountable Officer
NHS Shropshire, Telford and Wrekin CCG
15 June 2022

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 has been in operation for the period 1 April 2021 to 31 March 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 2021/22 – NHS Shropshire, Telford and Wrekin CCG

Name	Title	Appointment details	Salary (bands of £5,000)	Expenses payments	Performance pay and bonuses	Long-term performance pay and bonuses	All pension related benefits	Total (bands of £5,000)
Astakhar Ahmed*	Associate Lay Member, Patient and Public Involvement for Equality, Diversity and Inclusion	01/04/21 to 31/03/22	5-10	-	-	-	-	5-10
Martin Allen*	Secondary Care Clinician	01/04/21 to 31/03/22	10-15	-	-	-	-	10-15
Geoff Braden*	Lay member, Audit	01/04/21 to 31/03/22	15-20	-	-	-	-	15-20
Mark Brandreth	Interim Accountable Officer	01/09/21 to 31/03/22	100-105	-	-	-	80-82.5	185-190
Rachael Bryceland*	GP/Healthcare Professional	01/04/21 to 31/03/22	25-30	-	-	-	-	25-30
Laura Clare	Interim Director of Finance	01/04/21 to 31/08/21	50-55	-	-	-	50-52.5	100-105
Julie Garside (nee Davies)#	Director of Performance	01/04/21 to 31/03/22	110-115	-	-	-	30-32.5	140-145
Mary Ilesanmi*	GP/Healthcare Professional	01/04/21 to 31/03/22	25-30	-	-	-	-	25-30
Michael Matthee*	GP/Healthcare Professional	01/04/21 to 31/03/22	5-10	-	-	-	-	5-10
Donna McArthur*	Lay member, Primary Care	01/04/21 to 31/03/22	25-30	-	-	-	-	25-30

Claire Parker#	Director of Partnerships	01/04/21 to 31/03/22	110-115	-	-	-	30-32.5	140-145
John Pepper*	Chair and GP/Healthcare Professional	01/04/21 to 31/03/22	100-105	-	-	-	-	100-105
Adam Pringle*	GP/Healthcare Professional	01/04/21 to 31/03/22	25-30	-	-	-	-	25-30
Deborah Shepherd	Medical Director	01/04/21 to 31/03/22	85-90	-	-	-	22.5-25	110-115
Claire Skidmore	Interim Accountable Officer	01/04/21 to 31/08/21	45-50	-	-	-	30-32.5	75-80
Claire Skidmore#	Executive Director of Finance	01/09/21 to 31/03/22	90-95	-	-	-	42.5-45	135-140
Alison Smith	Director of Corporate Affairs	01/04/21 to 31/03/22	105-110	-	-	-	45-47.5	135-140
Fiona Smith*	GP/Healthcare Professional	01/04/21 to 31/07/21	40-45	-	-	-	-	40-45
Samantha Tilley#	Director of Planning	01/04/21 to 31/03/22	110-115	-	-	-	30-32.5	140-145
Stephen Trenchard	Executive Director of Transformation	01/04/21 to 28/11/21	80-85	-	-	-	20-22.5	100-105
Meredith Vivian*	Deputy Chair, Lay Member for Patient and Public Involvement	01/04/21 to 31/03/22	15-20	-	-	-	-	15-20
Audrey Warren*	Independent Nurse	01/04/21 to 31/03/22	5-10	-	-	-	-	5-10
Zena Young#	Executive Director of Nursing and 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-19 pandemic.

Pension benefits

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

Pension entitlements of senior managers 2021/22 – NHS Shropshire, Telford and Wrekin CCG – Audited

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31.03.22 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31.03.22 (bands of £5,000)	Cash Equivalent Transfer Value at 31.03.22 (£'000)	Cash Equivalent Transfer Value at 01.04.21 (£'000)	Real increase in Cash Equivalent Transfer Value (£'000)	Employer's contribution to stakeholder pension (rounded to nearest £00)
Mark Brandreth	Interim Accountable Officer (01/09/21 to 31/03/22)	2.5-5	2.5-5	65-70	140-145	1,201	1,108	71	0
Laura Clare	Interim Director of Finance (01/04/21 to 31/08/21)	2.5-5	5-7.5	25-30	40-45	326	282	32	0
Julie Garside (nee Davies)	Director of Performance	0-2.5	0-2.5	25-30	40-45	485	442	26	0
Claire Parker	Director of Partnerships	0-2.5	0-2.5	25-30	45-50	528	483	29	0
Deborah Shepherd	Medical Director	0-2.5	0-2.5	15-20	25-30	301	265	22	0

