NHS
Shropshire
Clinical Commissioning Group

Annual Report
2019/2020

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Please note the following report contains several links to signpost the reader to more information. These links and the associated information contained within them are not subject to audit.

Introduction from Shropshire Clinical Commissioning Group Chair and Accountable Officer

We are delighted to introduce our Annual Report for the year 2019/20, a year that has brought both significant challenges and opportunities and has seen continued progress for NHS Shropshire Clinical Commissioning Group (CCG).

In 2019/20 Shropshire CCG and the wider health and care system have been faced with a number of challenges.

There has been a much greater increase this year in the number of people attending the A&E departments. This is particularly the case in people who are taken to hospital by ambulance. This has resulted in a greater number of patients being admitted to hospital for care. This increase has been mirrored across the system and in terms of our population it is not just those that attend Shrewsbury and Telford Hospitals NHS Trust (SaTH) but also at other NHS hospitals in neighbouring systems. It has unfortunately meant that patients have had to wait longer for a bed in hospital than we would like.

The CCG has also seen a significant increase this year in the number of people who are eligible for Continuing Health Care and Funded Nursing Care. As a result of the increased costs associated with this together with increased emergency care activity and some other factors it is disappointing to report that the CCG is reporting a larger deficit this year than that which was planned for.

This has been a challenging financial year for the system as a whole with a number of our partners also not being able to meet their financial targets for the year.

There have however been successes this year as well. The CCG working with Shropshire Council and the independent sector has seen improvements in the number of patients being discharged from hospital in a timely manner at the right time.

Consistently this year the CCG has had one of the lowest Delayed Transfers of Care across the Midlands and has been below the national target.

We are grateful to our partners in working with us to discharge patients more effectively from the acute hospitals.

This year has seen the establishment of Primary Care Networks (PCNs) across the county which has seen GPs working together. Whilst still early days will we are sure these will grow in the coming months and years, working with partners to deliver a wider range of services in each locality.

We would also like to recognise the work that practices have put into developing extended primary care which means people now have a greater ability to book appointments in the evening and at weekends.

Shrewsbury and Telford Hospitals NHS Trust (SaTH) continues to have significant challenges and together with other system partners the CCG is committed to working with and helping the Trust to make improvements in quality. There are workforce challenges across the NHS currently and as a system we will see a significant number of staff retire in the next few years. The CCG is supporting SaTH and system partners in making sure that students are encouraged to take up posts locally when they qualify.

Shropshire CCG and Telford and Wrekin CCG have been working hard this year to start working more closely together as we move towards creating a single strategic commissioning organisation in April 2021.

The past few weeks have presented a more challenging environment in the NHS nationally and locally than any of us who work in the system have known before. This is due to the onset of Covid-19.

We have seen a number of patients infected start to rise and unfortunately we have seen a number of people die as a result. We would like to offer our deepest sympathies and condolences on behalf of the CCG to their families and friends for their loss.

The coming weeks and months are going to present new challenges for us all as citizens as well as the health and care system as we respond to this. There are robust plans in place across all partner organisations to ensure that we can look after people if they are being cared for at home, in hospital or another care setting.

We would like to say a huge thank you to all of the staff in the CCG for their continued hard work, commitment and support over the past year, and we are extremely appreciative of what they do for our population.

Finally we would just like to add that it has been an enormous privilege to be the Accountable Officer and Chair of the CCG and we are indebted to partner organisations, the CCG member practices and the Governing Body for their support.

Dr. Julian Povey
Chair

Mr. David Evans
Accountable Officer

Performance Report

Performance Overview

Statement of Purpose and Activities of the CCG

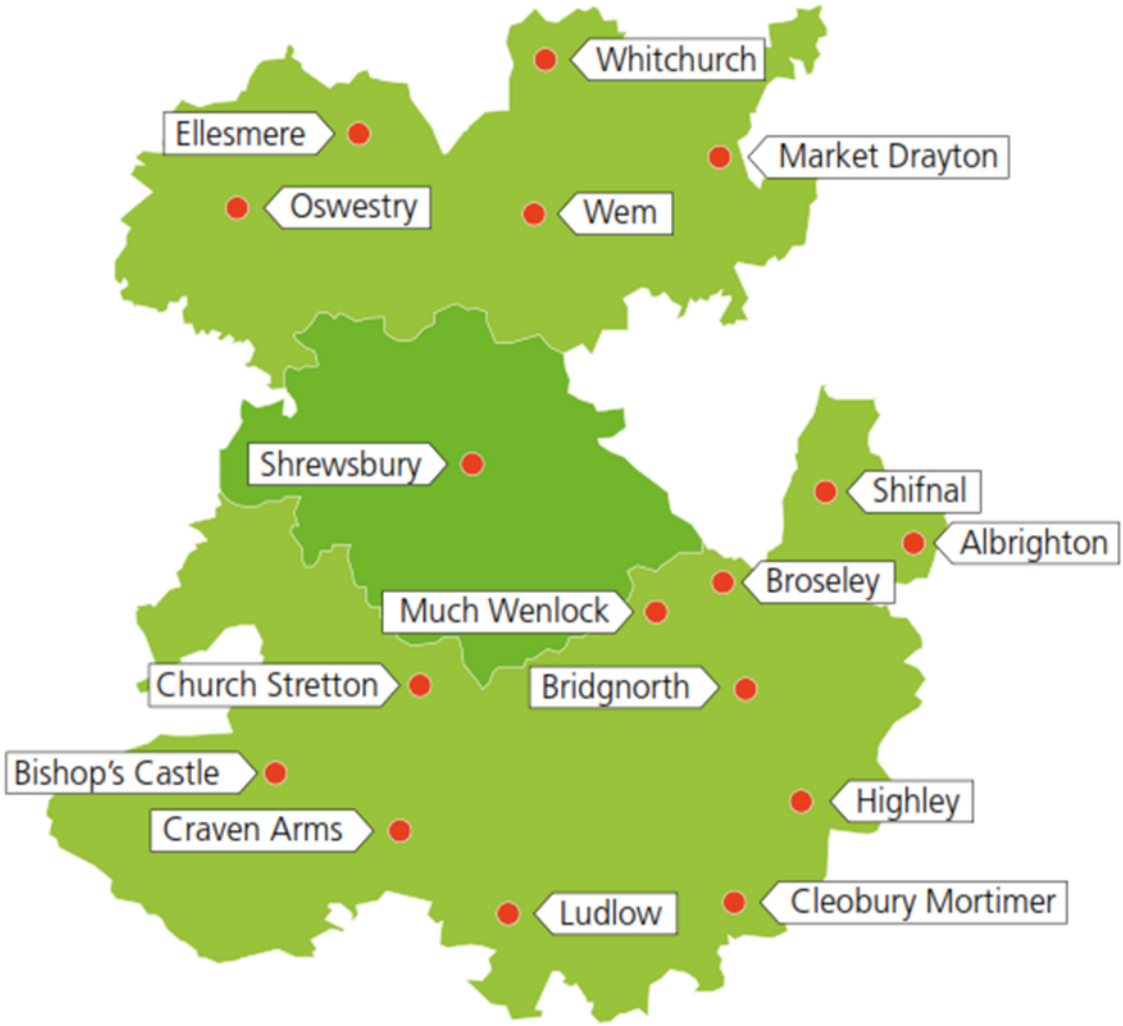
This section of the Annual Report provides summary information on NHS Shropshire CCG; its purpose, key challenges to the achievement of the organisation objectives and how the organisation has performed over 2019/20.

About us

NHS Shropshire 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 2013 and the principal location of our business is at William Farr House, Shrewsbury SY3 8XL. We are responsible for commissioning or 'buying' health and care services for people in the Shropshire CCG area.

We are allocated by NHS England a £475m budget to ensure high-quality, sustainable healthcare for our population. We are a clinically-led membership organisation, comprising 40 GP practices, and we are responsible for commissioning services for patients who are registered with a GP in Shropshire.

Our population



The activities undertaken by the CCG in 2019/20 were based on the needs of our local population. Key elements of this are set out below:

Shropshire currently has a population of 314,400, which is estimated to grow to 338,843 by 2039. The current census data tells us that 95.4 per cent of residents described themselves as White English/Welsh/Scottish/Northern Irish/British. Asian or Asian British ethnic groups are next largest in Shropshire, representing one per cent of the population.

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.

The 2011 Census showed 63,400 people aged 65 years and over living in Shropshire. This represents an increase of 23.8 per cent between 2001 and 2011. Shropshire has experienced significantly higher growth in this age group than nationally (10.9 per cent) and regionally (12.6 per cent). In 2001, the over 65s represented 18.1 per cent of the total Shropshire population. This has now risen to 20.7 percent in 2011, compared to 16.4 per cent for England and Wales.

Like many rural areas, the number of people aged 65 and over in Shropshire is expected to continue to rise. It is anticipated that by 2030, one in four people will fall into this age group.

Issues of frailty associated with this group of our 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.

Rural isolation remains a significant issue for the county and demographic profiles support this. National research highlights that three in 10 people aged 80 or over report feeling lonely. If applied to Shropshire that would total 1,930 people aged 80 or over. The five most deprived areas in Shropshire are located within the former district wards of Harlescott, Meole Brace, Monkmoor, Battlefield and Heathgates - all in Shrewsbury. Other deprived areas include the Castle, Gobowen, Gatacre and Cambrian in Oswestry; Market Drayton East and Whitchurch North in North Shropshire; and Ludlow Henley, Stokesay, Bridgnorth and Highley in South Shropshire.

In Shropshire, approximately seven per cent of over 65s have dementia; this figure is expected to increase to 7.5 per cent for all people aged 65 and over by 2021. The expected increase in Shropshire is likely to be at a faster pace than the expected increase in England overall. Prevalence estimates for dementia are thought to be more than double the recorded rate in Shropshire. There are different types of dementia. Some are preventable, such as vascular dementia, and some are not, like Alzheimer's.

The risk of developing vascular dementia can be reduced by making healthy lifestyle choices, such as having a healthy diet, maintaining a healthy weight, regular exercise, moderate alcohol intake, not smoking, and controlling blood pressure and diabetes.

Cardiovascular disease (CVD) is the most common cause of death in Shropshire, accounting for around 35 per cent of all deaths annually. Many premature deaths from CVD are preventable as they are caused by lifestyle risk factors, such as smoking and poor diet. Although Shropshire's rates of CVD are significantly lower than the national figures, males are significantly more likely to die prematurely from CVD than females. Evidence tells us that males who reside in the most deprived areas in Shropshire are significantly more likely to die prematurely than males in the less deprived areas. For females, there is no comparative difference in the same statistics.

Overall, the health of the population in Shropshire is good; both male and female life expectancy is significantly higher than the national average. However, inequalities in health persist in Shropshire.

Shropshire CCG works with Shropshire Council to ensure that we use the most up-to-date population profile data for our area, including the information contained in the local Joint Strategic Needs Assessment (www.shropshiretogether.org.uk/jsna/), to inform our commissioning decisions and ensure that addressing health inequalities is at the forefront of our decision making.

Our Commissioning Activities

Shropshire CCG is responsible for commissioning (or buying) and monitoring healthcare services as described in the 2006 National Health Service Act and as amended by the 2012 Health and Social Care Act.

These services include:

- Health services that meet the reasonable needs of all patients registered with our member practices, as well as people living in the Shropshire CCG area who are not registered with any GP practice
- Emergency care
- Paying for prescriptions issued by our member practices

To meet those needs, we commission a wide range of services, including:

- GP and primary care services
- Acute and other hospital services
- Community services
- Prescribing
- Mental health services
- Ambulance services
- Continuing healthcare
- Nursing home care

Local Challenges

Quality

During 2019/20 serious safety concerns highlighted in the 2018 CQC report that rated the CCG's main acute provider; Shrewsbury and Telford Hospitals NHS Trust (SaTH) "inadequate" continue to be a significant challenge. The CCG is an active member of the CQC Oversight Group, which involves NHS England/NHS Improvement, and CQC. The Group is monitoring on a monthly basis the action plan the Trust is progressing to improve the areas highlighted in the CQC report.

Further information regarding how the CCG supports improvements in quality can be found in the Improving Quality section (page 38).

Higher than expected intervention in MSK

NHS RightCare provides a suite of intelligence and tools to assist the CCG's plan and improve services. Elective musculoskeletal (MSK) activity continues to be identified by Shropshire CCG based on the NHS RightCare analysis as a significant outlier compared to other similar CCGs. Patients in Shropshire are more likely to receive surgical interventions rather than non-surgical

alternatives than the national average.

More information about how the CCG is responding to this challenge can be found in the "Our Achievements" section on page 30.

Frailty

An elderly population is more likely to have complex health and care needs associated with multiple comorbidities compared to the adult population. Emergency admissions have been increasing year on year and a significant proportion of this is for patients aged over 65. NHS England has identified that designing and commissioning an 'end-to-end' frailty pathway will improve patient outcomes, support people to live independently for longer, reduce dependency on services and also reduce the cost of crisis interventions within emergency settings for frail patients. Ensuring services are appropriate for a frail patient is particularly relevant for Shropshire given the ageing population. This is also supported by NHS RightCare data.

More details about how the CCG is responding to this challenge can be found in the Out of Hospital Transformation (Shropshire Care Closer to Home) section of the report on page 23.

Workforce

The recruitment and retention of key groups of health professionals continues to be a challenge for the health community. In addition in Shropshire, we continue to face the issue of many local GPs nearing retirement age, and the difficulties of attracting new staff to the area.

We continue to work with our partners across the health economy through the Sustainability Transformation Partnership (STP) and have developed a workforce strategy to address local workforce issues as well as working with Health Education England, NHS England and NHS Improvement.

The Shrewsbury and Telford Hospital NHS Trust (SaTH) faces its own issues around recruitment and we continue to see significant pressure in Accident and Emergency (A&E). Despite recruitment initiatives the rate of vacancies remains high for both doctors and nurses.

We are taking action to improve A&E performance, particularly with our continued commitment to the acute Trust's implementation plan for NHS Future Fit programme and the CCG's Shropshire Care Closer to Home Programme.

The Shropshire Care Closer to Home Programme is already demonstrating a positive impact and is expected to have an even greater impact once fully in place.

More information about how the CCG is responding to this challenge can be found in the Primary Care section on page 33.

Working in Partnership

The CCG continues to build on the strong history of partnership working in Shropshire with a number of its partners, through the Strategic Transformation Plan (STP). The CCG is leading with partners on a number of initiatives that are key to the delivery of the STP objectives and this will continue to be a key objective for 2020/21.

Providers

We know that pressures on social care are of particular concern in Shropshire. Plans supported by the Better Care Fund Programme have enabled better joined-up working between health and social care and will support the long-term transformation of Shropshire's health and social care economy, enhancing people's independence, health and quality of life through seamless and efficient care.

During the year, we have built on our work with social care partners locally to align our strategic objectives and ensure that, together, we continue to transform provision so that it is fit for the future.

Our joint work focused on reducing delayed transfers of care has proved hugely successful with targets in Shrewsbury and Telford Hospital NHS Trust continuing to be consistently met with ongoing significant progress to reduce the number in other key settings. Shropshire is now one of the best performing areas in the whole region for this measure.

In both Shropshire and Telford and Wrekin, demand for health and social care services will outstrip the funds available by 2020/21. As a local health economy, our focus is on switching towards preventative interventions and providing our population with the tools needed to live longer and healthier lives as well as transforming the ways in which care is delivered. We are working with other local health providers to take full advantage of recent rapid progress in treatments and technology.

More information about how the CCG is responding to this challenge can be found throughout the performance section, but particularly within the Better Care Fund section (page 25) the Sustainability and Transformation Partnership section (page 24) and the Out of Hospital Transformation section (page 23).

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

Shropshire Council

The Better Care Fund (BCF) continues to be an important focus for our partnership working with the Council. Switching care from an acute setting to a community setting relies in part on the success of the BCF. In addition we continue to work collaboratively on our local Care Closer to Home working model which forms an important element of the STP. This work is allowing us to explore in a more meaningful way how health and social care services can be delivered in more community settings, closer to people's homes and ultimately to be more integrated, so we

support the whole person and not just treat a disease.

More information about how the CCG is responding to this challenge can be found within the Better Care Fund section (page 25).

Health Overview and Scrutiny Committee, Shropshire Council

Our interaction with the Joint Health Overview and Scrutiny Committee has continued to be significant during 2019/20, with a number of service redesign projects discussed at the Committee, as well as regular updates on the progress of other initiatives i.e. our proposal to create a single CCG across Shropshire and Telford and Wrekin.

NHS Telford and Wrekin Clinical Commissioning Group (CCG)

As a neighbouring CCG we work collaboratively with NHS Telford and Wrekin CCG on a number of key issues including Local Maternity Services, Transforming Midwifery Care review, primary care working programmes and lead commissioning arrangements with shared providers. We generally work in partnership on procurement programmes, and are closely aligned when negotiating contracts with our provider Trusts. We also have a joint contracting function to support our commissioning processes and joint quality and finance functions across both CCGs.

We have continued to explore opportunities to work together over 2019/20, with our greatest focus now being on dissolving the existing CCGs to create a single strategic commissioner in April 2021, and to create a single staff structure to support both CCGs in the interim period.

Financial Performance

2019/2020 Financial Position

2019/20 has been a very challenging year financially for Shropshire CCG. Initially NHSE/I requested that Shropshire CCG plan for a £12.3m deficit, however this would have proved extremely challenging given the exit position of the previous financial year and therefore a financial plan for 2019/20 was agreed at a £22.9m deficit. At the time of plan submission, this also carried an unmitigated risk of £5.1m.

From early in the year a significant deterioration from the planned deficit became apparent and at Month 9 the CCG submitted a formal financial re-forecast which was agreed with NHSE/I.

The CCG ended the financial year with a total in year deficit of £47.3m. The majority of the overspend is deemed to be recurrent and the total underlying position is currently assessed as a £49.9m deficit, (one-off benefits have been utilised in year, such as slippage in investments and balance sheet flexibility, hence reducing the in year total).

The three main drivers of the deficit during 2019/20 have been:

- **Emergency Activity (including A&E, NEL and ambulance)**
  Emergency care budgets significantly overspent. The final overspend against plan was £7.6m (11%) in emergency spells of care in hospital, £0.8m (7%) in A&E attendances and £0.3m (2%) in ambulance conveyances.

- **Individual Commissioning (including CHC and Mental Health)**

Individual Commissioning Costs have also significantly risen in 2019/20. The overspend in this area was £12m (28%) over budget. The CCG has seen a steep increase in costs particularly in the area of Mental Health, Adult Joint Funded and Adult Fully Funded packages where both numbers and costs of care packages have risen.

- **Slippage in QIPP delivery**
  For the first time the CCG was able to identify QIPP schemes in the plan to fully meet the QIPP target so that these were in place at the start of the financial year. Significant progress has been made in year across the schemes identified and the CCG was able to deliver £16m of QIPP against the original target of £19.8m (81%). The remaining 19% slippage has contributed to the in year deficit however.

The CCG started the year with a cumulative deficit of £76.7m and is therefore now showing a cumulative deficit at the end of 2019/20 of £124m.

Throughout 2019/20 the CCG put in place a number of financial recovery actions to attempt to tackle the growing deficit including 'grip and control 'measures and enhanced financial governance procedures.

The CCG held regular sessions with the Governing Body and membership to maintain focus on the financial position and to identify additional cost saving opportunities across the system. The wider healthcare system was also engaged throughout through STP DOFs meetings and the STP System Operational Sustainability Group (SOSG).

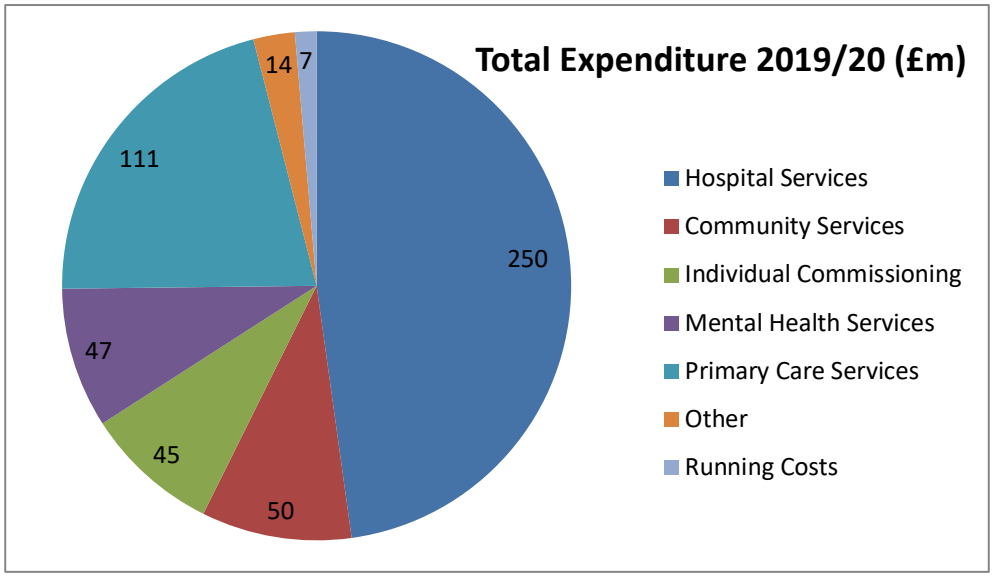
The STP has also established a medical and finance group bringing together senior leaders from all organisations to consider and progress opportunities to minimise costs and avoid high cost acute admissions.

As the CCG moves into 2020/21 it continues to work with NHSE/I locally to highlight areas of additional savings and improved governance. Recruitment to a single executive structure of the CCGs is now complete and in operation from January 2020, enhancing focus on the financial position and identification of QIPP/savings opportunities.

In 2019/20 the CCG received a total allocation of £476m to spend on the healthcare of its residents.

The chart below shows a breakdown of the CCG's expenditure (which exceeded allocation) for 2019/20 by spend type:

NHS Shropshire Expenditure 2019/20 (£523m)



- The CCG ended the year with an in year deficit of £47.3m.

Quality, Innovation, Productivity and Prevention (QIPP)

QIPP stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS.

In order to fund increases in activity, demography and any additional cost pressures the CCG will need to deliver recurrent QIPP plans year on year. In 2019/20 the CCG is forecasting delivery of a QIPP programme of £15.9m, this represented 81% of the target and the gap is one of the reasons that the CCG is in deficit this year.

The 2020/21 requirement for Shropshire CCG is currently a £15.4m target which represents 3% of the CCG allocation. It is important to note that as time goes on QIPP savings are becoming increasingly difficult to achieve as many of the 'quick wins', have already been identified. Given the challenging financial environment in which the CCG operates it has taken a robust approach to ensuring QIPP schemes that require investment will deliver a good return in terms of both patient and financial benefits. The focus in 2020/21 will be working as a system with partners across the health economy to deliver transformational schemes through the STP clusters/workstreams.

Adoption of Going Concern Basis

These accounts have been prepared on a going concern basis, (despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014).

The CCG ended the financial year with an in-year deficit of £47.286k. This was an increase of £24.432k on the plan set at the beginning of the year.

The impact of the global pandemic COVID-19 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, however it is recognised that there has been

a significant impact on how we operate.

Our assessment of going concern is made on the basis that 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 has taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt are not materially impacted. These steps include securing remote access to financial systems for all finance staff and budget holders, and working with our third party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected.