Claire Skidmore	Interim Accountable Officer (01/04/21 to 31/08/21)	0-2.5	0-2.5	20-25	35-40	299	268	21	0
Claire Skidmore	Executive Director of Finance (01/09/21 to 31/03/22)	2.5-5	2.5-5	25-30	55-60	419	376	30	0
Alison Smith	Director of Corporate Affairs	0-2.5	0-2.5	40-45	0-5	572	529	27	0
Samantha Tilley	Director of Planning	0-2.5	0-2.5	30-35	65-70	577	534	26	0
Stephen Trenchard	Executive Director of Transformation	0-2.5	0-2.5	15-20	0-5	257	229	16	0
Zena Young	Executive Director of Nursing and Quality	0-2.5	5-7.5	50-55	155-160	1,219	1,146	50	0

Compensation on early retirement or for loss of office

NHS Shropshire, Telford and Wrekin CCG does not have any compensation on early retirement or for loss of office to report during 2021/22 (2020/21: 0).

Payment to past members – Audited

NHS Shropshire, Telford and Wrekin CCG does not have any payments to past members to report during 2021/22 (2020/21: 0).

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 2020/21	20.34%	N/A
All staff: Percentage change compared to 2020/21	13.38%	N/A

The increase in the highest paid director salary reflects the creation of NHS Shropshire, Telford and Wrekin CCG as one, single commissioning organisation replacing NHS Shropshire CCG and NHS Telford and Wrekin CCG.

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 31 March 2022, remuneration ranged from £12k to £180k (-37% to +21% against 2020/21: £19k to £149k) 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.

Remuneration of NHS 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)	£21,777	£32,306	£54,764
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£21,777	£32,306	£54,764

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 NHS Shropshire, Telford and Wrekin CCG in the financial year 2021/22 was £175k to £180k (+20.6% to + 20% against 2020/21: £145k to £150k) 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
8.1	8.1	5.1	5.1	3.1	3.1

In 2021/22, 0 (2020/21: 0) employees received remuneration in excess of the highest-paid director/member.

Expenditure on consultancy

The CCG spent £989,000 on consultancy services in 2021/22. The majority of this related to payments to a consultancy firm for continuing care and transforming care projects.

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 31 March 2022.

For all off-payroll engagements as of 31 March 2022, paying more than £245* per day, lasting longer than six months and are new

Number of existing engagements as of 31 March 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.

NHS 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 31 March 2022 for more than £245* per day

Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 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 2021 and 31 March 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 year.(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 year. This figure should include both on-payroll and off-payroll engagements.(2)	22

Exit packages and severance payments

Exit packages agreed in the financial year 2021/22 – Audited

Compulsory redundancies	Number	£
Less than £10,000	1	4,495
£10,001 to £25,000	-	-
£25,001 to £50,000	-	-
£50,001 to £100,000	1	72,622
£100,001 to £150,000	-	-
£150,001 to £200,000	-	-
Over £200,001	-	-
Total	**2**	**77,117**

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 2021/22 – Audited

Employee benefits	Permanent Employees £'000	Other £'000	Total £'000
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 4.1.3)	-	-	**-**
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**

- The costs above include £428k for costs related to COVID-19
- The employer contribution rate for NHS pensions increased from 14.3 per cent to 20.6 per cent from 1 April 2019. For 2019/20 and 2020/21, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on the CCG's behalf
- The full cost and related funding have been recognised in these accounts and further detail explaining the reason for this increase can be found in note 4.5.

Staff Report

NHS Shropshire, Telford and Wrekin CCG has employed a headcount of 261 staff during 2021/22. This is equivalent to 220.4 WTE.

Staff analysis by gender as of 31 March 2022 (headcount)

Headcount by gender 2021/22 – Audited

Staff grouping	Female	Male	Unknown*	Total
Governing body	11	9	0	**20**
Other senior management (band 8C+)	18	10	0	**28**
All other employees	171	24	0	**213**
Total	**200**	**61**	**0**	**261**

Percentage by gender 2021/22 – Audited

Staff grouping	Female	Male	Unknown*
Governing body	55.0%	45.0%	0%
Other senior management (band 8C+)	64.3%	35.7%	0%
All other employees	80.3%	19.7%	0%

Staff analysis by gender as of 31 March 2021 (FTE)

Headcount by gender 2020/21 – Audited

Staff grouping	Female	Male	Unknown*	Total
Governing body	7.17	3.14	0	**10.31**
Other senior management (band 8C+)	12.64	6.46	0	**19.10**
All other employees	150.97	40.08	0	**191.05**
Total	**170.77**	**49.69**	**0**	**220.46**

Percentage by gender 2020/21 – Audited

Staff grouping	Female	Male	Unknown*
Governing body	69.5%	30.5%	0%
Other senior management (band 8C+)	66.2%	33.08%	0%
All other employees	79.0%	21.0%	0%

Staff composition by pay band

Staff analysis by band as of 31 March 2022 (headcount) – Audited

Pay band	Headcount
Band 1	0
Band 2	0
Band 3	1
Band 4	57
Band 5	31
Band 6	13
Band 7	36
Band 8 – range A	31
Band 8 – range B	18
Band 8 – range C	8
Band 8 – range D	6
Band 9	2
Medical	19
Very Senior Managers	13
Governing body (off payroll)	0
Total	**261**

Staff analysis by band as of 31 March 2022 (FTE) – Audited

Pay band	Headcount
Band 1	0.00
Band 2	1.00
Band 3	48.52
Band 4	26.97
Band 5	12.37
Band 6	31.90
Band 7	28.70
Band 8 – range A	25.30
Band 8 – range B	16.28
Band 8 – range C	7.80
Band 8 – range D	6.00
Band 9	2.00
Medical	4.72
Very Senior Managers	8.90
Governing body (off payroll)	0.00
Total	**220.46**

Sickness absence data

The sickness absence data for the CCG in 2021 was whole time equivalent (WTE) days available of 47898.55 and WTE days lost to sickness absence of 2671.78 and average working days lost per employee was 12.55 which was managed through the absence management policy.

Staff sickness absence 2021	2021 number
Total Days Lost	2671.78
Total Staff Years	212.88
Average Working Days Lost	12.55

Staff turnover

CCG Staff Turnover 2021/22	2021/22 number
Average FTE Employed 2021/22	213.73
Total FTE Leavers 2021/22	42.49
Turnover Rate	19.88%

The CCG Staff Turnover Rate for 2021/22 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 42.49. The CCG's average FTE staff in post during the year was 213.73. The CCG Staff Turnover Rate for the year was 19.88 per cent.

Other employee matters

The CCG recognises that discrimination and victimisation is unacceptable and that it is in the interests of the organisation and its employees to utilise the skills of the total workforce. It is the aim of the organisation to ensure that no employee or job applicant receives less favourable facilities or treatment (either directly or indirectly) in recruitment training/career progression or employment on 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 requires all its staff to undertake regular mandatory training on equality, diversity and human rights and to comply with our Equal Opportunities Policy.

We are committed to communicating and engaging with staff on a consistent and frequent basis, through one-to-ones, team meetings, staff consultation events, CCG staff briefings and staff newsletters. We are part of our regional Joint Staff Consultative Committee, which provides a forum for trade union staff representatives to meet and contribute to service change and development and for issues to be discussed.

During the COVID-19 pandemic, where the majority of our staff were working from home, we ran weekly ‘huddle’ meetings via Microsoft Teams. 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 is supported by the CCG's Health and Wellbeing Champion, who is one of the CCG's lay members.

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

Employees with a disability

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

The CCG's commitment to people with disabilities includes:

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

Trade union facility time

In 2021/22 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: (total cost of facility time ÷ total pay bill) x 100	0

Paid trade union activities

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

Health and safety

The 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 2021/22, due to the COVID-19 pandemic the majority of CCG staff have 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 have 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 have been identified as having a greater risk and have been either redeployed or provided with equipment to allow them to work from home.

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

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

Statement as to disclosure to auditors

Everyone who is a member of the membership body at the time the Members' Report is approved confirms:

- so far as the member is aware, 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 22.

An audit certificate will be received from our auditors following submission of the Annual Accounts.