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

As directed by the Group Accounting Manual 2019/20, the Governing Body has prepared the financial statements on a going concern basis as they consider that the services currently provided by the CCG will continue to be provided in the foreseeable future.

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 following is clear evidence that the CCG meets the requirement highlighted above and as set out in section 4.11 to 4.16 of the Department of Health Group Accounting Manual 2019/20:

- NHS Shropshire CCG was established on 1 April 2013 as a separate statutory body
- The CCG has been allocated funds by NHS England for the financial years 2019/20 and 2020/21
- The CCG has an agreed Constitution that directs the governance of its activities
- The CCG has been allocated indicative allocations to 2023/24; and
- The CCG continues to draw down on the allocated funds based on its cash requirements and in accordance with the arrangements put in place by NHS England.
- Detailed financial plans for 2020/21 were submitted to NHSE in March 2020 and were submitted to the Governing Body in May 2020.

With both continuity of service and future financial provision assured, the CCG’s financial statements have been prepared on the going concern basis. The temporary suspension of the NHS financial regime from 17 March 2020 as part of the COVID-19 response, does not undermine either the continuity of services or financial provision judgement, but strengthens it.

Performance Analysis

The NHS Constitution sets specific targets for commissioners of services. In the last year, we have been working with providers to ensure that we consistently meet these targets. The CCG has made good progress during 2019/20 against a number of these targets and plans to build on this solid foundation in 2020/21.

The CCG tracks the progress of its service providers (e.g. local hospitals, community services), against a number of national outcome indicators, and ensures that patients’ rights within the NHS

Constitution are maintained. Additionally, the CCG has set local priorities against which providers' progress is monitored. Performance reports are presented to the Board on a monthly basis and can be found on the CCG website.

The Performance Dashboard below shows up to 12 months' achievements from 1 April 2019 to 31 March 2020 against patient rights defined in the NHS Constitution. The data is provided via the CSU using the Aristotle tool.

2019-20 Ind Ref	Indicator Measure	Indicator Definition	Responsible Director & Manager	2019-20 Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD Position	Direction of change in Performance*	Data Reference Period	Availability of Performance Data
E.B.3	The percentage of referral to treatment (RTT) incomplete pathways) within 18 weeks	Incomplete RTT pathways performance	Julie Davies	92%	89.7%	90.2%	89.9%	89.4%	88.7%	89.2%	88.5%	87.9%	87.3%	86.9%	85.4%		88.4%	↓	Feb-20	Apr-20
E.B.18	Number of 52+ Week RTT waits			0	0	0	0	0	0	0	0	0	1	0	0		1	↔		
E.B.4	The percentage of patients waiting six weeks or more for a diagnostic test	Diagnostic test waiting times	Julie Davies	1%	1.2%	1.3%	1.0%	1.7%	2.3%	2.6%	1.1%	1.1%	1.5%	5.7%	5.5%		2.4%	↑	Feb-20	Apr-20
E.B.5	Patients should be admitted, transferred or discharged within 4hrs of their arrival at an A&E Department (**SaTH**)	A&E waiting times - total time in the A&E Department	Julie Davies	95%	68.2%	73.0%	71.1%	73.2%	73.4%	65.9%	64.4%	65.6%	60.5%	65.0%	63.2%	71.2%	67.9%	↑	Mar-20	Apr-20
	Patients should be admitted, transferred or discharged within 4hrs of their arrival at an A&E Department (**LHE**)				73.6%	77.7%	76.0%	78.6%	78.4%	72.1%	70.5%	71.1%	66.2%	70.9%	69.3%	76.1%	73.3%			
	No. of delays from Decision to Admit over 12hrs	12hr Trolley Breaches		0	15	0	0	1	1	1	44	61	348	411	187	94	1163	↓		
E.B.6	Two week wait (urgent referral) services (including cancer)	Cancer two week waits	Julie Davies	93%	81.8%	80.0%	82.2%	81.2%	86.4%	91.6%	93.0%	90.6%	92.0%	93.4%	94.3%		87.9%	↑	Feb-20	Apr-20
E.B.7	Two week wait for breast symptoms (where cancer was not initially suspected)				31.6%	12.7%	18.2%	14.7%	50.5%	80.9%	95.1%	89.5%	93.2%	92.3%	96.0%		55.13%	↑		
E.B.8	Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis	Cancer 31 day waits	Julie Davies	96%	96.9%	97.6%	96.2%	97.2%	97.9%	95.96%	97.4%	94.7%	98.3%	96.2%	93.5%		96.6%	↓		
E.B.9	Percentage of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a **Surgery**			94%	88.1%	74.2%	95.6%	83.6%	87.9%	90.0%	92.5%	88.9%	87.0%	83.9%	85.2%		87.3%	↓		
E.B.10	Percentage of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an anti-cancer **drug** regimen			98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97.5%	100%		99.7%	↑		
E.B.11	Percentage of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a **radiotheraphy** treatment course			94%	100%	100%	100%	96.9%	98.0%	93.5%	98.4%	100%	98.1%	97.1%	93.9%		97.7%	↓		
E.B.12	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an **urgent** GP referral for suspected cancer	Cancer 62 day waits	Julie Davies	85%	71.4%	76.6%	73.2%	70.5%	68.5%	66.0%	75.2%	74.7%	79.4%	68.0%	63.4%		71.6%	↓		
E.B.13	Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from a NHS Cancer **Screening** Service			90%	95.7%	76.5%	66.7%	100%	96.2%	90.0%	89.5%	72.7%	88.2%	72.2%	40.00%		85.1%	↓		
E.B.14	Percentage of patients receiving first definitive treatment for cancer within 62-days of a **consultant** decision to **upgrade** their priority status			T.B.C.	89.2%	84.9%	81.5%	83.0%	92.7%	85.7%	83.9%	84.1%	86.7%	81.6%	80.00%		84.8%	↓		
	Urgent referral to treatment waiting times (62 day referral to treatment - breaches 104+ days			0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	-		
E.B.23	Category 1 (mm:ss): 90th Percentile	Ambulance - response times by Category **(WMAS)**	Julie Davies	15mins	11:39	11:51	11:56	12:00	11:39	12:10	12:13	12:15	12:15	12:03	12:33	12:38	12:05	↓	Mar-20	Apr-20
	Category 2 (mm:ss): 90th Percentile			36mins	22:22	21:31	23:57	23:44	23:06	24:10	25:21	27:06	28:09	22:45	24:03	27:40	24:37			
	Category 3 (mm:ss): 90th Percentile			90mins	78:47	69:49	99:36	109:47	88:08	109:15	121:43	136:52	144:05	71:44	92:27	113:44	103:43			
	Category 4 (hh:mm:ss) : 90th Percentile			180mins	115:46	104:08	141:26	185:42	127:18	175:44	178:49	198:23	193:27	114:58	132:12	156:57	149:39			
	Category 1 (mm:ss): 90th Percentile	Ambulance - response times by Category **(Shropshire CCG)**	Julie Davies	15mins	20:16	19:46	23:25	22:52	20:38	21:00	22:43	22:50	21:29	23:29	23:55	23:12	22:06	↑	Mar-20	Apr-20
	Category 2 (mm:ss): 90th Percentile			36mins	34:51	32:21	36:54	37:08	39:09	39:38	38:10	41:54	45:09	38:07	37:57	45:03	39:02			
	Category 3 (mm:ss): 90th Percentile			90mins	81:14	71:59	95:54	106:25	89:30	134:01	129:48	149:01	168:15	87:00	104:58	125:23	111:26			
	Category 4 (hh:mm:ss) : 90th Percentile			180mins	122:44	111:52	163:58	144:28	90:49	165:10	175:21	180:56	209:21	108:49	108:31	141:43	140:10			
E.A.3	IAPT roll-out (receiving treatment)	Improving Access to Psychological Therapies	Julie Davies	22%	1.48%	1.52%	1.83%	2.31%	1.70%	1.77%	1.86%	1.72%	1.55%	1.90%	1.78%		19.42%	↓	Feb-20	Apr-20
E.A.S.2	IAPT moving to recovery			50%	57.9%	55.9%	50.6%	52.4%	52.3%	51.6%	51.1%	55.1%	50.4%	51.2%	53.2%		52.8%	↑		
E.A.S.1	Dementia Diagnosis Rate (65years+)	Estimated diagnosis rate for people with dementia		67%	71.0%	71.0%	71.2%	70.8%	71.1%	71.0%	70.6%	70.5%	71.0%	69.8%	69.5%	69.0%	69.0%	↓	Mar-20	
	Percentage to whom case finding is applied (SaTH)	Dementia Assessments	Julie Davies	90%	93.2%	94.8%	95.5%	94.4%	94.4%	96.8%	97.5%	98.6%	99.2%				96.2%	↑	01/12/2019 Published 04.03.20	Apr-20
	Percentage with a diagnostic assessment (SaTH)			90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Collection Suspended			100.0%	↔		
	Percentage of cases referred (SaTH)			90%	100%	100%	100%	100%	-	-	100%	100%	100%				100.0%	↔		
	Percentage to whom case finding is applied (RJAH)			90%	75.0%	75.0%	25.0%	80.0%	66.7%	100%	37.5%	42.9%	66.7%				58.7%	↑		
	Percentage with a diagnostic assessment (RJAH)			90%	-	-	-	-	-	-	100%	-	-	Collection Suspended			100.0%			
	Percentage of cases referred (RJAH)			90%	-	-	-	-	-	-	100%	-	-				100.0%			
E.H.1	The proportion of people that **wait 6 weeks or less** from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	IAPT waiting times		75%	95.9%	97.9%	95.6%	97.2%	99.5%	95.7%	94.3%	95.4%	96.2%	96.6%	96.1%		96.4%	↓	Feb-20	Apr-20
E.H.2	The proportion of people that **wait 18 weeks or less** from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period			95%	100%	99.5%	98.3%	99.6%	100%	99.1%	99.1%	99.2%	98.7%	99.6%	99.4%		99.3%	↓		
E.H.4	% of people receiving treatment in two weeks	Early intervention in psychosis (EIP)		56%	100%	75.0%	-	50.0%	100.0%	66.7%	100.0%	100.0%	75.0%	100.0%	66.7%		85.2%	↓	Feb-20	Apr-20
E.H.9	% of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services	Access to CYPMH		34%																
	Adult - 18 weeks delivery of equipment	Wheelchair	Julie Davies	92%	98.9%			99.6%			98.9%			Collection Suspended			99.1%	↓	Q3	Jan-20
	Child - 18 weeks delivery of equipment				97.5%			100%			100%						99.1%	↔		
	MRSA	HCAI		0	0	0	0	0	0	0	0	1	0	0	0	0	1	↔	Mar-20	Apr-20
	CDIF			43	3	5	8	5	2	6	3	4	6	6	4	3	55	↑		
	Mixed Sex Accommodation (MSA) Breaches	MSA		0	11	10	12	10	13	30	29	19	22	67	32		255	↑	Feb-20	Apr-20
	Number of patients NOT treated within 28 days of cancellation - **SaTH**	Cancelled Elective Ops		0	2			1			2						5	↓	Q3	Feb-20
	Number of patients NOT treated within 28 days of cancellation - **ShropCom**			0	1			0			0						1	↔		
	Number of patients NOT treated within 28 days of cancellation - **RJAH**			0	0			0			0						0	↔		
	Days delayed as a % of occupied beds. Average daily by Month - **SaTH**	Delayed Transfer of Care		3.5%	1.3%	0.8%	1.5%	1.7%	1.1%	1.6%	1.6%	2.4%	1.2%	1.2%	1.4%		1.4%	↓	Feb-20	Apr-20
	Days delayed as a % of occupied beds. Average daily by Month - **RJAH**				6.4%	3.4%	4.4%	6.4%	4.0%	4.9%	5.8%	5.9%	5.7%	4.4%	3.6%		3.6%	↑		
	Days delayed as a % of occupied beds. Average daily by Month - **ShropCom**				1.8%	3.2%	1.1%	1.5%	5.4%	2.2%	5.6%	6.6%	7.5%	4.5%	7.1%		7.1%	↓		
	Proportion of admissions to acute wards that were gate kept by the CRHT teams	Mental Health - CPA	Julie Davies	95%	97.6%			100%			95.3%						97.5%	↓	Q3	Feb-20
	Number of patients on CPA who are followed up within 7 days of discharge				99.1%			95.3%			96.1%						97.2%	↑		
	% of patients (SATH)	VTE assessments	Julie Davies	95%	94.2%			94.4%			94.6%						94.4%	↑	Q3	Mar-20
	% of patients (Shropcom)				97.8%			98.0%			97.9%						97.9%	↓		
	% of patients (RJAH)				99.8%			99.9%			99.9%						99.9%	↔		

The following table highlights our performance against the constitutional targets during 2019/20.

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. The total numbers waiting to be no more than the number in March 2019 by the end of the year.	At the end of January 2020 we achieved 86.9%. This was made up of 85.5% achievement at SaTH, 91.0% at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH), 98.2% at Shropshire Community Health NHS Trust (SCHT) and 84.6% at all other providers. Performance was impacted particularly at SaTH by the impact of overspill from emergency admissions and issues with consultant capacity arising from national changes to pension arrangements. The total count of people waiting is above the target at January by 1308 patients (6.8%).
Number of 52-week RTT pathways (incompletes): zero tolerance of over 52-week waits	At the end of January, published figures showed no Shropshire patients had been waiting over 52 weeks for treatment. The CCG did have one patient waiting over 52 weeks in December, but the patient was treated in January. In all other months of the year there were no 52-week waiters reported.
Diagnostic waiting times: patients waiting for a diagnostic test should have been waiting less than six weeks from referral	Waiting times for diagnostic tests have not been achieved regularly throughout the year and were 94.3% at January. This is due to an issue at SaTH in the recording

	of data around Echocardiography tests which emerged at the end of the calendar year and has now been resolved. Generally performance through the rest of the year was a little below the 99% standard.
A&E waits: patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	Significant work and initiatives have been actioned throughout the year by both the CCG and SaTH and support from the national Emergency Care Improvement Programme (ECIP) to improve performance. Further improvement actions have been identified for the coming year and are being monitored by the local A&E Delivery Board. Performance at SaTH remains a significant challenge with 65% of A&E attendances waiting less than four hours in January 2019. Improvement plans at SaTH are focused around improving patient flow and processes in the hospital to achieve quicker progress through A&E and earlier discharge, to reduce ambulance conveyances by developing alternative options other than A&E and implementing national recommendations around Same Day Emergency Care. Whilst workforce constraints have improved slightly during the year, it has remained a key factor in limiting

	significant improvement in A&E performance. The local system is not alone in the NHS in experiencing difficulties in achieving the A&E performance target. However, SaTH consistently performs poorly on this metric and the local system continues to work with NHS Impovement and SaTH to address workforce issues and recruitment initiatives have shown some success.

Cancer waiting times: First outpatient appointment for patients referred urgently with suspected cancer by a GP	Performance against the range of cancer targets has been encouraging through the year despite some significant capacity issues. Achievement of the 62-day cancer target has remained challenging due to the impact of Urological cancer where increased demand and capacity constraints have been experienced. The 14-day Breast Symptomatic performance was impacted by capacity issues early in the year but has been achieving over 92% in December and January. Figures for the end of January are shown below.

Description	Target %		Cumulative 18/19	Number of Months Achieved (out of 10)
Cancer urgent referral to first outpatient appointment (14 day referral)	93%	Achieved	87.25%	2
		Total Referrals	14813	
		Breaches	1888	
Proportion of patients with breast symptoms referred to a specialist who are seen (14 day referral)	93%	Achieved	50.46%	2
		Total Referrals	656	
		Breaches	325	
Cancer diagnosis to treatment waiting times (31 day first treatment)	96%	Achieved	96.85%	9
		Total Referrals	1997	
		Breaches	63	
31 days for subsequent cancer treatment (surgery)	94%	Achieved	87.5%	1
		Total Referrals	376	
		Breaches	47	
31 days for subsequent cancer treatment (drugs)	98%	Achieved	99.66%	9
		Total Referrals	597	
		Breaches	2	
31-Day Standard for Subsequent Cancer Treatments (Radiotherapy)	94%	Achieved	98.09%	9
		Total Referrals	575	
		Breaches	11	
Urgent referral to treatment waiting times (62 day referral to treatment) Not including Rare Cancers -	85%	Achieved	72.33%	0
		Total Referrals	1059	
		Breaches	293	
Extended 62-Day Cancer Treatment - Screening (part a)	90%	Achieved	86.32%	4
		Total Referrals	190	
		Breaches	26	
Extended 62-Day Cancer Treatment - Consultant upgrade (part b)	(tbc)	Achieved	85.31%	n/a
		Total Referrals	490	
		Breaches	72	

Category 1 ambulance calls: Category 1 calls to have an average emergency response within seven minutes and reach 90% of calls within 15 minutes	The performance in the CCG has generally not achieved the targets locally during 2019/20 in Call Categories 1, 2 and 3. The Category 4 call standard has been achieved in six of the nine months. Overall performance has deteriorated from the 2018/19 year as is true for many of the more rural CCGs within the West Midlands.
Mixed sex accommodation breaches (minimise breaches)	During 2019/20, 223 breaches have been reported up to the end of January. The majority of these relate to Critical Care at SaTH
Cancelled operations: patients who have operations cancelled on or after the day of admission, for non- clinical reasons, to be offered another binding date within 28 days	Up to the end of December there were six occasions where a patient had an operation cancelled and not re-booked within 28 days. All but one of these occurred at SaTH
Mental health: the proportion of people under adult mental illness specialties on Care Programme Approach, who were followed up within seven days of discharge from psychiatric inpatient care during the period	Published figures are at Q3, which show 97.2 per cent compliance on this measure for the year so far.

CCG Improvement and Assessment Framework (IAF)

In addition, the CCG itself is monitored by NHS England against the CCG Improvement and Assessment Framework (IAF) five key domains via monthly assurance meetings, on how well it is performing as a commissioner of services for the people of Shropshire. The outcomes of the annual meeting for 2019/20 with NHS England had not been published in time for the publication of this annual report but the table below presents the most up-to-date position for each key domain.

During 2019/20 NHS England and NHS Improvement have been developing a new framework of performance monitoring that enables them to monitor the NHS commissioning and provider organisations within a Sustainable Transformation Partnership and Integrated Care System. The NHS Oversight Framework (NHS OF) for 2019/20 outlines the joint approach that NHS England will take to oversee organisational performance.

For more information, see NHS England's website:
www.england.nhs.uk/publication/nhs-oversight-framework-for-2019-20/

The NHS OF has therefore replaced the NHS Improvement and Assessment Framework (IAF) and will inform the assessment of Shropshire CCG in 2019/20. This will enable joint working between the CCG, NHS England, Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs).

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

Better Health - IAF

Summary

IndNameFull	IndDomain	IndArea	Period	England value	Target or Standard	New data this release	05N: NHS Shropshire CCG Rate	05N: NHS Shropshire CCG Rank	05N: NHS Shropshire CCG Change
102a: Percentage of children aged 10-11 classified as overweight or obese	Preventing ill health and reducing inequalities	Obesity	2015-16 to 2017-18	34.2%			31.25%	(43/189)	↑
103a: Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	Quality of care and outcomes	Diabetes	2018-19	39.1%			37.99%	(134/191)	↑
103b: People with diabetes diagnosed less than a year who attend a structured education course	Quality of care and outcomes	Diabetes	2017-18 (2016 cohort)	12.1%			7.61%	(134/191)	↑
104a: Injuries from falls in people aged 65 and over	Preventing ill health and reducing inequalities	Falls	19-20 Q2	2065			860	(5/191)	↑
105b: Personal health budgets	New Service Models	Personalisation and patient choice	19-20 Q2	102			10	(182/191)	↑
105c: Percentage of deaths with three or more emergency admissions in last three months of life	Quality of care and outcomes	People with long term conditions and complex needs	2017	7.40%			4.93%	(16/189)	↑
106a: Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	Preventing ill health and reducing inequalites	Health inequalities	19-20 Q2	2211			965	(10/191)	↑
107a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	Preventing ill health and reducing inequalities	Antimicrobial resistance	2019 11	0.935	0.965	✓	0.949	(89/191)	↑
107b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Preventing ill health and reducing inequalities	Antimicrobial resistance	2019 11	8.37%	10%	✓	7.59%	(59/191)	↓
108a: The proportion of carers with a long term condition who feel supported to manage their condition	Quality of care and outcomes	People with long term conditions and complex needs	2019	57.3%			62.8%	(15/191)	
109a: Reducing the rate of low priority prescribing	Finance and use of resources	Finance and use of resources	19-20 Q2				Amber		→
121a: Provision of high quality care: hospital	Quality of care and outcomes	General	19-20 Q1				58	(157/189)	
121b: Provision of high quality care: primary medical services	Quality of care and outcomes	General	19-20 Q1				68	(23/189)	
122a: Cancers diagnosed at early stage	Quality of care and outcomes	Cancer services	2017	52.2%			49.18%	(152/189)	↓
122b: People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Quality of care and outcomes	Cancer services	19-20 Q2	77.8%	85%		68.39%	(174/191)	↓
122c: One-year survival from all cancers	Quality of care and outcomes	Cancer services	2017	73.30%	75%		72.70%	(102/191)	↑
122d: Cancer patient experience	Quality of care and outcomes	Cancer services	2018				8.8	(96/191)	↓
123a: Improving Access to Psychological Therapies – recovery	Quality of care and outcomes	Mental health	19-20 Q2	51.8%	50%		51.88%	(100/191)	↓
123b: Improving Access to Psychological Therapies – access	Quality of care and outcomes	Mental health	19-20 Q1	4.68%			4.87%	(74/191)	↓
123c: People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Quality of care and outcomes	Mental health	2019 09	76.6%	56%		75.00%	(124/191)	→
123f: Mental health out of area placements	Quality of care and outcomes	Mental health	2019 11	129		✓	131	(139/191)	↑
123g: Proportion of people on GP severe mental illness register receiving physical health checks	Quality of care and outcomes	Mental Health	19-20 Q2	30.0%	60%		34.1%	(60/190)	↑
123i: Delivery of the mental health investment standard	Finance and use of resources	Finance and use of resources	19-20 Q2				Green		→
123j: Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI)	Quality of care and outcomes	Mental Health	2019 10			✓	89.98%	(136/191)	↓
124a: Reliance on specialist inpatient care for people with a learning disability and/or autism	Quality of care and outcomes	Learning disability and autism	19-20 Q2			✓	56	(121/191)	
124b: Proportion of people with a learning disability on the GP register receiving an annual health check	Quality of care and outcomes	Learning disability and autism	2019-20			✓		(92/190)	→
124c: Completeness of the GP learning disability register	Quality of care and outcomes	Learning disability and autism	2018-19			✓	0.52%	(82/190)	↓
125a: Neonatal mortality and stillbirths	Quality of care and outcomes	Maternity services	2017	Null		✓	4.30	(100/190)	↑
125b: Women's experience of maternity services	Quality of care and outcomes	Maternity services	2018	82.7			81.0	(129/189)	↓
125c: Choices in maternity services	Quality of care and outcomes	Maternity services	2018	60.4			67.6	(9/189)	↑
125d: Maternal smoking at delivery	Quality of care and outcomes	Smoking	19-20 Q2	10.4%	6%		10.07%	(83/191)	↓
126a: Estimated diagnosis rate for people with dementia	Quality of care and outcomes	People with long term conditions and complex needs	2020 01	67.6%	67%	✓	69.83%	(76/191)	↓
126b: Dementia care planning and post-diagnostic support	Quality of care and outcomes	People with long term conditions and complex needs	2018-19	78.0%			79.31%	(76/191)	↓
127b: Emergency admissions for urgent care sensitive conditions	New Service Models	Integrated primary care and community health services	19-20 Q2	2497			1716	(12/191)	↑
127e: Delayed transfers of care per 100,000 population	New Service Models	Acute emergency care and transfers of care	2019 12	10.9		✓	7.0	(56/191)	↓
127f: Population use of hospital beds following emergency admission	New Service Models	Acute emergency care and transfers of care	19-20 Q2	982			815	(16/191)	↑
128b: Patient experience of GP services	New Service Models	Integrated primary care and community health services	2019	82.9%			87.99%	(13/191)	
128d: Primary care workforce	Leadership and workforce	Leadership and workforce	2019 03	1.06			1.21	(33/191)	↑
129a: Patients waiting 18 weeks or less from referral to hospital treatment	Quality of care and outcomes	Planned care	2019 12	83.7%	92%	✓	87.28%	(52/177)	↓
129b: Overall size of the waiting list	Quality of care and outcomes	Planned care	2019 12	4416584		✓	21703	(122/191)	↑
129c: Patients waiting over 52 weeks for treatment	Quality of care and outcomes	Planned care	2019 12	1467		✓	1	(62/191)	↑
130a: Achievement of clinical standards in the delivery of 7 day services	New Service Models	Integrated primary care and community health services	2017-18				2	(56/189)	
131a: Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	New Service Models	Integrated primary care and community health services	19-20 Q2	6.21%	15%		0.00%	(1/191)	↓
132a: Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by the CCG	Quality of care and outcomes	General	2018				Red		↓
133a: Percentage of patients waiting 6 weeks or more for a diagnostic test	Quality of care and outcomes	Planned care	2019 12	4.17%	1%	✓	1.46%	(47/191)	↑
134a: Evidence based interventions	Quality of care and outcomes	General	19-20 Q2				Amber		→
141b: In-year financial performance	Finance and use of resources	Finance and use of resources	19-20 Q2				Red		→
144a: Utilisation of the NHS e-referral service to enable choice at first routine elective referral	New Service Models	Personalisation and patient choice	2019 07	99.8%	100%		100.00%	(1/191)	↑
145a: Expenditure in areas with identified scope for improvement	Finance and use of resources	Finance and use of resources	19-20 Q2				Green		→
162a: Probity and corporate governance	Leadership and workforce	Leadership and workforce	19-20 Q2				Fully compliant		→
163a: Staff engagement index	Leadership and workforce	Leadership and workforce	2018	3.82			3.73	(130/183)	↓
163b: Progress against the Workforce Race Equality Standard	Leadership and workforce	Leadership and workforce	2018	0.14			0.10	(47/183)	↑
164a: Effectiveness of working relationships in the local system	Leadership and workforce	Leadership and workforce	2018-19				57.4	(182/189)	↓
165a: Quality of CCG leadership	Leadership and workforce	Leadership and workforce	19-20 Q2				Red		→
166a: Compliance with statutory guidance on patient and public participation in commissioning health and care	Leadership and workforce	Leadership and workforce	2018				Green		→