Annual Accounts

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000
Income from sale of goods and services	2	(0)
Other operating income	2	(1,014)
Total operating income		**(1,015)**
Staff costs	4	12,810
Purchase of goods and services	5	973,194
Depreciation and impairment charges	5	-
Provision expense	5	426
Other Operating Expenditure	5	381
Total operating expenditure		**986,810**
Net Operating Expenditure		**985,796**
Finance income		-
Finance expense		-
Net expenditure for the Year		**985,796**
Net (Gain)/Loss on Transfer by Absorption	7	72,994
Total Net Expenditure for the Financial Year		**1,058,790**
Other Comprehensive Expenditure		
Items which will not be reclassified to net operating costs		
Net (gain)/loss on revaluation of PPE		-
Net (gain)/loss on revaluation of Intangibles		-
Net (gain)/loss on revaluation of Financial Assets		-
Net (gain)/loss on assets held for sale		-
Actuarial (gain)/loss in pension schemes		-
Impairments and reversals taken to Revaluation Reserve		-
Items that may be reclassified to Net Operating Costs		
Net (gain)/loss on revaluation of other Financial Assets		-
Net gain/loss on revaluation of available for sale financial assets		-
Reclassification adjustment on disposal of available for sale financial assets		-
Sub total		**-**
Comprehensive Expenditure for the year		**1,058,790**

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	9	-	(0)
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		-	(0)
Current assets:			
Inventories		-	-
Trade and other receivables	10	3,618	5,758
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	11	375	201
Total current assets		**3,993**	5,959
Non-current assets held for sale		-	-
Total current assets		**3,993**	5,959
Total assets		**3,993**	5,959
Current liabilities			
Trade and other payables	12	(64,902)	(76,274)
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions	13	(2,406)	(2,679)
Total current liabilities		**(67,309)**	(78,953)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(63,316)**	(72,994)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions		-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(63,316)**	(72,994)
Financed by Taxpayers' Equity			
General fund		(63,316)	(72,994)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(63,316)**	(72,994)

The financial statements on pages 2 to 28 were approved by Shropshire, Telford and Wrekin Audit Committee and signed on its behalf by:

Mark Brandreth, Interim Accountable Officer
15 June 2022

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2021	0	0	0	**0**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating expenditure for the financial year	(985,796)			**(985,796)**
Transfers by absorption to (from) other bodies	(72,994)	0	0	**(72,994)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(1,058,790)**	**0**	**0**	**(1,058,790)**
Net funding	995,474	0	0	**995,474**
Balance at 31 March 2022	**(63,316)**	**0**	**0**	**(63,316)**

The notes on pages 11 to 17 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year		(985,796)
(Increase)/decrease in trade & other receivables	10	2,140
Increase/(decrease) in trade & other payables	12	(11,372)
Provisions utilised	13	(699)
Increase/(decrease) in provisions	13	426
Net Cash Inflow (Outflow) from Operating Activities		**(995,300)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		995,474
Net Cash Inflow (Outflow) from Financing Activities		**995,474**
Net Increase (Decrease) in Cash & Cash Equivalents	11	**174**
Cash & Cash Equivalents at the Beginning of the Financial Year		**201**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**375**

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

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

The CCG ended the financial year with an in-year deficit of £4m and a cumulative deficit position of £134m. This is in the context of a temporary financial framework being in operation in 2020/21 and 2021/22 due to COVID-19. In 2021/22 each healthcare system was given a funding envelope to operate within with a clear expectation that organisations would manage within this funding and report a break even position across the system. The Shropshire, Telford and Wrekin system has reported a £6.5m deficit in 2021/22.

The Health and Care Act was granted royal assent on the 28th April 2022. The Act enables the establishment of Integrated Care Boards (ICBs), across England and abolishes clinical commissioning groups, (CCGs) with effect from 1st July 2022. ICBs will take on the commissioning functions of CCGs and all of the CCG's assets and liabilities will transfer to the ICB, (NHS Shropshire, Telford and Wrekin Integrated ICB).

These changes, together with the ongoing impact of the COVID-19 pandemic, has required the CCG to review whether this creates material uncertainty regarding its going concern status.