Other Items of Strategic Importance

Out of Hospital Transformation (Shropshire Care Closer to Home)

In 2017 following a community services review, Shropshire CCG commenced a large-scale review and transformation of community-based services with a view to making the necessary changes to the overall system that are required to better deliver services closer to home. This was underpinned by the principles of keeping people as well as possible, for as long as possible in their own home or community environment and minimising the need for a hospital admission. This supports the delivery of the NHS Long Term Plan, which advocates collaborative whole system solutions, as well as locally supporting the Future Fit model.

Due to the scale of this programme of transformation, Shropshire Care Closer to Home (SCCtH) was broken down into three core phases, the detail and progress of which is outlined below.

Phase 1 – Frailty Assessment and Intervention

In 2019/20 The Frailty Intervention Team (FIT) based within the A&E Departments of both Royal Shrewsbury Hospital and Princess Royal Hospital in Telford continues to run five days per week at both sites. The Acute Frailty Network is pleased with what is being achieved.

Phase 2 – Case Management

In 2019/20 the CCG piloted Case Management (earlier identification of need, and provision of proactive preventative care) in eight pilot demonstrator site areas, with ongoing monitoring and capturing of positive impact and outcomes achieved through locally available integrated teams.

In January 2020, the CCG approved a proposed expansion and rollout strategy for Case Management to be implemented across the whole county over the coming year, in two key steps:

- **Step 1 – April/May 2020**
  Expand the existing eight demonstrator sites to work with an additional practice each, so that the teams are working with a total of 16 practices and their patients aged 65 and over
- **Step 2 – November 2020**
  Transition teams to work from five Wellbeing Hubs, and work with patients aged 65 and over spanning the whole Shropshire county, and including all practices. The preference is that these Wellbeing Hubs are aligned with the PCN geography to ensure that the integrated teams are locally available to that area and group of practices. It was agreed that the North PCN should in fact have two Wellbeing Hubs to reflect the South, due to

the geographical spread of that North Shropshire area. These Wellbeing Hub locations will be:

- North East
- North West
- Central/Shrewsbury
- South East
- South West
  Work is now underway to develop an implementation plan that captures how this could be delivered, including the required resource.

Phase 3 – Community-based Semi-acute Services

In 2019/20 Phase 3 models of care were approved by the CCG and a robust impact assessment has been undertaken with all provider and partner organisations in the system, to determine any potential unintended risk or negative impact on existing services and pathways once they are implemented.

The outcomes of this exercise are being considered by the CCG Clinical Commissioning Committee before agreeing next steps.

Ageing Well Strategy

A public, patient and stakeholder workshop around the Shropshire Ageing Well Strategy took place in February 2020. The session concluded with an exercise where everyone contributed to suggestions for strategic recommendations on what future health and social care services in Shropshire need to look like to be sustainable, and appropriately matched to predicted needs and changes in demand over the coming years.

The outcome report will be shared once finalised, and strategic recommendations agreed in readiness for Public Health publishing the final Shropshire Joint Strategic Needs Assessment (JSNA) document.

Additionally, this wealth of information will also be vital in the work being planned to review Shropshire community bed provision planned for 2020/21.

Shrewsbury Admission Avoidance Team

Winter 2018/19 demonstrated significant pressures in the acute setting. Medical bed capacity was on occasion insufficient for demand, and the CCG received reports of corridor waits and ambulance handover delays which cause concern from a patient safety and quality of care perspective.

In November 2020, the CCG launched a discrete admission avoidance team, as an interim “rescue” measure, pending full roll out of the SCCtH work in the Shrewsbury locality lead by the Local Authority. The service is achieving an 85% admission avoidance rate based on referrals and work continues across the system to increase the service to 24/7.

Sustainability and Transformation Partnership

Shropshire CCG is one of the local members of the Sustainability and Transformation Partnership (STP) for Shropshire, Telford and Wrekin. This partnership is the conduit for assessing how health and care services will need to change in order to meet the needs of local people and the aspirations of the NHS via the Long Term Plan. It reflects changes in the population, the workforce, technology and the difficult financial environment in which we work.

We want everyone in Shropshire, Telford and Wrekin to have a great start in life, supporting them to stay healthy and live longer with a better quality of life.

Our STP brings together a wide range of local organisations, patient representatives and care professionals to look at how we collectively shape our future care and services.

This strong community of stakeholders is passionate, committed and realistic about the aspirations set out in our plans.

Our thinking starts with where people live, in their neighbourhoods, focusing on people staying well.

We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we improve access when its needed.

STP priorities include:

- Investing in our hospitals to ensure they are offering state of the art facilities for every patient and protecting emergency services, now and into the future
- Developing our out of hospital programme, delivering Integrated Care in our communities, using all available resources to commission integrated health and care services that are clinically effective, cost effective and as close as possible to where people live with the greatest needs
- Using technology to help patients in rural communities, supporting GPs in establishing place-based care solutions, which help our overstretched teams in Primary Care
- Exploring options to reduce patient travel to access planned treatment and assessments by establishing Centres of Excellence in both hospitals
- Delivering the implementation plan for the Mental Health Forward View, ensuring delivery of the mental health access and quality standards, increasing baseline spend on mental health
- Working at a more local level to help tackle the causes of poor health, promoting the support that communities already offer and developing our wider workforce to ‘make every contact count’ with proactive identification of people at risk of ill health.

Better Care Fund

The Better Care Fund (BCF) is the joint programme spanning NHS and local government which seeks to join up health and care services. Nationally the BCF is a collaboration between NHS England, the Department of Communities and Local Government, the Department of Health and Social

Care and the Local Government Association who through a dedicated regional BCF Support Team (NHSE and LGA) help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the NHS Long Term Plan.

The BCF is the national programme through which local areas agree how to spend a local pooled budget in accordance with the programme's national requirements. The pooled budget is made up of CCG funding as well as local government grants, of which one is the iBCF. The iBCF was first announced in the 2015 Spending Review.

The BCF encourages integration; requiring CCGs and local authorities to enter into pooled budget arrangements with mandated minimum contribution from CCGs. It is administered by the Local Authority, with the responsibility for oversight and governance sitting with the Health & Well Being Board (HWBB).

Better Care Fund in Shropshire

The total 2019-20 budget for the Shropshire BCF is £41 million the minimum contributions from the CCG and the Local Authority – this does not include the iBCF value.

Shropshire CCGs contribution is a total of £21.6 million which is made up of services commissioned and funded by Shropshire CCG (£13.8m), the balance (£7.8m) of the CCG minimum contribution is passed to Shropshire Council to commission services. (The latter would include previous section 256 services, which under the 2006 Health and Social Care Act allows CCGs to make payments to local authorities to support specific services.)

During 2019/20 the Shropshire Better Care Fund (BCF) focused on the following themes:

- Prevention – keeping people well and self sufficient in the first place; community referral including Let's Talk Local and Social Prescribing, Dementia Companions, voluntary and community sector, population health management
- Admission avoidance – when people are not so well, how can we improve their health in the community; out of hospital focus (Shropshire Care Closer to Home, integrated community services, new admission avoidance scheme), carers and mental health
- Delayed transfers and system flow – using the 8 High Impact Model; joint equipment contract, assistive technology, integrated community service and 'Red Bag' initiative.

The full Better Care Fund Plan can be viewed on the Shropshire Better Together website.

Areas of work in 2019/2020

Cancer

Improving cancer pathways are a priority for the CCG. During 2019/20 the CCG has worked

as part of a system wide group to develop an STP Cancer Strategy led by a Strategic Cancer Board.

A number of key actions were undertaken during the year including:

1. Clinical representation on regional cancer boards and Expert Advisory Groups ensuring there is a local voice in improving consistency in cancer services across the West Midlands

2. Implementation of Best Practice pathways begun and posts funded to support the development and implementation

3. Protected Learning Time events took place to provide learning for GPs around cancer and end of life services

4. Faecal Immunochemical Testing implemented to improve diagnosis for patients with lower GI symptoms, but who do not meet the criteria for a two-week wait referral

5. Investment in video conferencing equipment to improve MDTs and reduce travel time

6. Consolidation of cancer service team onto one site which has improved communication, morale and workload management

7. More than 200 people attended community based 'Living well' sessions that focus on fatigue, emotional health and wellbeing, physical activity and nutrition

8. Living well video developed for patients to hear other patients' experiences

9. Pilot testing benefits of using a treatment summary to help patients to safely self-manage and take control

During 2020/21 the system will focus on delivering the strategy and key actions including:
- Implementing best practice cancer pathways
- Implementing 'My passport to living well with cancer' which will support patients to self-manage and have access to support mechanisms, details of signs and symptoms to look for and who to contact for help
- Improve advice, support and signposting for patients and carers

Children and Young People (CYP)

During 2019/20, it was identified that children and young people were waiting over 12 months for an Autism Spectrum Disorder (ASD) assessment and diagnosis. The CCG worked with a provider organisation to commission a short-term service to assess and diagnose CYP who had waited over 12 months.

During 2020/21, the CCG will work across the STP to develop a long-term sustainable pathway for ASD. The pathway will focus on offering the right support at the right time for patients. Parents and carers will be involved to ensure the pathway meets the CYP and their family's needs. There has been an increase in referrals and some of these are not appropriate for the service. Work is in progress to improve the referral process via a multiagency CYP panel led by education. The new pathway will ensure all CYP receive a care plan that can be used in all settings to support them to ensure they meet their educational and social potential.

Mental Health

- **Severe Mental Illness (SMI) Physical Health**

In January 2020 the CCG implemented SMI Physical Health support nurses to help practices

in completing the SMI – annual physical and mental health reviews. The uptake has been positive, which has enabled both primary care teams and secondary mental health services to work together, holding joint clinics, supporting and training each other, and patients stating they have benefited from the joint reviews. The CCG wants to promote the service to those who have not been in contact as yet and encourage them to get in touch.

- **SEND**

In January 2020 the CCG along with the Local Authority undertook a week-long joint Ofsted/CQC Local Area inspection of Shropshire provision for children and young people with special education needs and disabilities (SEND). Throughout the week, meetings were held with the local authority, our health providers, children and young people and parent /carers. An action plan across the system will be produced and shared to ensure appropriate actions are taken to meet the needs of SEND children in Shropshire.

Integrated Falls Prevention and Bone Health Strategy

In 2019 Shropshire and Telford and Wrekin CCGs worked with a number of stakeholders across our region to develop the Integrated Falls Prevention and Bone Health Strategy.

The stakeholder groups worked to identify what we do to:

- support people to stay well
- identify those people at risk of falling
- offer falls prevention interventions
- support people following a fall

We used this 'map' of falls related interventions and services and the wide range of national evidence to develop an integrated falls prevention and bone health pathway which helped us to identify how current services 'fit' into the pathway and to understand if there were any gaps.

The new strategy describes this pathway and has a primary focus on supporting people to stay well, to identify people at risk and to reduce that risk with a range of falls prevention interventions. The strategy, approved by both CCGs and Shropshire Council, has been well received by a range of public and stakeholder forums.

In 2020/21 Shropshire CCG will be working with Shropshire Community Health NHS Trust to implement the first phase of the strategy.

Fracture Liaison Service

The new Fracture Liaison Service, based at the Royal Shrewsbury Hospital, was launched in January this year. During the first month the team assessed over 70 people who have suffered a fragility fracture, 40% of whom have been referred for a DEXA scan.

A DEXA scan is used to diagnose osteoporosis. If a person does have osteoporosis they will be offered drug treatment and advice and support on how to manage the condition.

Care Homes

The Enhanced Health in Care Homes is an NHS England's framework developed from the learning of a number of nationwide Care Home-related innovation projects. Both Shropshire and Telford and Wrekin CCGs have used this framework to identify areas we need develop.

In October 2019 a Care Home Working Group was established to oversee these developments. We have developed a Care Home Dashboard to help inform the work and track progress on Care Home-related services and projects.

Fifteen local care homes have worked with us to implement a project to:

- identify how care homes support the needs of frail residents
- identify how our health and care system supports care homes in the care for frail residents
- understand the decision making processes that supports a resident with deteriorating health to be cared for in their own home
- understand the decision making processes that lead to a resident being admitted to hospital in an emergency.
- From this we are collating data to make recommendations on next steps and future developments.

With funding from Health Education England we have run quality improvement workshops for staff from the care homes that are part of the project. All the care homes involved in this work have identified a quality improvement project to implement in their care home in the first quarter of 2020/21. Follow-up workshops are planned to share learning and celebrate success.

Stroke Improvement Programme

In 2018/19 we reported on how Shrewsbury and Telford Hospital Trust (SaTH) is working on a number of improvements and developments to meet the targets of the Sentinel Stroke National Audit Programme. An aspect of this plan was to redesign the Stroke Rehabilitation Pathway to enable more people to receive their rehabilitation at or closer to their home.

In October 2019, the local acute and community trusts and the council began to test the first phase of this redesign.

This first phase included increasing the criteria of referral to the Early Supported Discharge Team to enable people that have had a longer stay in hospital to be discharged earlier than would normally have been the case. A number of community hospital beds at Bridgnorth were ‘ring fenced’ to allow people who were medically stable but still had care needs to have their rehabilitation in a community based setting.

This ‘test of change’ is still under way and evaluation is planned for early 2020/21 which will inform any adaptations to the model and also the future workforce requirements needed to fully implement an integrated team that have the skills, competency and capacity to support the rehabilitation needs of stroke survivors at or closer to home.

Ophthalmology Services

The CCG approved a proposal from SaTH to deliver one-stop eye injection clinics to help manage demand and capacity within the department. In 2020/21 the CCG and SaTH will continue to develop and deliver new innovative ways of working within ophthalmology such as virtual clinics for our diabetic eye and glaucoma patients.

NHS Diabetes Prevention Programme

Shropshire CCG has continued to support the local rollout of the NHS Diabetes Prevention Programme commissioned by NHS England. The focus of this programme is to identify pre-diabetic patients and encourage them to attend free diabetes education programmes; these encourage a healthy lifestyle and diet aimed at preventing diabetes. In 2020/21 the CCG will welcome a new provider to the area who will be delivering the NHS Diabetes Prevention Programme to our eligible patients.

Non-emergency Patient Transport

During 2019/20 Shropshire and Telford and Wrekin CCGs undertook a procurement exercise

for Non-emergency Patient Transport to meet their statutory obligations and ensure services continued to meet the local population needs.

This procurement process did not result in a provider being appointed. The CCGs have agreed with the incumbent provider to continue providing the existing service to ensure no disruption for patients. The CCGs will undertake a review of the issues that resulted in the non-appointment to ensure any future risks are minimised.

Outpatient Redesign

We need to ensure we commission planned care services that meet the needs of the local population and that patient's experience of appointments and treatments improves. During 2019/20 the CCGs and SaTH worked together to implement initial changes to outpatients, these included:

- implementing primary care referral criteria to ensure patients are referred to the right place first time
- introducing Clinical Assessment Services to ensure patients are seen by the most appropriate person
- introducing a virtual fracture clinic to reduce unnecessary appointments
- implementation of telephone clinics to replace face-to-face appointments

During 2020/21 both Shropshire and Telford and Wrekin CCGs will be working with local providers to deliver more wide scale transformation of outpatient services. This may include:

- implementing an improved advice and guidance system to reduce unnecessary appointments and improve support to primary care
- implementing patient led follow ups
- implementing alternatives to face-to-face appointments for example telephone helplines, virtual clinics, remote monitoring of patients.

Musculoskeletal (MSK) Redesign

It is estimated that one third of the population over 75 will have a chronic MSK problem, and one in five consultations are for patients with MSK problems. Within Shropshire work has taken place over a number of years to improve services in this area due to this high demand.

We have implemented a service delivering a community based triage, assessment and treatment service for MSK conditions. This has enabled a higher proportion of patients to have their condition managed within the community and has increased the use of conservative management. During 2019/20 the local health system partners have worked together to develop a clinically led pathway for delivery of MSK services across Shropshire, Telford and Wrekin. Focus groups have been undertaken to ensure there is a patient focus to the newly designed service.

During 2020/21 the local health economy plans to work together to implement the new MSK service which should streamline patient journeys and reduce unnecessary surgery.

Neurology Redesign

The neurology service delivered at SaTH has been challenged for many years, primarily due to workforce limitations. These challenges led to patients experiencing long waits to see a consultant, which in turn led to the decision to close to new referrals.

Following a system agreement that the local service cannot be reopened in its current form the CCGs have been working with SaTH and the Royal Wolverhampton Hospitals Trust to develop a sustainable neurology service across Telford, Wrekin and Shropshire.

During 2020/21 the CCGs plans to implement a nurse-led service to offer support to

patients diagnosed with a neurology condition.

Urgent Treatment Centre

Improving the way the NHS delivers urgent and emergency care has been high on the agenda for a number of years and is one of the NHS main national service improvement priorities. This looks at how Accident and Emergency Departments (A&E) can be improved and how access for patients can be made clearer.

One of the national priorities is to ensure every area has an Urgent Treatment Centre (UTC) in place during 2020/21. The aim of the UTC is to provide an alternative healthcare setting for patients to be seen and to reduce demand on A&E.

The UTC will assess and treat patients arriving at A&E with urgent, non-life threatening health conditions during one visit. The service will offer both booked and walk-in appointment slots 12 hours a day, seven days a week.

The CCG has been working with Telford and Wrekin CCG and SaTH to develop the local model for UTCs and a procurement exercise has been undertaken during 2019/20. The service will be in place by April 2020.

Single Provider for NHS111 and 999

In 2019/20 Shropshire and Telford and Wrekin CCGs supported the regional commissioner's proposal to award the contract for providing the NHS111 service to West Midlands Ambulance Service (WMAS), bringing together the management of NHS111 and 999 calls into an integrated service from November 2019.

The first step of the change was to transfer the service to WMAS from November 2019 with full integration coming on stream after the winter period in 2020. This will be the first such integration in the country and is believed will lead to real benefits for patients and staff and also fewer patients being sent ambulances inappropriately and a reduction in the number of patients asked to attend A&E.

The new model will support more patients being cared for in the most appropriate place for their needs.

This will also include more patients being provided with care over the phone by a team including GPs; other healthcare staff including advanced nurse practitioners; community mental health teams; pharmacists, dental nurses, paramedics and midwives.

Delayed Transfers of Care (DToC)

The national target for Delayed Transfers of Care from hospital is 3.5%. Overall, Shropshire Delayed Transfers of Care performance places it fourth place in the region. December 2019 compared to the same time the previous year, recorded decreases for both SaTH and RJAH, however, for the Community Trust there was an increase.

The figures are set out below:

Provider	% DTOC December 2019	% DTOC December 2018
SaTH	1.2%	1.4%
RJAH	5.8%	7.1%
SCHT	7.5%	3.3%

The CCG has continued to work with system partners to reduce delays further within

SaTH, SCHT and RJAH.

This includes delivering an Integrated Hospital Discharge Team to organise discharges as soon as individuals are identified as medically ready to leave hospital and increasing step down care to support people to return home or to rehabilitation care settings.

This winter has seen unprecedented demand on hospital services and some of the barriers to timely discharge have been the ability to find care providers who have the capacity to deliver the required packages of care for safe discharge. The difficulty can often be finding the care package for those in the most rural areas and patient choice in that they refuse an appropriate alternative interim placement whilst they await their preferred location of service delivery.

Transforming Midwifery Care (part of STP)

Over the last two years we have carried out a review of our local midwifery care. This has involved listening to the views and experiences of hundreds of women and their families to understand how they want to be cared for and supported before, during and after having a baby.

The review has also involved gathering the views of professionals working in or with maternity services and looking at the latest research, evidence and best practice across the country.

Pre-engagement activity has continued to take place during 2019 and particularly with those members of the community from the nine protected characteristics.

We have looked in detail at all the feedback and evidence and have developed a proposal for how we can transform the way midwifery care is delivered.

By making these changes, more women across Shropshire, Telford and Wrekin would get quality midwifery care closer to home improving outcomes for them and their babies.

It would also help create a great service for staff to work in. They will be able to work more flexibly to provide midwifery care where it is needed. The consultation will begin after the proposal has been through a robust national assurance process.