At this time, it is judged that the going concern status of the organisation remains unchanged on the following basis:

• The formation of the new organisation (ICB), has been approved by NHS England and the services currently provided by the CCG will transfer entirely to the new organisation together with its assets and liabilities;
• Government support is available to the NHS for all COVID-19 related costs and the CCG is fully participating in all financial returns and reviews;
• The CCG have taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt are not materially impacted. These steps include securing remote access to financial systems for all finance staff and budget holders, and working with our third party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the low value of the CCG's aged debt and its continued high achievement against the Better Payment Practice Code.

Although the financial position of the CCG and the issue of a Section 30 referral letter to the Secretary of State for Health in relation to the CCG for 2021/22 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 has submitted its 2022/23 financial plan covering the 3 months that the CCG will still be in operation and the 9 months once the ICB
On this basis, the CCG has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 **Accounting Convention**

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

1.3 **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 two pooled budget arrangements with Telford and Wrekin Local Authority, (in accordance with section 75 of the NHS Act 2006). Under the arrangements, funds are pooled for the Better Care Fund (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 17 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.

Notes to the financial statements (contd.)

1.6 **Revenue**

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

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

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

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

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

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

1.8 **Other Expenses**

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

1.9 **Property, Plant & Equipment**

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.

Notes to the financial statements (contd.)

1.9.2 Contd 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 year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.
At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

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

1.10.1 **The Clinical Commissioning Group as Lessee**
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

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

1.12 **Provisions**
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2020-21: 0.18%) 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 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

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

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

Notes to the financial statements (contd.)

1.15 **Contingent liabilities and contingent assets**

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

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

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

1.16 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.16.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

The CCG did not hold any such assets as at 31st March 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 31st March 2022.

1.16.4 **Impairment**

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

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 **Financial Liabilities**

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

1.17.1 **Financial Guarantee Contract Liabilities**

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

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

The CCG did not take financial guarantee contracts during 2021/22.

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 2021/22.

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.

Notes to the financial statements (contd.)

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**

Apart from those involving estimations (see below), management has made no critical judgements in the process of applying the clinical commissioning group's accounting policies that have a significant effect on the amounts recognised in the financial statements.

1.20.2 **Sources of estimation uncertainty**

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

Accruals - Continuing Health Care (CHC): The value of expected claims for CHC is estimated based on the number of days a patient has spent in a care home, multiplied by the daily charge of that provider. An estimate of future patients (accounting for expected growth), that are not yet in the CCG's CHC database is also made based on the number of days in a given month multiplied by the average monthly cost of existing patients included in the database.

Accruals - Prescribing: The CCG recognises the cost of drug prescribing based on data received from the NHS Business Services Authority (NHSBSA). Reports are received on a monthly basis, but reflect charges up to the end of February only. March costs are estimated using historical levels of expenditure. The NHSBSA uses a methodology for forecasting prescribing expenditure that is based on national averages and does not necessarily reflect local issues. Therefore consideration is given to the use of local knowledge to determine the appropriate level of expenditure to be included in the accounts. This review is undertaken and full disclosure of any proposed adjustments shared with the auditors.

1.21 **Gifts**

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

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

The CCG has identified 2 existing operating leases which will be re-classified as finance leases on 01/04/22. These are leases for office accommodation with NHS Property Services and Shropshire Local Authority. It has been estimated that this re-classification will have the effect on the Statement of Financial Position of increasing non-current assets by £1,059k and increasing financial liabilities by £1,059k. The current estimated impact on expenditure is minimal (£3k per annum), but guidance is awaited from NHSE/I regarding the funding of this.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

● 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

	2021-22 Total £'000
Income from sale of goods and services (contracts)	
Education, training and research	-
Non-patient care services to other bodies	-
Patient transport services	-
Prescription fees and charges	-
Dental fees and charges	-
Income generation	-
Other Contract income	0
Recoveries in respect of employee benefits	-
Total Income from sale of goods and services	0
Other operating income	
Rental revenue from finance leases	-
Rental revenue from operating leases	-
Charitable and other contributions to revenue expenditure: NHS	-
Charitable and other contributions to revenue expenditure: non-NHS	-
Receipt of donations (capital/cash)	-
Receipt of Government grants for capital acquisitions	-
Continuing Health Care risk pool contributions	-
Non cash apprenticeship training grants revenue	-
Other non contract revenue	1,014
Total Other operating income	1,014
Total Operating Income	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 2021/22 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 2021/22 expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1 Employee benefits

	Permanent Employees £'000	Other £'000	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

The costs above include £122k for COVID-19 related costs.

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 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 4.5.

4.1.1 Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in 2021/22.

4.2 Average number of people employed

	2021-22		
	Permanently employed Number	Other Number	Total Number
Total	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 year

	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**

	2021-22 Departures where special payments have been made	
	Number	£
Less than £10,000	-	-
£10,001 to £25,000	-	-
£25,001 to £50,000	-	-
£50,001 to £100,000	-	-
£100,001 to £150,000	-	-
£150,001 to £200,000	-	-
Over £200,001	-	-
Total	**-**	**-**

4.4 Analysis of Other Agreed Departures

	2021-22 Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
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 year. The expense associated with these departures may have been recognised in part or in full in a previous

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

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

4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) 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.

b) 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

	2021-22 Total £'000
Purchase of goods and services	
Services from other CCGs and NHS England	6,782
Services from foundation trusts	152,028
Services from other NHS trusts	482,301
Provider Sustainability Fund	-
Services from Other WGA bodies	-
Purchase of healthcare from non-NHS bodies	144,817
Purchase of social care	-
General Dental services and personal dental services	-
Prescribing costs	83,553
Pharmaceutical services	-
General Ophthalmic services	496
GPMS/APMS and PCTMS	84,353
Supplies and services – clinical	2,462
Supplies and services – general	10,338
Consultancy services	989
Establishment	1,944
Transport	182
Premises	1,043
Audit fees	126
Other non statutory audit expenditure	
· Internal audit services	-
· Other services	8
Other professional fees	1,501
Legal fees	136
Education, training and conferences	134
Funding to group bodies	-
CHC Risk Pool contributions	-
Non cash apprenticeship training grants	-
Total Purchase of goods and services	**973,194**
Depreciation and impairment charges	
Depreciation	-
Amortisation	-
Impairments and reversals of property, plant and equipment	-
Impairments and reversals of intangible assets	-
Impairments and reversals of financial assets	-
· Assets carried at amortised cost	-
· Assets carried at cost	-
· Available for sale financial assets	-
Impairments and reversals of non-current assets held for sale	-
Impairments and reversals of investment properties	-
Total Depreciation and impairment charges	**-**
Provision expense	
Change in discount rate	-
Provisions	426
Total Provision expense	**426**
Other Operating Expenditure	
Chair and Non Executive Members	350
Grants to Other bodies	32
Clinical negligence	-
Research and development (excluding staff costs)	-
Expected credit loss on receivables	(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	**381**
Total operating expenditure	**974,001**

The above includes expenditure dealt with under pooled budget arrangements as set out in Note 17.

COVID-19 costs included in the above figures total £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 fee 2021/22	£101k
Additional charge for 2020/21 statutory audit of Shropshire CCG accounts*	£12k
Additional charge for 2020/21 statutory audit of Telford CCG accounts*	£13k

* not known at time of audits and not accrued in 2020/21 accounts

The auditor's liability for external audit work carried out for the financial year 2021/22 is limited to £1 million.

Internal audit and counter fraud services are provided by CW Audit who are part of a Foundation Trust. The cost of these services was £40k in 2021/22, (included within other professional fees).

6.1 Better Payment Practice Code

Measure of compliance	**2021-22 Number**	**2021-22 £'000**
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	43,288	266,235
Total Non-NHS Trade Invoices paid within target	42,886	262,527
Percentage of Non-NHS Trade invoices paid within target	**99.07%**	**98.61%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	549	650,339
Total NHS Trade Invoices Paid within target	539	649,408
Percentage of NHS Trade Invoices paid within target	**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	**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. Net gain/(loss) on transfer by absorption

Shropshire CCG and Telford & Wrekin CCG merged to form one commissioning organisation on the 1st April 2021, (Shropshire, Telford & Wrekin CCG).

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.

The assets and liabilities transferred from the 2 CCGs into Shropshire, Telford & Wrekin CCG were:

	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)**

8. Operating Leases

8.1 As lessee

8.1.1 Payments recognised as an Expense

	2021-22			
	Land **£'000**	**Buildings** **£'000**	**Other** **£'000**	**Total** **£'000**
Payments recognised as an expense				
Minimum lease payments	-	410	-	**410**
Contingent rents	-	-	-	**-**
Sub-lease payments	-	-	-	**-**
Total	**-**	**410**	**-**	**410**

Buildings lease payments relate to expenditure with NHS Property Services Ltd for the rental of office accommodation (£231k), vacant space costs (£93k) and sessional/bookable space (£119k), and Shropshire Local Authority for the rental of office accommodation (£86k).