Medicines Management

Prescribing

Prescribing is the most common intervention in the NHS. Supporting prescribers and patients to manage medicines is important in order to ensure people get the best health outcomes from the medicines that are prescribed.

The Medicines Management Team has been working on a number of projects to improve the quality of care for patients and make the best use of medicines.

A joint health economy formulary across all Shropshire and Telford and Wrekin providers is now in place.

This year the team has focused on quality of prescribing to improve long term outcomes for patients, with a particular focus on reducing hospital admissions related to medicines (HARMs).

We have introduced IT systems, Eclipse and PINCER across the CCG GP practices to support clinicians in identifying patients at risk of HARMs and take appropriate action to reduce these risks where possible.

We have commissioned or delivered education programmes for Primary Care in asthma, COPD, diabetes, polypharmacy and pain management followed up with audits and support for practices to identify opportunities within their own practices.

Self Care

In March 2018 NHSE published "Guidance on conditions for which over the counter items should not routinely be prescribed in primary care". It listed 35 conditions, plus probiotics and vitamins and minerals, as areas where self care may be more appropriate.

This year we have focused on public education and engagement to help people become 'self care aware.' This has included bus and poster campaigns, and multiple patient events in libraries, GP practices and community settings.

Antibiotic Stewardship

Antimicrobial resistance remains a national and global threat to health with increasing bacterial resistance to those antibiotics in current use meaning infections are becoming harder to treat. This has continued to be a major focus throughout this year.

We have rolled out TARGET 'Train the Trainer' programmes to over 20 clinical staff across the CCG to educate and inform clinical practice in their own workplaces to continue promoting appropriate antibiotic use.

Shropshire continues to meet or exceed all national targets for reducing inappropriate antibiotic use.

Primary Care

During 2019/20, the CCG has continued to make clear progress in developing Primary Care Commissioning, linked with a maturing Primary Care directorate.

The CCG commissions Primary Care Services under delegated authority from NHS England and has a Memorandum of Understanding with NHS England which sets out roles and responsibilities and ensures robust contracts and support are provided to our practices.

Following the closure of Whitehall Medical Practice in September 2019 and the dispersal of its patients list, the CCG now has 40 practices across three localities.

The Primary Care Team has three Locality Managers who support the development of the localities and act as a first point of contact with the CCG. The managers work closely with the Locality Clinical Chairs.

2019/20 has seen the development of Primary Care Networks (PCNs) with the appointment of Clinical Directors to lead greater collaboration and drive change.
In Shropshire four PCNs exist:

- North Shropshire PCN
- Shrewsbury PCN
- South West Shropshire PCN
- South East Shropshire PCN.

The CCG is supporting them with development funding and there are regular meetings between the Head of Primary Care and the PCN Clinical Directors.

The focus for 2019/20 has continued to be the delivery of the GP Forward View and the implementation of Extended Access appointments for 100% of the CCGs population.

As part of this, the CCG has supported practices in accessing all available funding and support from regional and national development schemes as well as drawing on local resources. Practices have received investments and support around the following key areas:

- GP resilience
- Extended Access
- Training and development
- Estate and Technology including premises improvement grants
- Workforce development
- Productivity and workload
- Development of New Models of Care

A significant part of the funding received has been used to ensure that GP and other clinical appointments are available to patients in the evenings and at weekends. The Extended Access Service started on 1 October 2018 and is well utilised by Shropshire patients. Average utilisation of appointments is 83.5% (excluding DNAs) and 76% including DNAs.

The CCG has worked with providers to develop a Patient Survey that measures patient experience, in particular the experience of accessing the service and their overall satisfaction.

According to feedback collected by the CCG from 1 March to 18 July 2019, 99% of patients were either very satisfied or satisfied with the service, with 98% of patients being either very satisfied or satisfied with the ability to book appointments at weekend and evenings.

The Primary Care Team has continued to be successful in securing funding from NHS England and Health Education England to help develop and support a sustainable Primary Care workforce.

Key achievements include:

- the funding of eleven bespoke projects aimed at retaining GPs in practices
- the provision of a series of retention workshops for GPs
- funding for the local GP locum network to run training and development for Locum GPs
- the appointment of five more Physician Associates under the local PA Internship scheme
- continued investment in training and upskilling for nurses and health care assistants
- the development of specific support for GP trainees to ensure that, as far as possible, as many of these remain in the area once they are qualified
- Support for Primary Care Networks in developing their own, detailed approach to workforce planning based on current staffing data, patient engagement and demographic information including local health profiles and the prevalence of key health conditions
- Funding for five newly-qualified GPs to allow for an increased level of supervision and support.

Work has been ongoing since January 2018, to ensure that Shropshire have engaged with and are taking every advantage of being involved in the Time for Care Programme and implementing quality improvement techniques in the practice to improve service delivery.

Fifty percent of practices have benefitted from the PGP Quick Start Programme and/or Learning in Action course; we are currently bidding for our third wave of PGP Quick Start this spring, which will bring us to 65%. Three out of four Shropshire Primary Care Networks have arranged initial development sessions run by the Time for Care Team and at least six individual Practice Managers have recently taken part in the General Practice Improvement Leads Programme run nationally.

Significant work has been undertaken to complete a very detailed analysis of Primary Care Estates. It will culminate in the formation of an STP Primary Care Estates Strategy in summer 2020 that will provide the basis of coherent investment into estates at a critical time of change as PCNs drive how health services are delivered locally.

The work of the Primary Care Team is mainly overseen by the Primary Care Commissioning Committee which receives regular updates on the key priorities. A Primary Care Risk Register ensures that identified risks are monitored and mitigated and this is overseen on a quarterly basis by Primary Care Commissioning Committee.

During 2019/20, the Quality Team has worked with the Primary Care Team to provide oversight on quality issues relating to General Practice and the services that the CCG commissions from them, providing assurance to Primary Care Commissioning Committee.

A number of joint practice visits have taken place to test out a new quality support visit template and schedule.

A dashboard has been developed to capture up-to-date data, intelligence and CQC inspection reports as quality indicators in Primary Care. The dashboard will continue to be developed into 2020 and 2021 in light of the NHS Long Term Plan. This provides an overview of Quality and Performance of our Primary Care establishments.

A new tool including the Health Equalities Framework has been developed to help increase the uptake of annual health checks for adults with learning disabilities; improve accessible information in Easy Read format for families and carers; improve access to specialist services, and to help aid early identification of health inequalities to ensure timely investigations are requested if required.

Support and advice has been provided to Primary Care on refurbishment requirements and an ‘Infection, Prevention and Control’ educational session was delivered at a protected learning time event covering the following topics: sepsis, E.coli blood stream infection and Clostridium difficile.

There have been a number of CQC inspections during the year with the majority resulting in ‘Good’ and two ‘Outstanding’ reports.

However, there were two practices that received a report of ‘Requires Improvement’ and the CCG Primary Care Team have been working with them to support the necessary actions to move them to ‘Good’ overall at the next inspections.

In line with the National Quality Board’s definition of quality and the shared commitment to quality, Shropshire CCG will continue to drive improvement in systems and processes for monitoring and assuring quality and performance in Primary Care through this coming year.

In August 2019 the national GP Patient Survey reported that practices in Shropshire had higher than average patient satisfaction rates with an overall rating of 88% compared to 83% nationally

(89% in 2018). Tailored work has taken place with practices that were highlighted as having lower satisfaction levels.

The Primary Care Team has again reviewed all of the Locally Commissioned Services (LCS) that the CCG commissions from practices and which sit outside the main General Medical Services Contract. 2019/20 has seen many of the LCS move towards activity based payment giving the CCG a much more detailed picture of activity in Primary Care. 2020/21 will see movement towards aligning LCS across the STP and a range of improvements to individual service areas in line with guidance.

In the latter half of 2019/20, the focus has been on ensuring a balanced budget and development of a new Primary Care Strategy reflecting the priorities highlighted in the NHS Long Term Plan and new GP Contract both released in early 2019.

Sustainable Development

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities and the environment and are committed to minimise our footprint.

Actions to support sustainable development undertaken during the year are integral to this Annual Report, although outlined below we have pulled out some key themes and actions 2019/20. We have:

- developed a Sustainability Policy with our neighbour NHS Telford and Wrekin CCG in preparation for the creation of a single CCG in 2020/21, which will set out a number of key objectives the CCG will set itself.

- appointed a Board level Sustainability Champion.

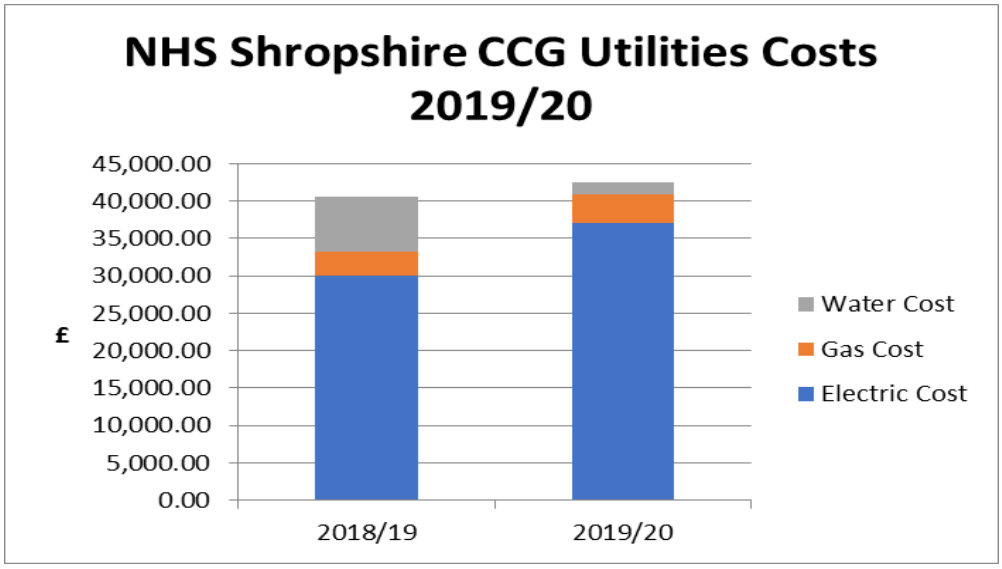
As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020.

More information on these measures is available here:

www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

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

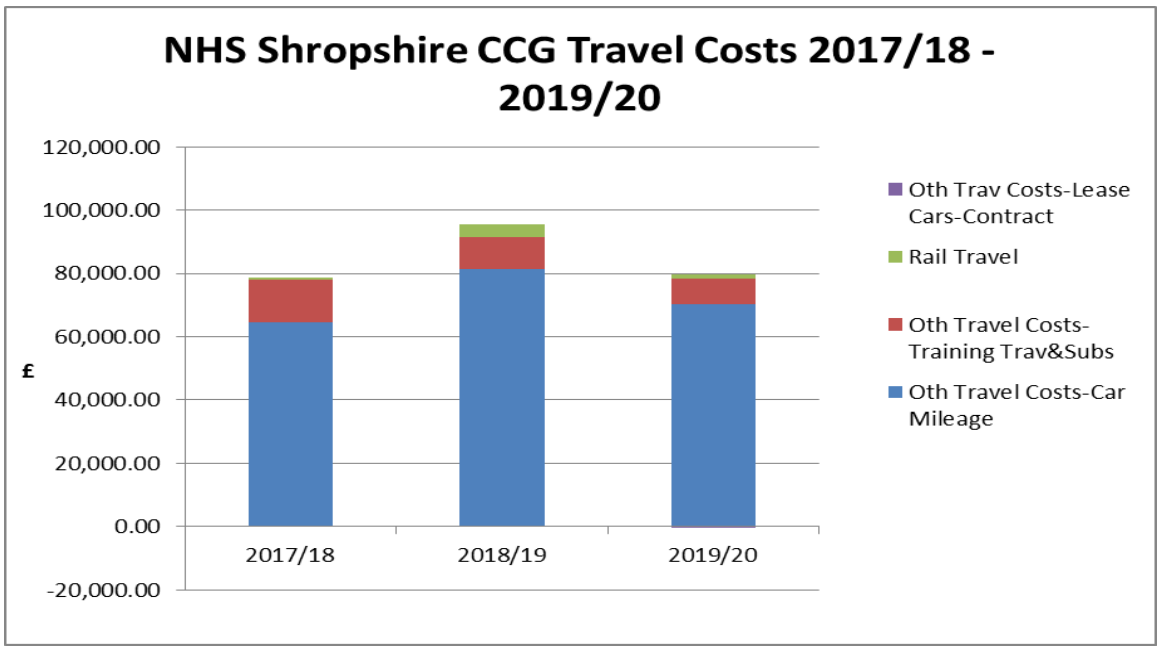
Energy



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

Travel

The CCG has seen a significant decrease in staff travel expenses between 2018/19 and 2019/20 with both car mileage and rail travel decreasing back to levels in 2017/18.



Improving Quality

Improvement in the Quality of Services

The Quality Team's role within the CCGs is to drive continuous improvements in all of the services it commissions, to ensure that patient experience person-centred care is safe, effective and efficient. In June 2019 Shropshire CCG and Telford and Wrekin CCG Quality Teams came together to work as one team to further increase effectiveness, integration and alignment.

As a system we commit to using all available resources to deliver improved quality by removing unwarranted variation and improving outcomes at a population health level. The CCG's current financial position is one of the most significant challenges, therefore it is crucial that the Quality Team works with all partners to identify where savings can be made whilst ensuring cost improvement programmes do not put patients at risk of coming to harm.

Our CCG ensures that quality is at the heart of the organisation and is embedded throughout the commissioning process. Over the next two years Shropshire CCG with Telford and Wrekin CCGs will look to align services and developments more closely with Local Authority teams. This will ensure Public Health, Social Care, Education and Housing pathways are developed in collaboration with health services to deliver interventions which are available and accessible in the right place, at the right time.

As Shropshire Care Closer to Home and community initiatives continue to develop, the CCG's Quality Team is exploring opportunities of working with the Local Authority to progress system wide quality monitoring processes. This will make best use of available resources and will support the successful management of health conditions.

We understand that there needs to be a significant change in the way services are commissioned and delivered to ensure that those requiring NHS care are supported to have choice and control in their healthcare.

Quality Assurance Principles and Processes

The fundamentals for the Quality Team in working with providers and patient representatives to gain assurances of the quality and performance of the organisation include:

- Drawing on timely intelligence from the Providers Board, to see that it is satisfying itself that performance is continually improving and that appropriate action is being taken to remedy problems as they arise
- Looking beyond written intelligence to develop an understanding of the daily reality for patients and staff, to make data more meaningful – including evidence of scrutiny of the 'so what' factor
- Seeking assurance that staff are clear about their responsibilities and accountabilities and how these fit with the organisation's vision and purpose

- Triangulation which ensures we can 'test' the intelligence and seek assurance by looking at more than one source and type of information, including through direct engagement with the organisations staff and its patients
- Patient representatives supporting quality assurance visits
- Seeking assurance of sustained improvement where remedial actions have been required to address performance concerns
- Offering appreciation and encouragement of sharing good practice where performance is excellent or improving
- Taking account of, and positively encouraging, independent scrutiny of performance, from regulators and scrutiny committees

In gaining the above information the Quality Team strives to ensure that decision and actions are based on 'assurance' and not just 'reassurance'. Embedded throughout all quality monitoring processes will be the quest for evidence to underpin the reassurances being given.

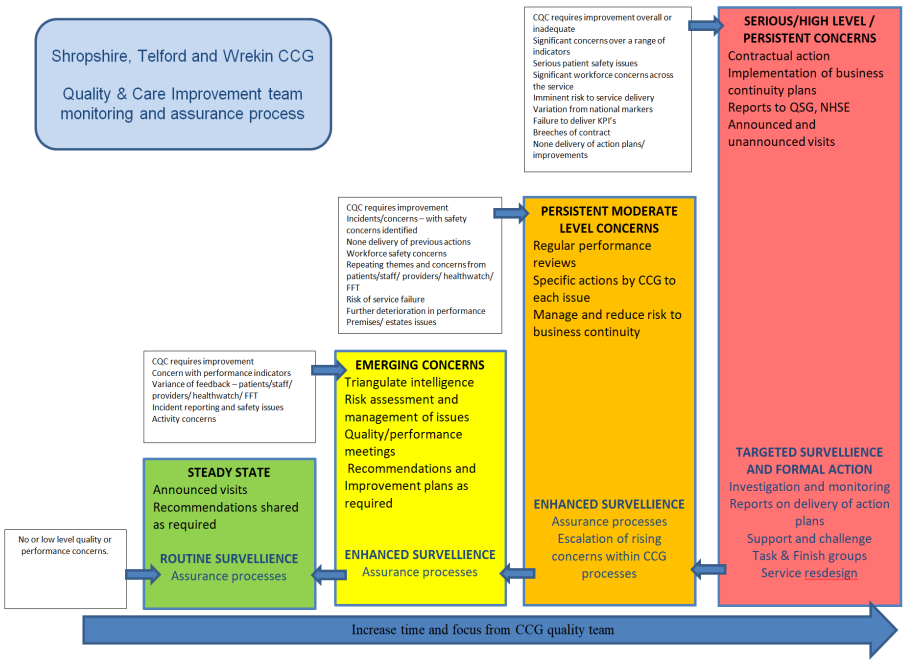
Assurance: Being assured through the Quality Team reviewing reliable sources of information and is satisfied with the course of action.

v

Reassurance: Being told by the executive or staff that performance or actions are satisfactory.

Monitoring and surveillance of provider risks are considered across four ascending levels to enable the Quality Team to operate responsively and appropriately to concerns identified.

Four ascending levels of concern		**Surveillance level**
Level 1	**Steady State**	**Routine**
Level 2	**Emerging Low Levels Concern**	**Enhanced**
Level 3	**Persistent Moderate Level Concerns**	**Enhanced & Escalation**
Level 4	**Serious/High Level / Persistent Concerns**	**Formal Action/ Risk Summit**



Quality across the system

- In June 2019 Shropshire CCG and Telford and Wrekin CCG Quality Teams came together to work as one team to further increase effectiveness, integration and alignment
- Quality leads are aligned to each provider contract linked with performance, contracting and commissioning with responsibility for driving best practice and monitoring of safe care in the key areas of work, for example Cancer Services; Emergency Care; End of Life Care; Pressure Ulcers and Sepsis
- The quality and safety of provided services is assured through quality schedules, site quality assurance visits, quality and contract review meetings CQRMs, and Commissioning for Quality and Innovation indicators (CQUIN)
- Quality dashboards are monitored with named quality leads aligned
- Quality leads are aligned to individual programmes of work and monitor the quality impact of cost improvement schemes
- Shropshire CCG with Telford and Wrekin CCG and Local Authorities drive the quality agenda across commissioned services through contract monitoring in conjunction with Ofsted, CQC, NHSE/I and Healthwatch
- Quality concerns and risks are shared at: weekly quality huddle meetings; monthly Quality Team meetings and Quality Committee (QC). The Quality Team holds its own risk register which is updated as required and formally reviewed by the whole team on a quarterly basis. Any high risk areas are included within the corporate risk register.

The highest quality risks during 2019/20 have been with the Acute Trust which has had a history of challenges: workforce provision, A&E performance and maternity services. The CCG has continued to jointly escalate with Telford and Wrekin CCG, concerns with the Provider and to NHS England/Improvement. The Trust was evaluated as “inadequate” by the CQC in 2018 and concerns have continued to be raised during inspections during 2019/20. Improvements in maternity services were noted in the latest CQC inspection. Action plans responding to the CQC inspection continue to be progressed.

Driving Quality Improvement 2019/20

West Midlands Quality Review Service (WMQRS)

WMQRS is a collaborative venture between NHS Organisations. The service works primarily within provider organisations to help improve the quality of health services. It was commissioned by NHSE to undertake a formative review of the management of quality functions at both NHS Shropshire and Telford and Wrekin CCGs. A comprehensive inspection took place over two days on 14 and 15 February 2019 and the actions identified implemented throughout 2019/20.

The visiting team included 10 senior leaders from provider and CCG organisations. Through individual interviews, focus groups and review of documentation the visiting team considered the CCG's internal arrangements of: quality surveillance; incidents; quality outcomes; leadership; the Boards' confidence in the Quality Team and the opportunities for working as a single quality function across both CCGs.

The reviewers were impressed by collaborative working across the Quality Teams and the commitment to improve quality. Many areas of good practice were acknowledged including: oversight of serious incidents; monitoring of Looked after Children (LAC); safeguarding approaches; The Learning Disability Review Programme (LeDeR); quality monitoring in primary care and the utilisation of business intelligence.

Areas for development identified included: a joint quality strategy; risk register with clearer controls; closer alignment between Performance and Quality Teams; wider use of patient stories and a single voice for quality across the two CCGs.

Positive progress has been made against the areas highlighted for development. In summary the following actions have been put into place to address these issues:

- joining of the two CCG Quality Teams
- clearly defined roles and responsibilities across the teams
- an interim structure in place with clear line management responsibilities
- Quality Leads assigned to contracts and working with closely with commissioners
- a joint Performance and Quality Board report
- a joint Quality Strategy
- an overarching quality operational plan
- an aligned Quality Risk register
- aligned Serious Incident processes
- aligned Complex Care teams and processes for completion of health assessments and agreement of funding contributions

Serious Incidents

In order to ensure mistakes in practice do not repeatedly occur, our providers are required to ensure that policies and procedures are robust enough to identify risks, manage those risks and create a learning culture. The CCG receives notification of serious incidents through the national Strategic Executive Information System (STEIS).

Our primary care systems and independent contractors are supported to use incident reporting systems to report incidents in order to identify and learn from events.

All Serious Incidents are managed in accordance with the NHS England (2015) Framework in which a Root Cause Analysis and action plans are shared with the CCG and providers. Incidents and Serious Incidents are analysed for trends and reported to the CCG Board Quality Committee.

The CCG's Serious Incidents (SI's) process has been reviewed in the last two years by internal auditors, which received significant assurance.

The CCG is working with providers to explore opportunities for reviewing SI's under the new national framework which is pending publication. It is anticipated that a more system wide process will become embedded to capture and share the learning across all providers involved in the patient's journey.

Independent and peer review processes will enhance the objectivity of reviews and provide a different perspective on the potential root cause and subsequent actions. In addition, by working closely with neighbouring CCGs it provides the opportunity to share learning, best practice and benchmarking that is presented at Quality Surveillance Groups (QSG).

Some of the key themes identified in the serious incidents reported during 2019/2020 are unexpected deaths, diagnostic incidents, pressure ulcers, self-inflicted harm, slips/trips/falls and treatment delays. Where learning is recognised, either immediately or as part of the root cause investigation, the CCG continues to monitor it through meetings and quality assurance visits to ensure it is being embedded.

The CCG has commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent audit into the deaths and serious incidents that have occurred at Shrewsbury and Telford Hospitals in the last two years. The detailed review, which is split into two phases, aims to seek assurance that serious incidents have been investigated in line with best practice; thus providing clarification that the Mortality Governance process is effective.

Through the process of Structured Judgement Reviews (SJRs) in phase two, assurances that learning is being embedded into practice as a result of the investigations is also a desired key outcome.

The audit report will outline the identified strengths and weaknesses in the provision of healthcare across the patient pathway, from pre-admission to post discharge, including end of life care. Therefore all key stakeholders who may have been involved in the patient's journey leading up to their death, have been notified that their contribution and involvement to the review may be required. The final report will be shared with providers and will be used to inform some of the future decisions in relation to changes to serious incident processes moving forward.

Quality Monitoring in Primary Care

Shropshire has 40 GP practices. There are four newly formed Primary Care Networks (PCNs) across Shropshire. These are: North Shropshire; Shrewsbury; South East Shropshire and South West Shropshire.

The CCG took over fully delegated commissioning responsibility from NHSE in April 2015. As such Primary Care is subject to the same monitoring of agreed quality indicators and potential action to be taken if quality is at risk.

The CCG recognises the importance of its role in supporting Primary Care to deliver high quality services whilst acknowledging that assuring quality in Primary Care creates complex challenges, particularly due to the large geographical area and the rurality of Shropshire. Quality Leads in conjunction with the Primary Care Team will monitor practice quality performance through the use of self-assessment, triangulation of indicators and quality assurance visits as deemed appropriate based on risk stratification, including the core quality measures and:

- Quality outcomes framework
- Improving patient outcomes
- Medicines management (main lead being medicines management team)
- Completion of e-declaration
- Practice and Primary Care Network resilience
- Business continuity

The CCG is establishing processes to receive reliable data on incidents, significant events and patient experience feedback. The Quality Leads for Primary Care will develop a framework to support the offer of a schedule of quality visits, incorporating a range of quality assurance measures and including sharing any learning from incidents. Quality concerns are included within the Primary Care Assurance Report and received by the CCG's Primary Care Commissioning Committee.

CCG Quality Leads for Primary Care work collaboratively with the HEE Training hub in identifying and arranging training opportunities for Practice staff which supports the development of new services and the delivery of high quality patient care and the achievement of the General Practice Nurse Ten Point Action Plan. Quality Leads are supporting the local future developments of the Training Hub which will become a more robust centre for the management of Primary Care staff development.

CCG Quality Leads for Primary Care establish strong links with regional Primary Care Nurse Lead's facilitating opportunities for sharing best practice and funding opportunities for innovative ways of working.

This includes establishing funding for rollout of digital nurse champions in 2020. This will provide an opportunity to look at how we can better use recent developments in technology so that people do not have to make long journeys for appointments – especially important for people living in the most remote rural communities in Shropshire.

As Placed Based working and Care Closer to Home initiatives establish across both CCGs, Quality Leads for Primary Care will work closely with commissioning colleagues to identify opportunities for different ways of working and how these can support development opportunities within the Primary Care Networks.

Quality in Care Homes and the Domiciliary Care Sector

Ensuring quality in care homes and the domiciliary care home sector is challenging and complex. The CCG has an important role in supporting providers to deliver high quality services and improvement plans, in order to contribute to the sustainability of out of hospital care.

These services provide care to frail, vulnerable people and often care is joint or wholly funded by the CCG under NHS responsibilities for continuing healthcare, a joint package of care, or through a contribution to the registered nursing care received.

Working in partnership with our Local Authority, Care Quality Commission and Healthwatch, the Quality Team has been offering both support and challenge to care homes across Shropshire and developed a dashboard to monitor quality indicators to gain assurance on the level of care and services care homes are providing.

The Enhanced Health in Care Homes (EHCH) Framework 2017, model of care is based on a suite of evidence-based interventions, which are designed to be delivered within and around a care home in a coordinated manner in order to make the biggest difference to its residents. All aspects of the care described in this framework are being tailored to meet the needs of Shropshire population, local circumstances and to each individual person's care needs.

EHiCH framework forms the basis for work being undertaken by the Frailty Collaborative and the Shropshire's Community based models of care (Care Closer to Home and Integrated Place Partnership Model of Care) to provide a coordinated approach to out of hospital health and social care.

Transforming Care Programme (TCP) (now known as the LD/ASD programme)

It is a local priority, in line with the national Long Term Plan, to transform care in order to improve health and care services so that more people can live in the community, with the right support closer to home. This is true for the whole population with targeted work in this area for people with a learning disability.

Through earlier intervention the aim is that fewer people will need to go into hospital for their care associated with their learning disability and/or mental health needs. For those people who do need to go into hospital, a plan of care and treatment to support a robust and safe discharge will be developed in a multiagency approach. This will ensure the length of stay in hospital is appropriate for the individuals needs and not due to other social, environmental or housing factors.

The Quality Team and Commissioners across Shropshire and Telford and Wrekin CCGs are working with the TCP team to:

- review placements and support everyone who is inappropriately in hospital to move to community-based support. Locally agreed plans are being developed to ensure quality care and support services based on the model of good care.
- work with our Local Authorities to have joint strategic plans to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour with the community
- maintain registers of people with learning disabilities and/or autism in: NHS funded care held within specialist commissioning; CCG locked rehabilitation provision; at risk on admission (ARR register).

The Learning Disabilities Mortality Review (LeDeR) Programme

This programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

The programme is led locally by the Quality Team, with the Local Area Contact (LAC) sitting

within the Quality Team. Every organisation across the health and social care system has trained reviewers.

Shropshire CCG is one of the best performing CCGs in the Midlands and East, having the lowest number of unallocated cases and the highest number of completed cases. Completion of the reviews within six months of notification is also being monitored by NHSE.

The CCG is developing a pool of reviewers, as well as continuing to support and train existing reviewers to ensure reviews are completed within this timeframe.

Since the LeDeR programme started in Shropshire and Telford and Wrekin in June 2017, there have been 55 deaths notified and 37 deaths reviewed. The average age of death is 57 years in line with the national average. Pneumonia and aspiration pneumonia is the leading cause of death.

The Quality Team, along with reviewers from providers, aim to maintain the high quality of reviews completed and ensure the learning from these reviews are embedded into practice to transform services for people with learning disabilities with the aim of reducing health inequalities. An example of practice developments taking place is work to support Primary Care to ensure learning disability registers within the community are maintained, in order that people with learning disabilities are invited to an Annual Health Check and are receiving timely screening, medication reviews, investigations and treatment.

Individual Commissioning (previously known as Complex Care)

The Individual Commissioning Teams across Shropshire and Telford and Wrekin are now working jointly and are responsible for assessing, planning and commissioning the following services:

1. The following quality indicators will be monitored for people in receipt of Continuing NHS Healthcare (CHC) and for all people who are assessed as having a Primary Health need it is then the responsibility of the NHS to provide both the assessed healthcare and social needs.

- Over 80% of applicants who have a positive checklist (as described in the National Service Framework (NSF) for CHC 2018 will have a Decision Support Tool (DST) undertaken within 28 days of receipt of the Checklist by the CCG.
- All Multi-disciplinary Teams (MDTs) will be constituted in accordance with the NSF for CHC 2018. This means that MDTs will be constituted by a Nurse and a Social Worker or two health care professionals from different professional backgrounds.
- Less than 5% of DSTs will be undertaken outside of an acute hospital setting. The national target is less than 15% however STW CCGs are setting a stretch target of 5%.

2. The following quality indicators will be monitored for people in receipt of Fast Track Care: it is for a person who has been assessed as having a rapidly declining condition that may be entering end of life.

- The CCG will accept over 95% of Fast Track referrals within 24 hours of receipt
- The CCG will offer all patients a choice of care either in their own home or in a care setting, the aim being for all people to have their end of life care in the setting that they choose
- The CCG will ensure that all Fast Track patients have a review of their needs within 12 weeks of being placed on a Fast Track.

3. The following quality indicators will be monitored for people in receipt of Funded Nursing Care (FNC): it is a payment made by the NHS to a care home, for the care provided by a registered Nurse.

- The CCG will ensure that FNC payments to homes that undertake regular activity with the CCG are paid by mandate thereby supporting the care home sector.

4. The following quality indicators will be monitored for people in receipt Joint Funding: it is provided between the Clinical Commissioning Group (CCG) and the Local Authority (LA) or a self-funding person when assessed that the NHS ought to contribute towards the cost of care.

- The CCG will develop a Joint Funding protocol that is used across both Shropshire and Telford Local Authorities.

Workforce – 'Quality is Everyone's Business'

Workforce across the system is a key challenge, we need to work together to embrace creative new solutions to ensure there is a sustainable, skilled and competent workforce for the future. The number of vacancies across the system remains a significant concern. Medical staff groups and nursing have a higher vacancy rate than the regional average. The average vacancy rate in social care is 5.6% which is below the Midlands and East average.

The Quality Team works closely with the STP strategic workforce group and Local Workforce Action Board (LWAB) to drive forward the changes required. Our local people strategy identifies four key areas for collective working:

- Attract, Recruit and Retain
- Workforce Planning and Modelling
- Education, Development & Training
- OD Leadership (Equality & Diversity)

Developments to identify, retain, further develop and systematically manage talented people within the system are continuing to be progressed. Offering system-wide secondments; development of a collaborative bank; and local career progression pathways with our local university are examples of the vision for the future.

Over the next three years success would be demonstrated by:

- Reduced vacancy rates
- Reduction in use of agency
- Reduced staff turnover and improved retention
- Reduction in sickness
- Staff survey responses being better than national average
- Strong leadership at all levels

Planning future workforce is a priority for the CCG and it has established close links with Staffordshire University. CCG is recognised as a clinical learning environment for student nurses and other healthcare professionals and registered health professionals within the CCG act as clinical mentors.

Our Aspiration – To Create Outstanding Quality by:

- a commitment to true patient-centred care, personalised care where patients have ownership of their own care, but also routinely inform development and delivery of future

services based on the learning of their lived experiences
- driving a culture change within our organisations to work in an integrated way. Reducing medical models of care when appropriate
- strengthening of integrated multi-disciplinary working across these organisations to ensure our population receive care in the right place at the right time (inclusive of acute and community health services, Social Care, Domiciliary Care and Private Providers)
- changing the approach to develop a dynamic system that strengthens an individuals' ability to self-care
- streamlining care with robust pathways to ensure there is sufficient capacity for planned care designed to improve patient experience and outcomes
- supporting people in crisis with the right care, at the right place. Making sure people can navigate a simplified urgent care system to meet both physical and mental health needs.
- the overarching ambition that all of our providers will move to good and beyond within the next five years.

How We Plan to Improve Quality over the Next Five Years and Achieve Our Aspirations

- Quality leads across the system will adopt the National Quality Boards' Shared Commitment to Quality, which sets out the nationally-agreed definition of quality according to five core pillars – safe; effective; positive experience; well-led; and sustainable use of resources
- A Local Quality Surveillance Group will be established to operate across our local and regional systems and will report in to a national QSG
- Quality issues will be addressed proactively and systematically in order to monitor early warning signs and quality risks across pathways and services, whilst at the same time recognising and adhering to individual statutory responsibilities
- There will be a focus on aligning the quality improvement approaches and methodologies used across the system to standardise processes for monitoring improvement of care and services. The CCG will consider stretched key performance indicators to deliver high quality safe care.
- Development of approaches in leading quality transformation, innovation and improvement across our system, in alignment with the pending national Improvement Framework currently being developed.
- Promote effective use of data in order that full analysis of the data provides a story and firm evidence of the gaps and risks on which to base the developments and improvements required
- Work collaboratively with patients and services users, utilising peer leadership approaches to co-producing our services.

Shropshire CCG – View of Quality

Safeguarding

The Safeguarding Team (Designated Nurse for Children and Looked after Children, Named Nurse for Adults) continues to offer advice, guidance, support and training across the health economy to professionals including dentists, pharmacists and GPs.

A new updated CCG GP safeguarding practice audit template has been devised and agreed for Shropshire and Telford and Wrekin for 2020. Safeguarding performance dashboards, policy and procedures and serious case rapid reviews on-going work in progress to monitor and update with publication of reviews via children's partnership board.

The guidance for Looked After Children (LAC) has been disseminated to GPs to ensure that knowledge around this area of work is up to date and that GPs have received a useful document to assist their practice. The recording of 'hosted' looked after children should also be completed by GP medical practices. LAC dashboard monitoring continues via Clinical Quality Review Meeting (CRQM).

Adult safeguarding statutory legislation (MCA/DOLs & Making Safeguarding Personal Principles), policies and procedures development is on-going in line with the Care Act (2014) and the Adult Safeguarding: Roles and Competencies for Health Care Staff (2018). The Adult Safeguarding Lead Nurse continues to work closely with the Telford and Wrekin Council.

In respect of Adult Safeguarding the CCG Adult Safeguarding Leads continue to work alongside multiagency colleagues to identify and consider implications in respect of responsibilities resulting from the Mental Capacity Amendment Bill (2019 for both the joint CCGs and Providers).

This remains an ongoing process and the Leads are liaising closely with the Executive Nurse. The Lead for this has joined the NHSE National Group for MCA/DOLs and Liberty Protection Safeguards as NHSE regional representative.

There are significant delays noted at a national level in the publication of the Code of Practice, Regulations and Impact Assessment which makes implementation preparation difficult. The Head of Safeguarding at NHSE/I has recently stated to CCGs: “DHSC are due to consult on the MCA / LPS guidance and Code of Practice around June 2020 and we are advising against making local commissioning arrangements until the national guidance is available.”

Currently one Domestic Homicide Review (DHR) has been forwarded to the Home Office for consideration. Internally identified recommendations for the CCG have been actioned. One further DHR is pending its final draft.

The Adult Safeguarding Forum 2019/20 Programme continues with funding provided through Shropshire Partners in Care for 2020/2021.

The forum provides support and shared learning, in respect of local themes and trends, with our residential care and domiciliary care providers across both Shropshire and Telford and Wrekin CCG areas. The Adult Safeguarding Team assists in identifying agenda items and presents topics to the groups where appropriate.

In response to the introduction of the Adult Safeguarding: Roles and Competencies for Health Care Staff 2018 a three-year training programme is under way. Additional training support, to ensure compliance with the programme, is being provided through Mental Capacity Act Peer Supervision Groups on a quarterly basis. Additional face-to-face training is planned to complement the available e-learning modules.

Infection Prevention and Control

Shropshire Clinical Commissioning Group is committed to reducing and preventing avoidable healthcare associated infections to support high quality and safe patient care. We have continued to work in partnership with our providers throughout the year to maintain low numbers of Methicillin resistant Staphylococcus aureus (MRSA) blood stream infection and supported the review of Clostridium difficile infection cases to share learning to improve patient outcomes.

Reduction in Gram negative blood stream infections particularly Escherichia coli (E. coli) blood stream infection remains a priority across our local health economy (LHE) and work progresses with raising awareness on the prevention of urinary tract infections by encouraging hydration.

The CCG is working locally with system partners to prepare for coronavirus cases in co-ordinating appropriate action and resources in line with national guidance and requirements to protect the public’s health, and to plan for any changes in the situation, should they arise.

In 2020/21 collaborative working will continue and we will build on assurance processes currently in place with providers and partner organisations. We will continue to lead on influencing the Local Health Economy (LHE) Infection Prevention Control Strategy in provider organisations with a focus on minimising the risk of infection and ensuring people are cared for in a safe clean environment and are protected from avoidable harm.

Use of Patient Insight

Patient Insight is used by the CCG as part of its continuing commitment to improving the quality

and safety of our services. The Insight Service collates, aggregates, analyses and reports quality data, complaints, Patient Advice and Liaison Service (PALS) enquiries as well as enquiries from MPs on behalf of local residents. This supplies a wealth of valuable information to influence service improvements for the benefit of all. It provides us with sight of issues as they arise, which often means that they can be resolved ahead of time.

Patients and the public engage with us on a daily basis and contact the CCG through a number of channels on a wide range of issues from eye-drops to Non-Emergency Patient Transport.

Examples of two of the most common issues dealt with during the last year are as follows:

The largest number of enquiries received by PALS followed the announcement that one of Shropshire's GP Practices was to close.
The CCG wrote to all patients a number of times prior to the Practice closure with advice including how to register with a new GP Practice. The majority of over 3,000 patients found a new Practice without difficultly but approximately 50 patients contacted the CCG asking for assistance with registration. Managers contact staff in other Practices and advised patients on the options open to them (that differed depending on where their home address was) with the majority of issues resolved within a matter of days.

Complaints about GP Practices are usually resolved by the Practice themselves but patients have the alternative option of going to NHS England as the commissioner of the service. Many patients contact the CCG wishing to raise a complaint about their GP Practice but have to be signposted to the Practice and/or NHS England.

To try to reduce the number of patients incorrectly coming to the CCG, information (with the contact details for NHS England) is provided on our website, answering machine message and within automated responses to emails received from the public.

Additionally, where Practice websites are found to contain incorrect or out-of-date information, they are being provided with the correct details so that patients are given the right information from the start.

The CCG very much welcomes and encourages patients, their families and carers to share an account of their experiences of local health services so that this can be widely used to stimulate reflection and influence service improvement for the benefit of all patients. The CCG's role is pivotal in gaining assurance of the quality and safety of the health services being provided. Listening to the views and experiences of our patients remains a key and fundamental part of this.

Patient Experience

During 2019/20, we received:

- Complaints – 127
- MP Letters – 55 Patient
- Patient Advice and Liaison Service (PALS) Enquiries - 340

A total of 522 Insight issues have been recorded.

Should a complainant feel dissatisfied with the CCG's response, they are offered the opportunity to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) for independent

review. During 2019/20 three cases were referred to the PHSO. Two of these are still being investigated, the other has been closed by PHSO and was not upheld. A further complaint that was referred to PHSO in 2017/18 has now been closed and was also not upheld.

Engaging People and Communities

In order for us to develop and deliver services that our patients and wider public want it is vital that we work together.

The CCG cannot work in isolation shaping and planning future services without listening and considering the important views of our patients and wider public.

Therefore the CCG needs to continue and enhance its approach to pro-actively seeking out and listening to the views of all its stakeholders including our patients, carers, GPs, NHS staff, the public and our partners as well as anyone with an interest in health and social care.

Engagement at the CCG

Engagement is continually developing at the CCG where the methods are evolving to support a more joined up approach. By fostering an increasing range of methods, from surveys through to face-to-face meetings, the reach on engagement activity is increasing.

This is particularly important when considering the rurality of the area with the added challenges of broadband reception across the County. The CCG is becoming more pro-active in its engagement approach and is carefully using the finite resources it has to foster open and transparent conversations with the public about local services.

This year has seen the engagement become more personal with a focus on creating ‘conversations’ in the local community and wider public through dedicated activity. These have been through informal channels such as pop-ups through to formal activity such as presentations and feedback sessions.

Engaging with our Stakeholders

We have increased our impact with stakeholders through a more pro-active approach to getting out and about in the community meeting people face-to-face to hear their questions and feedback on a range of topics.

This approach has been developed from a national NHS England campaign ‘What Matters to You’ where the concept has been rolled out and adapted.

We have used it to open up conversations with people on a range of services and developments from the Shropshire Care Closer to Home Programme through to the commissioning of new services.

We recognise we have a finite resource and we are looking at ways at how we best manage those. A significant development to support engagement has been the facility to now produce

surveys in-house through the purchase of specialist software and training. This means the CCG can respond flexibly to meet its engagement needs and provide a quick and easy channel both online and in print to make having a say more accessible to a wider audience.

Shropshire Care Closer to Home

Having conversations and opening up dialogues on challenging and complex topics has been the key focus of engagement work to help drive the design of the potential new services which form the core of this major transformation programme.

The momentum of the engagement activity continues to build with opportunities for key stakeholders, patients and the public to participate in a number of ways.

Formal stakeholder events, which focus on programme updates and a co-design approach for ideas and innovation on specific areas of the programme, continue apace; ensuring that patient and public representatives are not only kept informed of progress as Shropshire Care Closer to Home evolves, but also play a pivotal role in helping to shape and develop new models of care by being actively involved and engaged.

These are supplemented by face-to-face wider engagement with patients and the public through 'pop-up' events. At these community-based activities, displays are supplemented by information with from the programme managers on hand to answer questions and note comments and queries.

A most successful development has been the creation of a dedicated Shropshire Care Closer to Home newsletter, which includes programme updates and raising the profile of the programme. It was launched in May 2019 and is produced every fortnight with a controlled circulation of nearly 250 to patients and members of the public as well as stakeholders who cascade across their own networks.

The Transforming Midwifery Care Programme (formerly known as the Midwife Led Unit Review)

An extensive amount of engagement activity has been undertaken through the Transforming Midwifery Care Programme since the review began in 2017. This engagement has continued throughout the options appraisal and pre-consultation phase ahead of a formal public consultation yet to be launched. It has included women and their families, staff working in and with maternity services, GPs, patient groups, local councillors, MPs, the Joint Health Overview and Scrutiny Committee (HOSC) and the Health & Wellbeing Boards.

The programme team has also continued to work closely with both Healthwatch organisations, the Maternity Voices Partnership and a patient reading group to develop materials and the consultation plan. Dedicated pages for the Transforming Midwifery Care consultation have been developed and are hosted on the Sustainability and Transformation Partnership website.

Existing websites and social media groups, including the Maternity Voices Partnership and those attached to the local media, are monitored regularly to gather feedback and help shape further communications and engagement activity.

A pre-consultation engagement exercise took place with seldom heard groups during the summer of 2019. In October 2019, following a gap analysis of this work, a second wave of engagement was undertaken. It is planned that this activity will continue until the assurance process concludes and the public consultation is launched.

The purpose of this engagement is to listen to the views of people who don't normally engage with the NHS to ensure that any particular needs are considered in developing the new model of midwifery care.

The main target audience is women who have recently had a baby or those who are likely to have a baby in the near future. There is a particular focus on engaging with people who are most likely to be impacted by the proposed changes and those groups belonging to one or more of the nine protected characteristics as identified through an equality impact assessment.

Engagement Campaigns

Self Care has been a focus of a sustained 12-month campaign supporting the work of the Medicines Management Team. It was also designed to meet the objectives of the Long Term Plan around prevention and support the Primary Care Networks in delivering patient information.

There was a novel approach to this campaign work with tailored messaging featuring practical top tips for people on a range of common health issues. These included sunburn and indigestion through to Vitamin D as well as minor pain. These were rolled out on a monthly schedule and distributed directly to practices. For patients there were a range of leaflets with health information and advice. To support the practice network there were a range of resources including posters through to website content.

For Self Care Week in November an engagement programme was developed involving going out into the community to meet patients and public face-to-face through our practice network. Practices also supported the campaign with their own in-house displays helping to cascade the key health messages.

This year the CCG also used new channels for a supporting campaign promoting what to stock in a medicine cabinet to help common ailments. To increase reach across the County, a tailored bus advertising campaign was organised using routes across Shropshire. This was consolidated with pillar advertising at keep points such as Shrewsbury Bus Station and local shopping centres guiding people on what to have in their medicines cabinets.

Reducing Health Inequalities

We acknowledge the need to ensure that the most vulnerable groups have access to quality services. Shropshire CCG is committed to reducing health inequalities for our population through working with our partners in the public, voluntary and third sector. Shropshire CCG is committed to ensuring the population it serves is engaged in the design of the services commissioned.

The health of the population in Shropshire overall is good;

- both male and female life expectancy is higher than the national average.
- overall rates of mortality for males and females are significantly lower than the national average
- life expectancy has increased in the total population in the last decade and overall mortality has decreased.

However, Shropshire CCG is not complacent in this position, recognizing that health inequalities are present in Shropshire and increase with longevity.

The increase in life expectancy, and the overall reduction in mortality, has not had an equal impact across all sections of the population, this is why the CCG and Local Authority are committed to closing the health inequalities gap for the Shropshire population.