8.1.2 Future minimum lease payments

	2021-22			
	Land **£'000**	**Buildings** **£'000**	**Other** **£'000**	**Total** **£'000**
Payable:				
No later than one year	-	90	-	**90**
Between one and five years	-	289	-	**289**
After five years	-	-	-	**-**
Total	**-**	**379**	**-**	**379**

Future minimum lease payments relate to the lease held with Shropshire Local Authority which commenced in June 2021.

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years have not yet been agreed. Consequently this note does not include future minimum lease payments for this arrangement.

8.2 As lessor

The CCG does not hold any leases as a lessor.

9 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 01 April 2021	-	-	-	-	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	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2022	**-**	**-**	**-**	**-**	**0**	**-**	**361**	**39**	**400**
Depreciation 01 April 2021	-	-	-	-	0	-	361	39	400
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**0**	**-**	**361**	**39**	**400**
Net Book Value at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Purchased	-	-	-	-	-	-	(0)	-	(0)
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**
Asset financing:									
Owned	-	-	-	-	-	-	(0)	-	(0)
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2021	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

9 Property, plant and equipment cont'd

9.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2021-22	2020-21
	£'000	£'000
Land	-	-
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	-	166
Furniture & fittings	-	-
Total	**-**	**166**

10 Trade and other receivables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	608	-	3,478	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	160	-
NHS accrued income	600	-	971	-
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	1,496	-	476	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	485	-	342	-
Non-NHS and Other WGA accrued income	142	-	139	-
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	(23)	-	(3)	-
VAT	295	-	182	-
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	16	-	13	-
Total Trade & other receivables	**3,618**	**-**	**5,758**	**-**
Total current and non current	**3,618**		**5,758**	
Included above:				
Prepaid pensions contributions	-		-	

10.1 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	**2021-22 Non DHSC Group Bodies £'000**	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	318	9	2,756	362
By three to six months	-	-	1	(1)
By more than six months	-	1	145	31
Total	**318**	**9**	**2,902**	**392**

10.2 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**	**Other financial assets £'000**	**Total £'000**
Balance at 01 April 2021	(3)	-	**(3)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(20)	-	**(20)**
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	**(23)**	**-**	**(23)**

11 Cash and cash equivalents

	2021-22	2020-21
	£'000	£'000
Balance at 01 April 2021	201	84
Net change in year	174	116
Balance at 31 March 2022	**375**	**201**
Made up of:		
Cash with the Government Banking Service	375	201
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**375**	**201**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2022	**375**	**201**
Patients' money held by the clinical commissioning group, not included above	-	-

12 Trade and other payables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	2,084	-	9,081	-
NHS payables: Capital	-	-	-	-
NHS accruals	1,881	-	2,844	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	13,644	-	8,668	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	17,228	-	40,949	-
Non-NHS and Other WGA deferred income	-	-	7	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	146	-	134	-
VAT	-	-	-	-
Tax	124	-	119	-
Payments received on account	-	-	-	-
Other payables and accruals	29,795	-	14,472	-
Total Trade & Other Payables	**64,902**	**-**	**76,274**	**-**
Total Current and Non-Current	**64,902**		**76,274**	

Other payables include £873k outstanding pension contributions at 31 March 2022

13 Provisions

	Current 2021-22 £'000	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	0	-	118	-
Redundancy	407	-	1,160	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	352	-	187	-
Continuing care	1,648	-	660	-
Other	0	-	555	-
Total	**2,406**	**-**	**2,679**	**-**
Total current and non-current	**2,406**		**2,679**	

	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 2021	**-**	**-**	**118**	**1,160**	**-**	**-**	**187**	**660**	**555**	**2,679**
Arising during the year	-	-	-	87	-	-	282	1,155	-	**1,524**
Utilised during the year	-	-	(112)	(83)	-	-	(117)	(167)	(220)	**(699)**
Reversed unused	-	-	(6)	(757)	-	-	-	-	(335)	**(1,098)**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2022	**-**	**-**	**0**	**407**	**-**	**-**	**352**	**1,648**	**0**	**2,406**
Expected timing of cash flows:										
Within one year	-	-	0	407	-	-	352	1,648	0	**2,406**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2022	**-**	**-**	**0**	**407**	**-**	**-**	**352**	**1,648**	**0**	**2,406**

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 31/03/2022, 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 31st March 2022 and these are expected to be processed within the new financial year.