Tackling this challenge is a theme throughout our commissioning plans and we work closely with the local Public Health function, within Shropshire Council, to develop schemes to address health inequalities. Whilst the Shropshire county Joint Strategic Needs Assessment is an important tool to inform what the health inequalities are across the county, the action for the CCG work is to focus on particular areas of need.

The Shropshire Better Care Fund has been a significant enabler to delivering the joined-up approach to reducing health inequalities. As a result, Shropshire CCG has worked closely with Public Health on the development of a Healthy Lives Programme, which includes work streams on:

- Social prescribing
- Diabetes and cardiovascular health
- Fire service safe and well
- Mental health and dementia.

Focus on Social Prescribing

Shropshire held a Social Prescribing event in 2019 to celebrate the success of the model being tested in the Oswestry area. Social prescribing is an opportunity to address the whole needs of the individual. Referrals can be received from multiple sources: GP practices, Adult Social Care, the voluntary sector, local pharmacy, Family Matters, and the Mental Health Team.

The model is built on the existing Community and Care Co-ordinator Programme that has been in place for a number of years in GP practices, developed as the needs of the population demanded. The NHS Long Term Plan cites social prescribing, committing resource to develop the approach nationally. We are privileged in Shropshire to be at the forefront of the developing Social Prescribing Programme.

Focus on Fire Service Safe and Well

Shropshire Fire and Rescue Service continues to work with health partners, Shropshire Council and Citizen's Advice to better identify and support the most vulnerable members of our community (including the elderly, disabled and people living alone).

The home fire safety checks continue to help in the design of the service to give support, guidance and direct referral to other appropriate support. If a householder answers "Yes" to any question and agrees to a referral, it will trigger an automatic email from the Fire Service to the appropriate organisation and the householder will be contacted by that organisation for further assessment and support.

2019-20 has seen a further increase in the number of visits associated with this scheme to ensure a wider reach across the community.

NHS Health Check Shropshire

Shropshire Council's Public Health Department work collaboratively with General Practice to provide the NHS Health Check service. Invites and take-up of the service continue to rise year-on-year for patients having attended a Health Check appointment.

The continued close working between organisations has also helped focus our support on patient lifestyle choices such as weight management, smoking and physical inactivity.

This work provides an important platform to increase the impact of preventative work in Shropshire and to ultimately impact on the wider health and wellbeing of residents, and reduce their need to access more acute provision. In addition to the schemes set out above, our Better Care Fund includes a work stream around preventative programmes of work and promoting healthy lifestyles.

Addressing health inequalities in our county requires a joined-up approach across agencies. The CCG is committed to partnership working regarding which more detail can be found in the following section.

Addressing health inequalities through transformation programmes

The Future Fit Programme demonstrates the systems commitment to addressing health inequalities. As part of the Future Fit Programme a range of Equality Impact Assessments were carried out, considering the needs and views representative of the nine protected characteristics under the Equality Act 2010 and Public Sector Equality Duty 2011:

Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

In addition, particular attention was paid to a further four groups:

- People living in rural areas
- People living in areas of deprivation
- Carers
- Welsh speakers, as a first language.

We also engaged with “seldom heard” groups and groups who are either likely to be more impacted by the proposals or are likely to have more health needs. These have included military personnel and families, asylum seekers, refugees and homeless people.

This work has developed valuable skills and knowledge in relation to our approach to health inequalities as a CCG, which is now being utilised in subsequent transformation programmes, such as those relating to the Review of Maternity services and Shropshire Care Closer to Home.

Health and Wellbeing Strategy

Shropshire CCG is an active member of the local Health and Wellbeing Board (HWB) – Shropshire Health and Wellbeing Board (HWBB). The CCG’s Chair Dr Julian Povey and Accountable Officer David Evans and Dr Julie Davies, Director of Performance, sit on the HWBB. The Board brings together key health and care organisations to improve the health of local people and ensure fair access to services. The Health and Wellbeing Board meets to understand local needs, agree priorities and to ensure that NHS organisations and Shropshire Council work closely.

The key functions of the HWB are to:

- undertake a Joint Strategic Needs Assessment (JSNA)
- develop a Joint Health and Wellbeing Strategy (JHWS)
- ensure that commissioning plans and activities of CCGs and the Council are consistent with the JSNA and JHWS
- support development of joint commissioning, integrated delivery and pooled budgets
- encourage integrated working under the Health and Social Care Act 2012

The Shropshire Health and Wellbeing Strategy has been refreshed and will be a mechanism to deliver the NHS Long Term Plan. This work has been undertaken in partnership with Shropshire Council, Healthwatch and the Voluntary and Community Sector Assembly, overseen by the Health and Wellbeing Board.

The Strategy is aimed at improving health and wellbeing outcomes for the people of Shropshire, focusing on: ***starting well, living well and ageing well***. The strategy is regularly reviewed by the CCG Governing Body and the Health and Wellbeing Board’s sub committees.

The key priorities identified by the Health and Wellbeing Board are:

- Prevention – encouraging people to make good choices at every stage of life

- Sustainability – promoting independence at home
- Promoting accessible and joined-up care.

We continue to recognise the benefits of working in partnership and have fostered good working relationships with our Health and Wellbeing Board partners. During 2019/20 the HWBB has reviewed its role within the Care Closer to Home programme and through two workshops held in 2019 the following three priorities were identified as a Health and Wellbeing Board focus within the programme:

- Adverse Childhood Experiences
- Workforce
- Healthy Weight and Physical Activity

Accountability Report

Corporate Governance Report

Members' Report

Member Profiles

Our CCG consists of 40 GP member practices that are working together to ensure the local population has high quality and sustainable healthcare services.

Name of Practices

1. Albrighton Medical Practice	21. Marysville Medical Practice
2. Alveley Medical Practice	22. Much Wenlock & Cressage Cressage Medical Practice
3. Belvidere Medical Practice	23. Mytton Oak Medical Practice
4. Bishops Castle Medical Practice	24. Plas Ffynnon Medical Centre
5. Bridgnorth Medical Practice	25. Pontesbury Medical Practice
6. Broseley Medical Practice	26. Portcullis Surgery
7. Brown Clee Medical Practice	27. Prescott Surgery
8. Cambrian Medical Practice	28. Radbrook Green Surgery
9. Churchmere Medical Group	29. Riverside Medical Practice
10. Church Stretton Medical Practice	30. Severn Fields Medical Practice
11. Claremont Bank Surgery	31. Shawbury Medical Practice
12. Cleobury Mortimer Medical Centre	32. Shifnal and Priorslee Medical Practice
13. Clive Medical Practice	33. South Hermitage Surgery
14. Craven Arms Medical Practice	34. Station Drive Surgery
15. Dodington Surgery	35. The Beeches Medical Practice
16. Drayton Medical Practice	36. The Caxton Surgery
17. Highley Medical Centre	37. The Meadows Medical Practice
18. Hodnet Medical Centre	38. Wem and Prees Medical Practice
19. Knockin Medical Centre	39. Westbury Medical Centre
20. Marden Medical Practice	40. Worthen Medical Practice

Composition of Governing Body

The Governing Body is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically in accordance with the principles of good governance. It does this by setting the vision and strategy, budgets and commissioning plans for the organisation to ensure services are commissioned effectively, in order to achieve our vision of delivering the right care, in the right place, at the right time.

During 2019/20 the CCG has undergone a Management of Change process of its senior management to create a single Accountable Officer and Director structure shared with our neighbour, NHS Telford and Wrekin CCG. As a consequence the Director structure has changed at the end of quarter three with some existing Directors no longer on the Governing Body and new Directors added. Where this is the case dates have been added below to reflect these changes.

As of 31, March 2020, the make-up of our Governing Body was as follows:

Dr Julian Povey – Chair

Mr Keith Timmis – Lay Member for Governance & Audit, Vice Chair

Mr David Evans – Accountable Officer

Mrs Claire Skidmore – Chief Finance Officer - up to 31 December 2019

Mrs Claire Skidmore – Executive Director of Finance – from 1 January 2020

Dr Stephen James – GP Member

Dr Jessica Sokolov – Medical Director - to 31 December 2019

Dr Jessica Sokolov – Executive Director of Transformation – from 1 January 2020 to 15 March 2020

Professor Steven Trenchard – Interim Executive Director of Transformation – from 16 March 2020

Dr Finola Lynch – GP Member, Deputy Clinical Chair

Dr John Pepper – GP Member

Dr Priya George – GP Member

Dr Colin Stanford – GP Member

Dr Deborah Shepherd – Locality Chair (Shrewsbury and Atcham)

Dr Michael Matthee – Locality Chair (North)

Dr Matthew Bird – Locality Chair (South)

Mr Kevin Morris – Practice Representative

Dr Alan Leaman –Secondary Care Consultant

Dr Julie Davies – Director of Performance and Delivery – up to 31 December 2019

Dr Julie Davies – Director of Performance – from 1 January 2020

Mrs Nicky Wilde – Director of Primary Care

Mrs Christine Morris – Director of Nursing, Quality and Patient

Experience – up to 31 December 2019

Mrs Christine Morris – Interim Executive Director of Quality – from

1 January 2020

Mrs Frances Beck – Director of Partnerships from

1 January 2020

Mrs Gail Fortes Mayer – Director of Planning and Contracting

Mrs Sam Tilley – Director of Corporate Affairs – up to 31 December 2019

Mrs Sam Tilley – Director of Planning from 1 January 2020

Miss Alison Smith – Director of Corporate Affairs – from 1 January 2020

Mrs Sarah Porter – Lay Member for Transformation

Mr Meredith Vivian – Lay Member for Patient and Public Involvement

The remuneration report contains details on all Governing Body Members in post during the 2019/20 year

Committees, including Audit Committee

The Governing Body is required to appoint an Audit and Governance Committee, chaired by the Lay Member for Audit and Governance.

Full details of the membership of the Governing Body's Committees can be found in the Annual Governance Statement. Details of the members and work of the Remuneration Committee can be found in the Remuneration Report.

Register of Interests

Declared interests, interests or conflicts are recorded in the CCG register of interests, required by section 140 of the NHS Act 2006. Shropshire CCG updated its Conflict of Interest Policy during 2017/18 in line with updated guidance from NHS England and all Governing Body Members have undergone Conflict of Interest training. The CCG continues to monitor the application of its policy and staff adherence to it. An audit of our Conflicts of Interest was carried out during 2019/20, the outcome of which is contained within the Audit section of the Governance Statement.

The Governing Body's register of interests can be downloaded from the CCG website.

Personal data related incidents

Information on data security performance is shown in the Annual Governance Statement section later in the report under the section entitled 'Information Governance'.

Statement of Disclosure to Auditors

Each individual who is a Governing Body 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 the audit report
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS Shropshire CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Although the CCG is not required to produce an annual Slavery and Human Trafficking Statement, as set out in the Modern Slavery Act 2015, the CCG continues to work with its partners in the Shropshire Safeguarding Children Board and Keeping Adults Safe in Shropshire Board to highlight concerns about Modern Slavery and promote a unified approach to identifying such crimes, especially when they affect children or adults with care and support needs.

As leaders in the commissioning of health care services for the population of Shropshire and as employers, the CCG provides the following statement in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practices.

"The CCG is a proactive member of the Adult and Children Safeguarding Boards and will work with our colleague agencies to ensure this commitment is met. Shropshire CCG believes there is no room in our society for modern slavery and human trafficking. Shropshire CCG has zero tolerance for modern slavery and breaches in human rights and will ensure this is built into the processes and business practices that we, our partners and our suppliers use."

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 Mr David Evans to be the Accountable Officer of NHS Shropshire CCG from 1 October 2019.

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
- For 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)
- For 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 a financial statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

To the best of my knowledge and belief and subject to the disclosures below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter. However in 2019/20, the CCG has not met its statutory financial duty. This has resulted in an over spend against allocation and the CCG being unable to meet its control total for the year. As the CCG has not had adequate arrangement in place to achieve value for money and this has resulted in an adverse value for money opinion.

I also confirm that:

- The CCG remains in legal directions formally issued by NHS Commissioning Board (NHS England) which came into force on 4 April, 2016
- A section 30 letter was issued due to the CCG not meeting its statutory financial duties
- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.
- That 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 judgements required for determining that it is fair, balanced and understandable.

Mr David Evans
Accountable Officer

24 June 2020

Governance Statement

Introduction and Context

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

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

As at 4 April 2016, the Clinical Commissioning Group was subject to legal directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006. This remains the case in 2019/20. Prior to that, during January 2016, NHS Shropshire CCG had been placed into the 'Special Measures' regime, in order to provide a structured approach for the CCG to improve its performance, whilst remaining accountable for its functions. These 'Special Measures' also remain in place.

The framework associated with Legal Directions and Special Measures continues to provide assurance that any agreed action plans are effective and are being achieved.

Special Measures focused on:

- Agreement of a control total for the CCG's forecast outturn in 2016/17, 2017/18 and 2018/19
- Production of a Financial Recovery Plan to achieve the control total
- Recruitment of a substantive Executive Team.

Legal Directions focused on:

- All senior CCG appointments
- The production and implementation of a Financial Recovery Plan.

The full 'directions' issued by NHS England can be found on NHS England's website.

As an initial step in 2016/17 the CCG was required as part of its Legal Directions and Special Measures to complete a capacity and capability review and develop an associated implementation plan. These actions were completed to NHS England's satisfaction and have provided the platform for further improvements in the CCG's infrastructure to support its sustainability.

We have continued to work hard over the past year to build on the steps made since legal directions were placed on us and to reach our aspiration to achieve financial balance. We do this whilst maintaining high quality services for patients and to subsequently move out of Legal Directions and Special Measures.

Whilst we still face considerable financial challenges, some of the specific actions completed over the past year include:

- A new Accountable Officer and Director Team were appointed as a result of a Management of Change process to create a single senior management team across both NHS Shropshire CCG and NHS Telford and Wrekin CCG to respond to the NHS England requirement to save 20% on CCG running costs and to prepare for the transition to a single Strategic Commissioner in 2020/21.
- The CCG has reviewed and updated its Constitution to reflect improvements in the way it operates in accordance with the latest NHS England guidance.
- The CCG continues to develop and implement a number of key commissioning plans including a review of Midwifery Units and the development of Shropshire Care Closer to Home.

Scope of responsibility

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

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

Governance Arrangements and Effectiveness

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

Responsibilities and Decision-Making

The relationships between the CCG Membership Body and the CCG Governing Body are defined in the CCG's Constitution, which can be found on the CCG website.

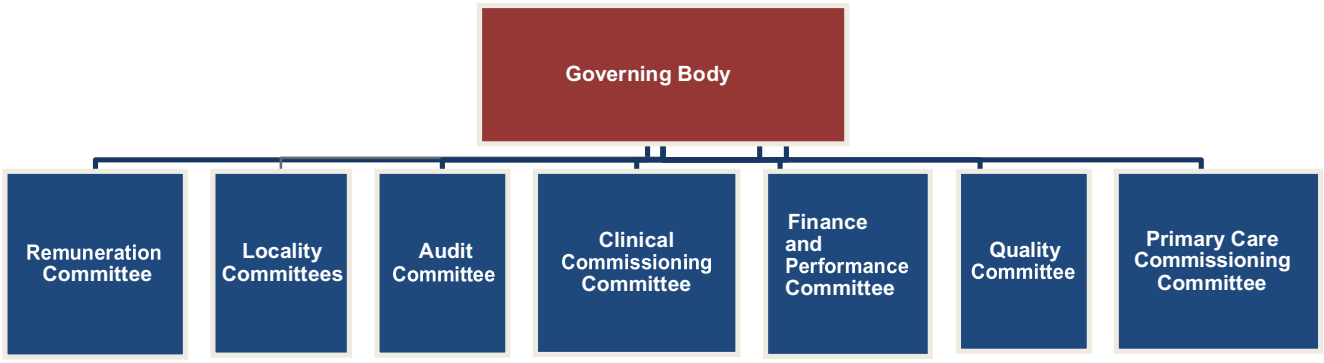
www.shropshireccg.nhs.uk/about-us/who-we-are/constitution-and-the-nhs-constitution/

Furthermore, responsibilities defined within the Constitution cover areas such as shared principles, leadership, fostering excellence, supporting the Governing Body and education. All of these areas engender the principles of good governance.

Details regarding the CCG's approach to decision making, information about membership, the Governing Body, its sub committees and overall effectiveness can be found later in this section.

CCG Governing Body and Membership Body

The CCG Governing Body established a new committee structure during the latter part of 2016/17. This structure, set out below remains current in 2019/20. The structure sets out the lines of accountability and decision making and supports the organisation to fulfil its function. The current committee structure is set out below.



Clinical Commissioning Group Governing Body

The Governing Body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 NHS Act, inserted by section 25 of the 2012 NHS and Social Care Act, together with any other functions connected with its main functions as may be specified in regulations or in the CCG constitution. The Governing Body has responsibility for:

Ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically, and in accordance with the group's principles of good governance (its main function).

Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act.

Approving any functions of the group that are specified in regulations.

These responsibilities are encapsulated in the following core activities:

- Lead the setting of vision and strategy
- Approve consultation arrangements for the commissioning plan and approve the 2019/20 commissioning plan
- Monitor performance against delivery of the annual commissioning plan
- Provide assurance of strategic risk
- Ensure the public sector equality duty is met
- Ensure active membership of the Health and Wellbeing Board (HWBB)
- Secure public involvement
- Promote the NHS Constitution
- Delegate assurance of continuous improvement in quality to the Quality Committee
- Promote improvement in the quality of primary care medical services
- Monitor the clinical quality of commissioned services
- Have regard to the need to reduce health inequalities
- Promote involvement of patients, their carers and representatives in decisions about their healthcare
- Act with a view to enable patients to make choices
- Promote innovation
- Promote research
- Promote education and training
- Promote integration of health services where this would improve quality or reduce inequalities
- Have responsibility for all financial duties.

The Governing Body's functions and procedures are defined in the CCG's constitution and in the Standing Orders appended to the constitution.

The Governing Body membership and attendance during 2019/20 is set out below:

Name	Title	Attendance as of 31 March 2020
Dr Julian Povey	Chair	6 of 6
Mr David Stout	Interim Accountable Officer to 29 September 2019	3 of 3
Mr David Evans	Accountable Officer from 1 October 2019	2 of 3
Dr Finola Lynch	GP Member	6 of 6
Dr Stephen James	GP Member	5 of 6
Dr John Pepper	GP Member	6 of 6
Dr Priya George	GP Member	6 of 6
Dr Jessica Sokolov	Medical Director up to 31 December 2019	3 of 4
Dr Jessica Sokolov	Executive Director of Transformation from 1January 2020 to 15 March 2020	2 of 2

Professor Steven Trenchard	Interim Executive Director of Transformation from 16 March 2020	0 of 0
Mr Kevin Morris	Practice Representative	6 of 6
Dr Deborah Shepherd	Locality Chair (Shrewsbury and Atcham)	5 of 6
Mrs Claire Skidmore	Chief Finance Officer and Deputy Accountable Officer up to 31 December 2019	4 of 4
Mrs Claire Skidmore	Executive Director of Finance (Chief Finance Officer) from 1 January 2020	2 of 2
Dr Julie Davies	Director of Performance and Delivery up to 31 December 2019	4 of 4
Dr Julie Davies	Director of Performance from 1 January 2020	2 of 2
Mrs Samantha Tilley	Director of Corporate Affairs up to 31 December 2019	4 of 4
Mrs Samantha Tilley	Director of Planning from 1 January 2020	2 of 2
Ms Dawn Clarke	Director of Nursing Quality and Patient Experience to 31 May 2019	1 of 1
Mrs Christine Morris	Director of Nursing Quality and Patient Experience to from 1 June 2019 to 31 December 2019	3 of 3
Mrs Christine Morris	Director of Nursing Quality and Patient Experience from 1 January 2020	2 of 2
Mrs Fran Beck	Interim Director of Partnerships from 1January 2020	0 of 2
Miss Alison Smith	Director of Corporate Affairs from 1 January 2020	2 of 2
Mrs Nicky Wilde	Director of Primary Care	4 of 5
Mrs Gail Fortes-Mayer	Director of Planning and Contracting	2 of 4
Mr Keith Timmis	Lay Member for Governance and Audit	5 of 6
Mrs Sarah Porter	Lay Member for Transformation	5 of 6
Mr Meredith Vivian	Lay Member for Public and Patient Involvement (PPI)	5 of 6
Dr Alan Leaman	Secondary Care Consultant	6 of 6
Dr Matthew Bird	Locality Chair (South)	6 of 6
Dr Michael Matthee	Joint Locality Chair (North)	5 of 6
Dr Colin Stanford	Lay Member from 1 April 2019	4 of 6
Observers		
Ms Rachel Robinson/ Ms Jo Robbins	Observer - Shropshire Council	3 of 6
Ms Lynn Cawley	Observer - HealthWatch Shropshire	5 of 6

The Governing Body held meetings in public throughout 2019/20. As set out in the introduction, during 2019/20 the CCG has continued to operate in a challenging financial climate and since April 2016, has been subject to NHS England Legal Directions. As a result of this, the CCG has:

- Responded positively and fundamentally changed its focus, fostering a culture of support for formal financial recovery, whilst retaining an emphasis on the quality and safety of services
- Continued to lead the development of the NHS Future Fit Programme and play an active part in the development of the local Sustainability and Transformation Plan (STP)
- Continued to focus efforts on improving the performance of contracted providers in meeting national and local performance indicators
- Invested time and resource in making sure the CCG organisational structure is suitable for the future
- Listened to local doctors, nurses and patients' needs and expectations and worked alongside them in redesigning and improving local services.

During the year, as the table of membership and attendance highlights, there have been some personnel changes in the Governing Body. However, the CCG has ended 2019/20 with a full complement of Governing Body Members.

Locality Committees

The CCG is a membership organisation, comprising the 40 GP practices located within the geographical area of Shropshire (excluding the Borough of Telford and Wrekin, which has its own CCG). There are three Locality Committees, which meet regularly to conduct business that informs and supports the work of the CCG.

Each member practice has nominated one GP and Practice Manager to represent the practice in all matters considered at the Locality Committee and vote on decisions, when required. The majority of decision making is delegated to the CCG Governing Body. The purpose of the Locality Committees is to:

- Ensure an effective clinical contribution to the work of the CCG Governing Body to shape and achieve clinical and strategic objectives, thereby helping to mitigate potential risks and embed the principles of clinically led commissioning.

The manner in which each Locality discharges these duties is agreed between the Locality Committee and the CCG Governing Body and set out within the Locality Committee Terms of Reference.