14 Contingencies

The CCG has no contingent assets or liabilities to disclose.

15 Financial instruments

15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the 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.

15.1.1 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.

15.1.2 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.

15.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

15.1.4 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.

15.1.5 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.

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'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	911	-	911
Trade and other receivables with other DHSC group bodies	468	-	468
Trade and other receivables with external bodies	1,483	-	1,483
Other financial assets	-	-	-
Cash and cash equivalents	375	-	375
Total at 31 March 2022	**3,237**	**-**	**3,237**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Loans with group bodies	-	-	**-**
Loans with external bodies	-	-	**-**
Trade and other payables with NHSE bodies	615	-	**615**
Trade and other payables with other DHSC group bodies	3,677	-	**3,677**
Trade and other payables with external bodies	60,340	-	**60,340**
Other financial liabilities	-	-	**-**
Private Finance Initiative and finance lease obligations	-	-	**-**
Total at 31 March 2022	**64,631**	**-**	**64,631**

16 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
986,725	(929)	985,796	3,993	(67,309)	(63,316)

17 Joint arrangements - interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2021-22 Assets	Liabilities	Income	Expenditure
			£'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	0	0	0	24,522
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin CCG and Telford & Wrekin LA	Better care fund promoting integrated working	0	0	0	14,315
Transforming care programme S75 arrangement	Shropshire, Telford & Wrekin CCG and Telford & Wrekin LA	The transforming care programme for people with learning disabilities	0	0	0	1,947

17.1 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	2021-22 £'000
Assistive Technologies	1,799
Care navigation/Co-ordination	1,927
Enablers for Integration	4,100
Healthcare Services to Care Homes	216
Integrated Care Planning	3,566
Intermediate Care Services	3,487
Personalised Healthcare at Home	348
L A Schemes	9,078
Total	**24,522**

Telford & Wrekin Local Authority	2021-22 £'000
Rehabilitation and Reablement	5,950
Assistive Technologies	683
Preventative Services	130
Carers	223
Management Charges	65
Shropshire Community Health Trust	3,925
Shrewsbury and Telford Hospital	1,899
Maintaining Eligibility	910
Care Act Implementation	530
Total	**14,315**

18 Related party transactions

During 2021/22 the following Governing Body members and key members of management declared interests with other organisations that have undertaken material transactions with the clinical commissioning group:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Adam Pringle (GP/Healthcare Professional) - Sessional work for Shropshire Doctors Co Operative Ltd (Shropdoc)	1,316	0	409	0
Meredith Vivian (Deputy Chair & Lay Member) - Trustee of the Strettons Mayfair Trust	6	0	3	0

The Department of Health and Social Care is regarded as a related party. During the year the clinical commissioning group has had material transactions with entities for which the Department is regarded as the parent Department. These include:

NHS 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 2021/22 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.

19 Events after the end of the reporting period

Following the Health and Care Act 2022, Shropshire, Telford & Wrekin CCG will become Shropshire, Telford & Wrekin Integrated Care Board, (ICB) on the 1st July 2022. All of the services, assets and liabilities from the CCG will be transferred to the ICB.

20 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:

	2021-22 Target	**2021-22 Performance**
Expenditure not to exceed income	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	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	9,685	9,656

The excess of expenditure above the revenue resource limit has occurred in the following context:

NHS England set the CCG an in-year control total of break-even and the CCG is reporting an outturn of £4.3m deficit The CCG brought forward a deficit of £130.1m and therefore the cumulative outturn is £134.4m deficit.

It should be noted that a report to the Secretary of State under section 30 of the Local Audit and Accountability Act has been issued for the breach of financial duties, i.e. failure to contain expenditure within the Revenue Resource Limit.

21 Analysis of charitable reserves

	2021-22 £'000	2020-21 £'000
Unrestricted funds	-	-
Restricted funds	1	1
Endowment funds	-	-
Total	**1**	**1**

The clinical commissioning group holds a charitable donation of £1k for use towards staff welfare.

22 Losses and special payments

The CCG did not incur any losses or special payments in 2021/22.