The Locality Committees' membership and attendance is set out below:

Name	Title	Medical Practice	Attendance
North Locality Committee			
Dr A Booth	General Practitioner	Baschurch	0 of 6
Mr Nicholas Storey	Practice Manager		6 of 6
Dr TW Lyttle	General Practitioner	Churchmere Medical Group	2 of 6
Ms Jenny Davies	Practice Manager		4 of 6
Dr G Davies (stopped attending 28/11/2019)	General Practitioner	Clive	0 of 4
Dr A Schur (started attending 23/01/2020)	General Practitioner		2 of 2
Mrs. Zoe Bishop	Practice Manager		0 of 6
Dr N Raichura (stopped attending 18/07/2019)	General Practitioner	Hodnet	2 of 2
Dr J Mehta (started attending 28/11/2019)	General Practitioner		3 of 3
Mrs Christine Charlesworth	Practice Manager		5 of 6
Dr J Davies	General Practitioner	Knockin	3 of 6
Mrs Mary Herbert	Practice Manager		3 of 6
Dr Michael Matthee **(Co-Chair)**	General Practitioner	Market Drayton	6 of 6
Mrs Michele Matthee	Practice Manager		6 of 6
Dr S Eslava	General Practitioner	Oswestry - Cambrian	3 of 6
Mr K Morris	Practice Manager		5 of 6
Dr S Lachowicz	General Practitioner	Oswestry - Caxton	5 of 6
Mr James Bradbury	Practice Manager		6 of 6
Dr Y Vibhishanan	General Practitioner	Oswestry - Plas Ffynnon	6 of 6
Ms Sarah Williams	Practice Manager		5 of 6
Dr A C W Clark	General Practitioner	Shawbury	0 of 6
Mrs Joanne Clark (stopped attending 23/01/2020)	Practice Manager		4 of 5
Ms Kirsty Arkinstall (started attending 27/02/2020)	Practice Manager		1 of 1
Dr C Rogers	General Practitioner	Wem / Prees	6 of 6
Mr Richard Birkenhead (stopped attending 18/07/2019)	Practice Manager		0 of 2
Ms Caroline Morris (started attending 28/11/2019)	Practice Manager		1 of 3
Dr K Lewis **(Co-Chair)**	General Practitioner	Westbury	4 of 6
Mrs Helen Bowkett	Practice Manager		2 of 6
Dr R Clayton	General Practitioner	Whitchurch – Dodington	5 of 6
Mrs Elaine Ashley	Practice Manager		3 of 6
Shrewsbury and Atcham Locality Committee			
Dr Deborah Shepherd **(Chair)**	General Practitioner	Locum GP	7 of 7
Dr John Pepper	General Practitioner	Belvidere	5 of 7
Ms Caroline Davis	Practice Manager		6 of 7
Dr M Fallon	General Practitioner	Claremont Bank	7 of 7
Ms Jane Read	Practice Manager		7 of 7

Dr E Baines	General Practitioner	Marden	6 of 7
Mrs Zoe George	Practice Manager		7 of 7
Dr J Visick	General Practitioner	Marysville	4 of 7
Mrs Izzy Culliss	Practice Manager		5 of 7
Dr S Watton	General Practitioner	Mytton Oak	4 of 7
Mr Adrian Kirsop	Practice Manager		3 of 7
Dr R Bland	General Practitioner	Pontesbury	2 of 7
Ms Heather Brown	Practice Manager		5 of 7
Dr H Bale / Dr. B Roberts	General Practitioner	Radbrook Green	7 of 7
Ms Angela Treherne	Practice Manager		2 of 7
Dr P Rwezaura	General Practitioner	Riverside	5 of 7
Ms Tracy Willocks **(Vice Chair)**	Practice Manager		3 of 7
Dr D Martin	General Practitioner	Severn Fields	4 of 7
Mr Tim Bellett	Practice Manager		4 of 7
Dr L Davis	General Practitioner	South Hermitage	3 of 7
Mrs Caroline Brown	Practice Manager		5 of 7
Dr E Jutsum	General Practitioner	The Beeches, Bayston Hill	5 of 7
Ms Kim Richards / Mrs. Helen Steel	Practice Manager		4 of 7
Ms Joanne Beason (Practice closed on 30/09/2019)	Practice Manager	Whitehall - Malling Health	3 of 4
Dr K McCormack	General Practitioner	Worthen	6 of 7
Ms Cheryl Brierley	Practice Manager		1 of 7
South Locality Committee			
Dr Matthew Bird **(Chair)**	General Practitioner	Albrighton	6 of 6
Ms Val Eastup	Practice Manager		4 of 6
Dr D Abbotts	General Practitioner	Alveley	1 of 6
Mrs Lindsey Clark	Practice Manager		5 of 6
Dr A Penney / Dr. P Gardner	General Practitioner	Bishops Castle	4 of 6
Ms Sarah Bevan	Practice Manager		1 of 6
Dr S Wright (stopped attending 02/05/2019)	General Practitioner	Bridgnorth	1 of 1
Dr G. Potter (started attending 11/07/2019)	General Practitioner		5 of 5
Mrs Sandra Sutton / Ms. Dude Newell	Practice Manager		3 of 6
DrM Babu	General Practitioner	Broseley	5 of 6
Ms Nina Wakenell	Practice Manager		5 of 6
Dr W Bassett	General Practitioner	Brown Clee	4 of 6
Ms Vicki Brassington	Practice Manager		0 of 6
Dr A Chamberlain	General Practitioner	Church Stretton	4 of 6
Ms Emma Kay	Practice Manager		6 of 6
Dr P Thompson	General Practitioner	Cleobury Mortimer	5 of 6
Mr Mark Dodds	Practice Manager		2 of 6
Dr J Bennett	General Practitioner	Clun	5 of 6
Mr Peter Allen	Practice Manager		5 of 6
Dr D Appleby / Dr. M Carter	General Practitioner	Craven Arms	5 of 6
Mrs Susan Mellor-Palmer	Practice Manager		6 of 6
Dr S Allen	General Practitioner	Highley	2 of 6
Mr S Consul	Practice Manager		2 of 6

Dr C Beanland	General Practitioner	Ludlow – Portcullis	1 of 6
Mrs Rachel Shields	Practice Manager		5 of 6
Dr G Cook	General Practitioner	Ludlow – Station Drive	4 of 6
Ms Jodie Billinge	Practice Manager		0 of 6
Dr J Bailey (stopped attending 09/01/2020)	General Practitioner	Much Wenlock & Cressage	1 of 5
Dr J Wentel (started attending 05/03/2020)	General Practitioner		1 of 1
Mrs Sarah Hope	Practice Manager		2 of 6
Dr R Shore / Dr. P Leigh	General Practitioner	Shifnal & Priorslee	1 of 6
Ms Theresa Dolman	Practice Manager		3 of 6

Key Achievements/Areas of Work

The membership, through all three Locality Committees, has considered key areas of CCG work to ensure that clinical voices are embedded in the decision-making processes. Some of the areas of work presented or discussed at the Locality Committees over the last 12 months include:

- Social Prescribing
- Care Co-ordination Centre
- SOOS (Shropshire Orthopaedic Outreach Service)
- Community Respiratory Service
- Ultrasound Referral Guidance
- Mental Health – IAPT (Improving Access to Psychological Therapies), Perinatal Mental Health, BeeU Service
- Medicines Management – 0-18 Mental Health Pathway, Eclipse Live
- Transforming Midwifery Care
- Diabetic Foot Screening
- Workshops – Respiratory, Antibiotics, RightCare

Localities continue to review their locality plans, and to use Locality Assurance Frameworks to raise and track responses to issues and concerns identified.

Practices are working with the Locality Managers and wider Primary Care Team to develop collaborative working, including offering Extended Access across the county. They are now involved in developing Primary Care Networks and implementing the new NHS Long Term Plan.

Meetings continue to have high levels of attendance and ongoing enthusiasm to improve the services which we commission.

Quality Committee

The role of the Quality Committee is to ensure that the work of commissioned services, including jointly-commissioned services, is being delivered in a high quality and safe

manner. The Quality Committee provides assurance that quality sits at the heart of everything that Shropshire Clinical Commissioning Group does.

During 2019-2020, the Quality Committee's priorities have been:

- To monitor and review the safety and quality of commissioned services and ensure that safeguarding arrangements for children, young people and adults at risk of harm are appropriately scrutinized
- To ensure that risks relating to quality of services commissioned are adequately identified, evaluated and managed and, where necessary, to escalate risks or areas of concern
- To ensure that adequate structures and processes are in place to manage all clinical and non-clinical governance issues relating to quality, safety and patient experience
- To encourage and foster an environment of continuous quality improvement and the development of evidence-based practice in all areas of clinical service delivery
- To ratify Clinical Commissioning Group (CCG) policies and procedures in relation to the processes supporting healthcare governance relating to quality, safety and patient experience.

The Quality Committee membership and attendance is set out below:

Name	Title	Attendance as at 31 March 2020
Mrs Christine Morris	Director of Nursing, Quality and Patient Experience from 1 May 2019 to 31 December 2019 Interim Executive Director of Quality from 1 January 2020 to 24 February 2020	7 out of 7 1 out of 1
Mrs Maggie Bayley	Interim Executive Director of Quality from 24 February 2020	2 out of 2
Dr Julie Davies	Director of Performance and Delivery	8 out of 11
Dr Jessica Sokolov	GP Member/ Medical Director	2 out of 11
Dr Alan Leaman	Secondary Care Consultant	11 out of 11
Dr Finola Lynch	GP Member	4 out of 11
Mr Meredith Vivian	Chair and Lay Member for Patient and Public Involvement (PPI)	8 out of 11
Mr Keith Timmis	Lay Member for Governance and Audit	11 out of 11
Mrs Sarah Porter	Lay Member for Transformation	10 out of 11

Areas of Focus for the Quality Committee

The Quality Function

Following the review of Shropshire CCG's Quality Function undertaken in February 2019 by West Midlands Quality Review Service, the Quality Committee has received and supported new quality

management arrangements. These have included a joint quality strategy; risk register with clearer controls; closer alignment between performance and quality teams; wider use of patient stories and a single voice for quality across the two CCGs.

Assuring Quality and Safety

The quality and safety of provided services is assured through quality schedules, site visits, quality and contract review meetings CQRM's, and Commissioning for Quality and Innovation indicators (CQUIN). Quality specialists report each month to the Quality Committee on the results of this assurance work and risk areas are highlighted for closer scrutiny.

In light of serious safety concerns emerging at Shrewsbury and Telford NHS Trust (SaTH) the Quality Committee has continuously sought reassurance that policies, practices and systems that secure patient safety are in place and are being implemented.

The Committee has not been assured that services are safe at SaTH and has escalated its concerns to the Governing Body. This year, Dr Edwin Borman, Director of Clinical Effectiveness at SaTH, and Mrs Barbara Beal, Interim Director of Nursing (SaTH) have separately attended Quality Committee to provide detailed explanation of systems, procedures and practices to underpin patient safety within their organisation.

It has been and remains clear to the Quality Committee that the Trust was under extreme pressure and that more work was needed before the intense scrutiny could be relaxed.

The Quality Committee will continue to focus much of its attention on seeking assurances that the Trust is doing everything it can to secure patient safety and, just as important, that patients experience of SaTH services are positive.

Serious Incidents

In order to ensure mistakes in practice do not repeatedly occur, our providers are required to ensure that policies and procedures are robust enough to identify risks, manage those risks and create a learning culture.
Shropshire CCG receives notification of serious incidents through the national Strategic Executive Information System (STEIS). Our primary care systems and independent contractors are supported to use incident reporting systems to report incidents in order to identify and learn from events.

All Serious Incidents have a Root Cause Analysis and lessons are shared with the CCG and providers. Incidents and Serious Incidents are analysed for trends and reported to the CCG Board Committees.

The Quality Committee regularly receives detailed analysis of Sis, their cause and the work being undertaken to learn from them and put in place remedial action. The CCG's SI process has been reviewed in the last two years by internal auditors and has been adjudged to provide 'significant assurance'.

Infection Prevention and Control

The Quality Committee gives particular priority to the work being undertaken across the health care system in Shropshire to ensure infection is prevented and that arrangements are in place to control it when it arises. The Committee receives a quarterly report from the CCG's specialist IPC Team.

Shropshire Clinical Commissioning Group is committed to reducing and preventing avoidable healthcare associated infections to support high quality and safe patient care. Partnership work with providers has continued throughout the year to maintain low numbers of Methicillin resistant Staphylococcus aureus (MRSA) blood stream infection. The IPC team supported the review of Clostridium difficile infection cases to share learning to improve patient outcomes.

Reduction in Gram-negative blood stream infections, particularly Escherichia coli (E. coli), remains a priority across the local health economy (LHE) and work progresses with raising awareness on the prevention of urinary tract infections by encouraging hydration.

The CCG is working locally with system partners to prepare for coronavirus cases in co-ordinating appropriate action and resources in line with national guidance and requirements to protect the public's health, and to plan for any changes in the situation, should they arise.

In 2020/21 the CCG IPC Team will continue to work collaboratively and build on assurance processes currently in place with providers and partner organisations. The team will continue to lead on influencing the LHE Infection Prevention Control strategy in provider organisations with a focus on minimising the risk of infection and ensuring people are cared for in a safe, clean environment and are protected from avoidable harm.

Safeguarding

The Quality Committee seeks assurance from specialist staff that robust Safeguarding arrangements are in place to protect both adults and children. The Committee receives detailed quarterly reports from Adult and Children Safeguarding leads on policy and practice measures across the county and more frequent reporting where Safeguarding risks arise.

Along with colleagues at Shropshire Council and West Mercia Police, Shropshire CCG is one of the three statutory safeguarding partners within the Keeping Adults Safe in the Shropshire Network.

This means, as well as ensuring the NHS Trusts and other organisations from which care is commissioned, play their part in helping safeguard adults, there is a wider preventative duty.

One of the critical issues that the safeguarding network has been concerned with is the number of older people who have experience safeguarding concerns that involve domestic abuse.

This is one of the reasons the network organised a Joint Partnership Prevention Event: Looking at Domestic Abuse and Older People. Eighteen different organisations managed stalls at the conference. The gathering heard from survivors, leading national researchers and campaigning groups and the Shropshire Domestic Abuse Service.

One success in this area has been the work led by Police and Crime Commissioner colleagues in the creation of a hospital-based Independent Domestic Abuse Advisors Service which provides support to people experiencing domestic abuse who attend hospital, which has been a new development this year.

There has also been a call to ensure frontline staff know how to “make safeguarding personal” which means ensuring safeguarding focuses on finding out what outcomes the person at the centre wants from being involved in safeguarding and working hard to ensure all staff remain responsive to these.

NHS staff asked Shropshire CCG’s specialist Safeguarding Team to create briefing cards to act as a quick reference guide to Making Safeguarding Personal spelling out what this means to help shape frontline practice.

2019/2020 also saw the creation of a new Safeguarding Strategic Partnership, which means that there is a stronger central partnership office overseeing and coordinating the work of the children’s and adults safeguarding networks, as well as the Community Safety Partnership.

When it comes to children safeguarding the Quality Committee is particularly concerned by the still high number of children in Shropshire that are suffering neglect and the increase in young children being involved in ‘County Lines’; for example gangs and drug use in Shropshire.

The Committee has heard that the CCG has, in line with national and local changes, worked with Telford CCG to update its Children Safeguarding policy. Following on from recent Government legislation, Serious Case Reviews have been replaced by Safeguarding Practice Reviews and national serious case inquiries (NSCIs).

The CCG has been involved in three practice reviews and recommended a national serious case inquiry in the past year. The learning from the recent children practice has been looked at and actions and timescales for implementation agreed and monitored by the CCG Quality Team and reported through to the Quality Committee.

The Quality Committee has focused considerable attention on the challenges that arise from the high number of looked after children hosted by Shropshire.

The Committee has sought assurance that all steps are being taken to ensure that rigorous monitoring is undertaken to ensure that looked after children have access to the health services they need and that their homes are safe and healthy.

The Committee has heard that CCG specialists take a leadership role within the safeguarding system to support children who are vulnerable including support for children who run away or who are emergency housed from other areas.

The CCG has been working with Shropshire Community Health Trust over monitoring of support for Shropshire looked after children that require medical interventions to ensure that services are available and that they are safe and deliver a positive patient experience.

Finance and Performance Committee

The Finance and Performance Committee scrutinises the CCG's financial plans and decisions including reviewing monthly financial performance identifying key issues and risks. The Committee oversees the delivery of Quality, Innovation, Productivity and Prevention (QIPP plans and reviews the performance of the main services commissioned by the CCG, alongside ensuring that robust financial governance in the exercise of the CCG's financial responsibilities is embedded within the CCG.

The Committee reviews all performance targets for which the CCG is responsible, both nationally and locally, and provides assurance to the CCG Governing Body in relation to performance, making recommendations where necessary and when improvements are required.

The Finance and Performance Committee membership and attendance is set out below:

Name	Title	Attendance as at 31 March 2020
Mr Kevin Morris	GP Board Representative	9 of 12
Mrs Claire Skidmore	Chief Finance Officer	10 of 12
Dr Julie Davies	Director of Performance and Delivery	12 of 12
Mrs Gail Fortes-Mayer	Director of Planning and Contracting	3 of 12
Mr Keith Timmis	Lay Member for Governance and Audit	12 of 12
Mr Meredith Vivian	Lay Member for Patient and Public Involvement	8 of 12
Mrs Sarah Porter	Lay Member for Transformation	11 of 12
Dr Michael Matthee	North Locality Chair (North)	12 of 12

The Finance and Performance Committee's purpose is to:

- Undertake on behalf of the CCG Governing Body objective scrutiny of the CCG's financial plans and decisions and where appropriate the development and delivery of a Financial Recovery Plan
- Review the CCG's monthly financial, contracting and performance position, and forecasts for the main services commissioned by the CCG identifying key issues and risks requiring discussion or decision by the CCG Governing Body
- Oversee the delivery of organisational Quality, Innovation, Productivity and Prevention (QIPP) schemes and their ongoing performance, including achievement of recovery actions, with referral back to the Clinical Commissioning Committee if a fundamental review

is required

- To review the detailed reports on performance against the full set of targets and objectives for the relevant period
- To provide assurance to the Governing Body that a detailed review of the CCG's performance has been properly undertaken, that management action to minimise poor performance is taking place appropriately and effectively and that responsible managers are clearly identified and held to account
- To ensure that there are appropriate performance management systems in place to provide the accurate reporting of delivery of all targets
- To ensure that risks relating to performance against key targets and objectives are adequately identified, evaluated and managed and, where necessary, to escalate risks or areas of concern to CCG executives and the CCG Governing Body. This will ensure that they are appropriately recorded within the Risk Register or Board Assurance Framework.

During 2019/20 the Committee considered the following:

- Monthly consideration of the CCG's financial position including QIPP and contracting
- Oversight of the activities of the QIPP Programme Board, taking regular updates from its Chair
- Review of the deterioration in the CCG's financial position; challenge of management activities to address deviation from the financial plan and oversight of the development and application of financial recovery actions
- Review of the month 9 reforecast modelling in order to recommend CCG sign off for the position
- Oversight of financial planning for future years
- Oversight of performance, supported by regular reporting of all key organisational targets and allowing consideration of recovery actions where required
- In year the committee has started to receive a copy of the STP finance report so that they also see the wider system picture for finance

Areas of Focus for the Finance and Performance Committee

The CCG's Finance and Performance Committee has continued to focus its scrutiny on the delivery of the CCGs finance and performance objectives throughout 2019/20.

The Committee was challenged in agreeing the annual budget and QIPP plan due to the significant level of savings/spend reduction required to reach the agreed control total and the number of schemes which were considered to be at high risk of non delivery due to the level of ambition required.

The CCG's recent history of financial deficit remains a significant challenge. Year-on-year opportunities to reduce expenditure through innovation and improved productivity become more and more difficult and requires system approaches and sign up to working differently.

In 2019/20 the CCG began this process with new schemes to commence, working with system partners, in relation to providing care closer to home and new services such as frailty provision however the ambitions set at the start of the year have not been fully achieved to date despite rigorous oversight and scrutiny from the Committee. The committee will continue to monitor closely the progress of the efficiency programme as we move into 2020/21.

The Committee has scrutinised financial performance each month during the year, paying particular attention to the underlying position and the level of risk underpinning the year-end forecast. There has continued to be a dedicated process for fortnightly review of QIPP scheme delivery and progress, managed through the programme management office and reporting directly to the Finance and Performance Committee.

Throughout 2019/20 the CCG has looked to align its financial systems and processes with our neighbouring CCG ensuring that duplicated effort is minimised as we come together to work at system level. This has brought with it a greater level of workforce resilience to help manage risk.

In its oversight of the CCGs Integrated Assurance Framework the Committee has continued to view with concern the deterioration in the main acute providers performance across several indicators including A&E wait breaches of the four and 12-hour targets being amongst the worst in the country, resulting in quality risk summits in the year. Performance against the national cancer targets has shown improvement. The CCGs reporting processes to the Governing Body have aligned quality with performance to show interrelationship of both these important areas.

The outlook for the 2020/21 year continues to be as challenging as the CCG looks to join with NHS Telford and Wrekin CCG.

Clinical Commissioning Committee

The Committee is responsible for providing assurance to the Governing Body that the CCG is commissioning services in line with the needs of the local population and the strategic objectives of the CCG, including services and service changes to ensure financial balance, and that the commissioning of services is evidence based and is inclusive of national and local requirements.

The responsibilities of the Clinical Commissioning Committee are to:

- Oversee and recommend to the Governing Body the development of a commissioning strategy for the organisation, ensuring the meaningful involvement of stakeholders and the public in its development
- Oversee, and recommend to the Governing Body, the development of an Annual Business Plan and commissioning intentions for providers, ensuring they encompass national and local requirements together with CCG objectives for the commissioning and delivery of healthcare
- Oversee the contribution to the Joint Strategic Needs Assessment, making recommendations as appropriate to the Governing Body, and ensuring that the outcomes are reflected in the priorities set by the CCG for its commissioning and decommissioning of healthcare services
- Recommend to the Governing Body joint commissioning arrangements with Shropshire Council and other partners, ensuring that these arrangements are effective
- Initiate service reviews, where it is felt that services do not provide sufficient quality and

value for money

- Oversee the development of care pathways and services that support the vision of the CCG and promote clinical quality and safety, making recommendations to the Governing Body as appropriate
- Oversee the development of new schemes and services (with the exception of any Primary Care Co-Commissioning programmes of work), reviewing appropriate business cases to ensure that all necessary evidence is provided to support effective decision making, and provide recommendations to the Governing Body as appropriate
- Either make decisions on the commissioning and decommissioning of services, in line with delegated limits as set out in the Scheme of Reservation and Delegation, or provide recommendations to the Governing Body as appropriate (with the exception of any primary care co-commissioning programmes of work)
- Oversee an investment and disinvestment prioritisation process on behalf of the Governing Body and evaluate the success of pilot schemes (with the exception of any primary care co-commissioning programmes of work)
- Ensure robust arrangements exist for local patient and public involvement, demonstrating that patients and stakeholders have been engaged appropriately in setting the CCG's priorities and in significant service change, as required
- Ensure that CCG policies and procedures are followed, including governance arrangements as set out in the scheme of delegation, prime financial policies, and standing orders.

In addition, the Committee will ensure that equality and diversity is proactively considered and promoted as part of the Committee's business and its decision making.

The Clinical Commissioning Committee membership and attendance is set out below:

Name	Title	Attendance as at 31 March 2020
Mrs Sarah Porter	Lay Member for Transformation	11/11
Dr Julie Davies	Director of Performance and Delivery	10/11
Mrs Gail Fortes-Mayer	Director of Planning and Contracting	3/11
Mr David Stout	Interim Accountable Officer to 29 September 2019	3/8
Mr David Evans	Accountable Officer from 1 October 2019	0/3
Dr Steve James	GP Board Member	3/11
Dr Julian Povey	CCG Chair	4/11
Dr Alan Leaman	Secondary Care Consultant	11/11
Mrs Claire Skidmore	Chief Finance Officer	5/11
Mrs Christine Morris	Director of Nursing, Quality and Patient Experience	4/11
Mr Kevin Morris	Practice Representative	8/11
Dr Finola Lynch	GP Member	6/11
Dr Deborah Shepherd	Locality Chair (Shrewsbury and Atcham)	9/11
Dr Jessica Sokolov	Medical Director	8/11

Mr Meredith Vivian	Lay Member Patient and Public Involvement	10/11
Mrs Nicky Wilde	Director of Primary Care	6/11
Dr John Pepper	GP Member	9/11
Dr Katy Lewis	Locality Chair (North)	8/11
Dr Matthew Bird	Locality Chair (South)	8/11
Dr Priya George	GP Member	5/11

Areas of Work

During 2019/20, the Clinical Commissioning Committee considered the following areas and provided recommendations on actions to the Governing Body:

- Progress on reviewing, revising and approving policy documents including; Flash Glucose Monitoring Policy and Prescribing of Lidocaine 5% Plasters Policy. The Committee also reviewed and approved joint policies with Telford and Wrekin CCG which included; the joint Value Based Commissioning Policy and the joint Individual Funding Referral Policy

- Developed new pathways including; Big 6 Paediatric Urgent Care Pathway Guidance, Back Pain Pathway, Treatment Pathway for Plaque Psoriasis and Neurodevelopment Pathway for 0-25 BeeU Service principle of model agreed

- Commissioning intentions were discussed in detail by the Committee prior to final draft being presented to a future Governing Body meeting

- Oversaw progress on all areas of the Shropshire Care Closer to Home programme which included discussions and approval of the business case for Demonstrator sites and concepts of Phase 3 Models and this enabled the Programme Team to undertake a robust three-month Impact Assessment

- Revised service specifications agreed for Fracture Liaison Service, Community Equipment, Stroke Services, Sheldon Ward (RAJH) and Frailty Intervention Team (SaTH).

- Considered the options appraisal for Transforming Midwifery Care and approved the process recommended by the Programme Board take forward to the Governing Body

- Oversaw the development of a specification for a new model of care for MSK services jointly with NHS Telford and Wrekin CCG

- Development of the following strategies; Medicines Management Strategy, Cancer Services Strategy and Special Educational Needs and Disability (SEND) Refreshed Strategy and approved the Statement of

Intent

- Discussed and agreed the business case to implement a pilot Admission Avoidance Scheme for the Shrewsbury Locality

- Agreed additional investment for the Improving Access to Psychological Therapies (IAPT) service to enable swift recruitment

- Agreement to broaden scope to develop an Integrated Falls Prevention and Bone Heath Strategy and approved a joint business case with NHS Telford and Wrekin CCG.

Audit Committee

The Audit Committee is a statutory committee of the CCG Governing Body, as defined in the Health and Social Care Act 2012, and has been established according to the requirements of the CCG Constitution. The role of the Audit Committee is to support the Governing Body by critically reviewing governance and assurance processes on which the Governing Body places reliance. In particular, the Audit Committee provides assurances to the Governing Body on:

- The Governing Body Assurance Framework – providing assurance that the framework provides the necessary controls and assurances within it and that the process for managing and identifying risks is aligned to the strategic objectives of the CCG
- Disclosure Statements – reviewing the disclosure statements that flow from the CCG's assurance processes before they are approved by the Governing Body, including seeking assurances on the rigour in producing them and the quality of the data behind them.

The duties of the Committee have been driven by the requirements of the Audit Committee Handbook and priorities identified by the CCG and the key duties of the Audit Committee broadly encapsulate these areas:

- The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across all activities that support the achievement of the CCG's objectives. Its work dovetails with that of the Finance and Performance Committee.

- The Committee ensures that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and CCG

- The Committee reviews the work and findings of the external auditors and considers the implications and management's responses to their work

- The committee reviews the findings of other significant assurance functions (e.g. authorisation), both internal and external, and considers the implications for the governance of the CCG

- The Committee satisfies itself that the CCG has adequate arrangements in place for countering fraud and reviews the outcomes of counter-fraud work. It also approves the counter-fraud work programme
- The Committee satisfies itself that the CCG has appropriate security management arrangements in place.
- The Committee reviews reports and seeks positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- The Committee monitors the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance.
- Ensures that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG
- Reviews and approves the annual report and financial statements on behalf of the Governing Body and the CCG

The Audit Committee membership and attendance is set out below:

Name	Title	Attendance as of 31 March 2020
Mr Keith Timmis	Lay Member for Governance and Audit	7 of 7
Mrs Sarah Porter	Lay Member for Transformation	7 of 7
Mr Meredith Vivian	Lay Member for PPI	3 of 7

Areas of Work

The Audit Committee is constituted from the Lay Members of the CCG with the above three as full members.

During 2019/20 the Audit Committee sought to streamline its work further by reviewing the annual work plan and agendas. The committee determined that some items that would previously have been brought to the Audit Committee would be better dealt with through other mechanisms. This enabled greater focus on the key governance issues for the CCG.

Following the risk-based approach, the Audit Committee paid particular attention to the findings from various reviews of Complex Care/Continuing Healthcare with the CCG. This resulted in regular reviews of progress towards completing actions with the relevant Managers/Directors attending Audit Committee meetings to provide the necessary insight.

In response to concerns previously raised by NHS England in relation to controls around the employment of interim staff, the Audit Committee received regular updates as a source of assurance that required procedures were being complied with.

The Audit Committee reviewed the Governing Body Assurance Framework at each meeting. The focus was on reviewing the controls, the sources of assurance of their effectiveness, and the initiation and completion of actions to address any gaps in controls, as well as sources of assurance to achieve the target residual risk levels.

A review of the Governing Body Assurance Framework (GBAF), carried out by Internal Audit at the end of the year, gave a Level A assurance.

The Audit Committee agreed to a further reduced level of work in 2019/20 at 145 days, with an agreement that additional days could be deployed if further risk areas for review arose during the year. This reduction reflected the improvement in Internal Audit ratings seen during 2018/19.

The Audit Committee continued to monitor the completion of agreed actions arising from Internal Audit reviews at each meeting, with Executives and Directors requested to attend Audit Committee meetings where concerns about progress were identified. Where appropriate, the Governing Body was notified, through the Audit Committee report, where there were concerns about progress in completing outstanding actions.

The Chair of the Audit Committee continues to provide a written report to Governing Body meetings covering the key matters discussed at each Audit Committee including clear recommendations where it is felt that action is required.

Additional work

The Audit Committee reviewed waivers of the normal tendering process, losses and special payments as they arose during the year, including approving the write-off of historical debts from previous years that were not considered recoverable

The Hospitality and Sponsorship Register was reviewed during the year in line with the strengthened disclosures agreed previously.

Any governance concerns from Governing Body Committees were discussed at each meeting through verbal input from the Lay Members who chair/attend each of the Committees.

Updates to a number of CCG policies were reviewed and approved.

Internal audit

CW Audit Services are our appointed internal auditors. An internal audit work plan of 145 days was agreed by the Audit Committee for 2019/20, focusing on the key areas of risk for the CCG. The reviews that were carried out by internal audit are detailed within the Head of Internal Audit Opinion.

In 2019/20, the improvement in findings from Internal Audit Reviews seen in 2018/19 continued, with no audits attracting limited assurance. There is still work to do to move towards the target of Significant Assurance for each review, but the hard work of CCG staff is reflected in the improvements seen to date.

Counter Fraud

The Audit Committee agreed a work plan by CW Audit Services for counter-fraud for the year, which was split between proactive work and investigations. The Committee receives a report against each of the Standards for Commissioners at least annually and appropriate action is taken in relation to any NHS Counter Fraud Authority quality assurance recommendations. There is a proactive work plan to address identified risks and whilst there is a dedicated member of the Governing Body responsible for this area it is supported by the whole Executive team.

Regular progress reports were received by the Audit Committee during the year and any issues that resulted were addressed. This included work on the National Fraud Initiative, a data-matching exercise that identifies potential concerns from a range of financial information sources.

No fraud was identified during the year and the committee took assurance that our systems are sufficient to maintain suitable control. There was one significant investigation, following an internal disciplinary process. Our Local Counter Fraud Specialist referred this to the national counter fraud team. Their conclusion was that there was no evidence of fraud in this case.

External Audit and Financial Reporting

The Audit Committee agreed the 2019/20 work plan for external audit at the start of the year. The Audit Committee monitored progress of the work during the year, with particular focus on the actions around producing the Annual Accounts and other Governance Statements.

Grant Thornton provides our external audit. It noted improvements in the CCG processes for producing the annual accounts, but provided recommendations of areas that needed further work.

Our focus during the year has been on continuing to reduce the level of outstanding debtors and creditors and, in particular, to improve the evidence to support continuing healthcare transactions. The Audit Committee has continued to work in conjunction with the Finance and Performance Committee to monitor the actions to improve the basic financial processes of this function.

Review of Effectiveness of the Audit Committee

At each meeting of the Audit Committee, a review of the effectiveness of the previous meeting is carried out with agreed changes made for future meetings as appropriate.

The Audit Committee carried out a self-assessment of effectiveness, in line with the Audit Committee Handbook. This identified some minor improvements members were keen to implement and was also used to inform the work to develop arrangements for the establishment of shared functions with Telford and Wrekin CCG.

Remuneration Committee

The Remuneration Committee was established in accordance with our constitution.

The membership of the Committee continues to comprise all of the Lay Members. Where matters regarding Lay Members were being discussed, a changed membership in line with the Terms of Reference was put in place to avoid any Conflicts of Interest.

The Committee makes determinations about pay and remuneration for employees, people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme. In doing so, the Committee seeks assurance from the Chief Finance Officer and the Accountable Officer that its decisions take into consideration the financial envelope within which the CCG is managed.

This includes:

- Determining the remuneration and conditions of service of the senior team
- Considering severance payments of the Accountable Officer and other senior staff
- Seeking HM Treasury approval as appropriate.

In September 2019, the Governing Body agreed to establish a Committees in Common arrangement with Telford and Wrekin CCG to co-ordinate decisions on the new shared executive team.

Shropshire CCG Remuneration Committee met as a Committees in Common on two occasions; and met separately on five occasions as a single committee during 2019/20. The membership, attendees and subsequent attendance is set out below:

Name	Title	Attendance as of 31 March 2020
Mr Keith Timmis	Lay Member for Governance and Audit	5 of 5
Mrs Sarah Porter	Lay Member for Transformation	5 of 5
Mr Meredith Vivian	Lay Member for PPI	5 of 5
Dr Julian Povey	Chair	1 of 1
Mr David Stout	Interim Accountable Officer to 29 September 2019	1 of 1
Mr David Evans	Accountable Officer from 1 October 2019	2 of 3
Dr Alan Leaman	Secondary Care Consultant	1 of 1

Areas of Work

The Remuneration Committee made decisions including the annual pay review for non-Agenda for Change staff, remuneration for the interim AO, remuneration for new joint executive posts including the incoming Accountable Officer and Mutual Agreed Resignation Scheme for directors.

Primary Care Commissioning Committee

On 17 March 2015 NHS England issued us with the delegation agreement to assume delegated commissioning responsibilities for primary medical services. A Primary Care Commissioning Committee was set up to discharge the delegated responsibilities. This includes the following:

- General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract)
- Newly designed enhanced services (Local Enhanced Services and Directed Enhanced Services)
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers
- Making decisions on 'discretionary' payment (e.g. returner/retainer schemes)
- Undertaking a needs assessment to inform commissioning of primary [medical] care services in the Shropshire CCG area
- Undertaking reviews of primary [medical] care services in the Shropshire CCG area
- Co-ordinating a common approach to the commissioning of primary [medical] care services generally
- Managing the budget for commissioning of primary [medical] care services in the Shropshire CCG area.

Primary Care Commissioning Committee Attendance during 2019/20 is set out below:

Name	Title	Attendance as of 31 March 2020
Dr Colin Stanford	Chair, Lay Member	5 out of 6
Mr Keith Timmis	Lay Member – Governance	6 out of 6
Mrs Sarah Porter	Lay Member – Transformation	6 out of 6
Mr Meredith Vivian	Lay Member – PPI	5 out of 6
Mr David Stout	Interim Accountable Officer to 29 September 2019	0 out of 6
Mr David Evans	Accountable Officer from 1 October 2019	0 out of 6
Dr Julian Povey	Chair of the CCG & GP Member	1 out of 6
Mrs Claire Skidmore	Chief Finance Officer and Deputy Accountable Officer to 31 December 2019 Executive Director of Finance from 1 January 2020	3 out of 5 0 out of 1
Dr Alan Leaman	Secondary Care Consultant	0 out of 6
Mrs Nicky Wilde	Director of Primary Care	5 out of 6
Mrs Christine Morris	Director of Nursing Quality and Patient Experience from 1 May 2019 to 31 December 2019 Interim Executive Director of Quality from 1 January 2020 to 24 February 2020	2 out of 4 1 out of 1
Mrs Sam Tilley	Director of Corporate Affairs to 31 December 2019	4 out of 5

Miss Alison Smith	Director of Corporate affairs from 1 January2020	0 out of 1
Dr Jess Sokolov	Medical Director to 31 December, 2019 Executive Director of Transformation from 1 January 2020	1 out 1 1 out of 5
Dr. Deborah Shepherd	Locality Chair	5 out of 6
Mr Kevin Morris	Practice Representative	3 out of 6
Dr Stephen James	GP Member	4 out of 6
Dr Finola Lynch	GP Member	3 out of 6

Areas of Work

The Committee's work programme for the year has included:

1. STP Primary Care Strategy

2. GPFV Progress / GPFV Funding Methodology

3. Primary Care Networks Confirmation Process

4. Achieving Sustainable GP Workforce – Targeted Retention

5. Extended Access and Extended Hours

6. Shifnal Premises Development Full Business Case

7. Riverside Medical Practice Final Business Case

8. Primary Care Strategy – Updated June 2019 (including Governance and Transformation Board)

9. Primary Care Networks

10. Primary Care Estates

11. Primary Care IT

12. Primary Care Quality / Performance

13. Whitehall Medical Practice Closure

14. Whitchurch Primary Care Centre – update

15. Primary Care Prescribing

16. GP Patient Access Survey Results

17. Clive Medical Practice – Branch Closure

18. Estates Strategy Update

Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have highlighted our Corporate Governance arrangements in this report and draw on best practice available, including those aspects of the Corporate Governance Code we consider to be relevant to the CCG.

Promoting transparency in decision-making is a fundamental way of working for the CCG. The systems and processes in place to support and promote transparency include having processes for managing conflicts of interest and procurement, well-defined standing orders, a clear scheme of reservation and delegation, and prime financial policies.

During 2019/20 the CCG has reviewed and updated its constitution to ensure it continues to reflect best governance practice.

The CCG's Scheme of Reservation and Delegation sets out how the decision-making responsibilities of the CCG are shared between the membership and the Governing Body and its various committees.

Discharge of Statutory Functions

In light of the 2013 Harris Review's recommendations, we have reviewed all of the statutory duties and powers conferred on us by the National Health Service Act 2006 (as amended) and other associated legislative regulations. As a result, we are clear about the legislative requirements associated with each of the statutory functions for which we are responsible, including any restrictions on delegation of those functions.

Risk Management Arrangements and Effectiveness

We are committed to ensuring that we have in place structures that will effectively manage risks to a level that is in line with our key aims as set out in our Constitution. Some of these risks are internal and will be controlled by our internal controls and the internal control system. Others are external and arise due to unpredictable changes in the economic, business, political, technological and financial environment.

Preventing and Deterring Risk

We work to prevent risks from developing in the first instance, by making sure that employees are aware of their own areas of work and develop processes and procedures that help to eliminate any risks. This also includes providing appropriate mandatory and specialist training where required – i.e. information governance, manual handling, infection prevention and fire safety training. We also provide communications and advice about issues related to fraud risk and who to contact should any employees have concerns. However, there are always risks inherent to programmes of work which need to be identified and managed.

Identification of Risk

We identify our significant risks from the following sources:

- The investigation of incidents, claims and complaints
- Concerns raised by stakeholders, patients and staff
- Expertise of directors and managers
- Issues raised by CCG committees and groups
- External organisation reports and inspections
- External and internal audits and surveys
- Carrying out risk analyses or relevant assessment work.

Analysing the Risk

The following factors are taken into account when the risk is analysed:

- The full extent of the consequences of the risk
- The likelihood of the risk occurring
- Any means by which the risk is currently controlled or mitigated
- How we will be assured that the risk is being adequately managed.

Developing Further Mitigating Controls/Accepting the Risk

Following analysis of the risk, the relevant lead manager, in conjunction with other interested parties, will consider the circumstances identified and decide whether further mitigating controls are necessary. This may mean seeking advice from more senior CCG employees.

Monitoring the Risk

Through the processes described in the policy below, all identified significant risks are monitored to ensure:

- The level of risk that we are prepared to accept in the pursuit of our strategic objectives is acceptable to the organisation and our stakeholders (risk appetite, described as 'Post Mitigation Assessment of Risk Level' on the CCG Assurance Framework)
- The risk is communicated to all relevant parties
- That identified systems of internal control are working effectively, reducing risk to an accepted level
- Identified assurances have been received by the Governing Body.

We see risks and potential risks in a positive way - as a tool for learning and developing and making sure that processes and procedures are in place to mitigate any such risks developing in the future. Employees are encouraged to report any potential risks in their directorate and where appropriate, for these to be added to the Corporate Risk Register. It is the responsibility of the appropriate Director to raise this risk within the Executive Team to identify any mitigating actions or to consider whether the risk is significant enough to be included in the Governing Body Assurance Framework.

Work with patients and public – either through formal routes like complaints, PALS, Healthwatch or our patient advisory group, or informally through other patient groups – helps to identify other potential risks. Where these are identified, they are passed to the appropriate lead manager or Director for consideration or follow-up with the patients or public to get a greater understanding of the issue.

Capacity to Handle Risk

Our Governing Body, Finance and Performance Committee, and Audit Committee in particular, consider organisational risks at each of their meetings, thereby demonstrating senior level ownership of the risk management process across the organisation. However, each of the Governing Body Sub Committees will also review the Corporate Risks periodically. Risks are also regularly reviewed and highlighted at weekly Executive Team meetings.

Our Risk Management Policy defines the structures, processes, roles and responsibilities that support the effective management of risks of all kinds to a level that is in line with our key aims as set out in the CCG constitution. In doing so, we use the framework to take all reasonably practicable steps in the management of risks: in commissioned services, associated with staff, associated with visitors, with regard to organisational reputation, organisational assets and any other issue, as an integral part of our management processes.

Each Executive Director takes responsibility for risks associated with their work portfolio and ensures that their Directorate Risk Registers reflect these risks and feed into the overall Corporate Risk Register and ultimately the Governing Body Board Assurance Framework (GBAF).

There is a process for escalating the risk onto the GBAF when appropriate. Staff in Directorates are encouraged to raise any potential risks with their Director in order to make sure Directorate Risk Registers are up to date and reflect real, time-sensitive risks. During 2019/20 the CCG has continued to utilise an Issues Log to complement the GBAF and ensure that where risks are realised there continues to be focus on mitigation and resolution and that the Governing Body has oversight of this.

The Director of Corporate Affairs has oversight of the Governing Body Board Assurance Framework and Issues Log as well as the Corporate Risk Register and Issues Log and therefore has responsibility to ensure that these documents are kept up to date through working with Executive Directors to review their respective risk areas and update them accordingly.

The committees of the Governing Body provide written and verbal updates on a regular basis, allowing Governing Body Members the opportunity to question and challenge their work and to get more information, where required.

Risk Assessment

During 2015/16 and 2016/17, we identified deteriorations in our financial position, exposing control weaknesses within the organisation. This has had a significant impact on the delivery of key system objectives and has resulted in us failing to remain within our financial allocation. As a result of the significant financial and operational challenges facing the CCG, we have been subject to NHS England Legal Directions since April 2016 and continue to be subject to a formal monitoring and oversight process with NHS England. We were able to reach the financial control total set by NHS England in 2016/17. However, this has not been the case for 2017/18, 2018/19 and 2019/20. The CCG continues to operate in a challenging financial environment and manage a number of organisational risks.

The Governing Body Assurance Framework (GBAF) is a key document and considered in detail at

the Governing Body, Finance and Performance Committee and Audit Committee. It is updated on a regular basis and directors are held to account for the assessments made in it. Each of the risks that are included in the GBAF is regularly reviewed and key controls and key assurances identified and monitored. Where any gaps in controls or assurances are identified, then mitigating actions are identified and taken to make sure the risk is appropriately managed.

A summary of the risks from the Governing Board Assurance Framework during 2019/20 are set out as follows along with a snapshot of their mitigating actions:

- Finance

Risk to Delivery	Mitigating Actions
There is a risk that we will fail to achieve our planned control total for 2019/20.	Action plan in place; In addition to the key controls already in place (for example, Committee and Governing Body scrutiny of the finance position; Prime Financial Policies; finance, contracting, QIPP governance and procedures), a financial recovery plan was developed. Actions described included: - Enhanced governance and increased grip and control measures; - Executive team sought to accelerate QIPP in year delivery and plans for 20/21; - Early agreement of year end position with our two main acute providers; - Joint working across CHC and finance teams with a focus on sharing good practice and harmonising procedures. Finance focus on robust information to support forecasting and QIPP delivery.

- Quality and Safety

Risk to Delivery	Mitigating Actions
There is a risk that we will fail to commission safe, quality services for our population.	Workforce oversight of providers via CQRMs, STP Strategic Workforce Group and LWAB continues Systemwide People Plan in development to align with NHSE People Plan. Procurement for serious incidents and mortality review complete. Review to be timetabled to commence and be completed by late 2020.

	Action plan to address the limited assurance in place. New SI policy and process to be shared with Quality Committee in September 2019. Revised Quality Strategy produced awaiting sign-off from NHSE/I

- NHS Constitution

Risk to Delivery	Mitigating Actions
There is a risk that we will fail to meet our NHS Constitution targets either fully or sustainably.	Fortnightly A&E Delivery Group includes clinical input and focuses on actions to improve ED systems and processes and reducing stranded patient numbers. A&E Delivery Group focusing on demand management with particular emphasis on admission avoidance. SaTH committed to significant investment in both nursing and medical workforce. Focus on system wide demand and capacity planning. Cancer performance has improved in Q3 and breast symptoms and 2wk are now achieving. 62 day cannot be delivered until wider capacity issues resolved for Urology. Progress has been made in this area with SaTH, agreeing a formal partnership arrangement with UHNM which will see increased access to robotic surgery from February 2020. The gaps in controls and assurance have been escalated with SATH via the System Urgent Care Director. Clinical representation for planned care now through the Elective Transformation Board.

- Transformation

Risk to Delivery	Mitigating Actions
There is a risk that we will fail to effectively lead transformation of local health services across acute, community, and primary care to ensure sustainability for the future.	NHSE continues to regularly meet with the CCG to oversee its recovery plans and implementation process. In May 2019 both SCCG and T&W CCG approved plans to become a single strategic commissioner. Plans to achieve this by 1 April 2021 are underway. This will support the recovery programme by reducing costs, duplication and inefficiencies and will create a more robust commissioning voice that is aligned to the STP footprint. Although the creation of the single strategic commissioner has been delayed by 12 months to April 2021, as a result of NHSE/I declining the CCCs application, work still continues to bring the CCGs

	closer together in the intervening period. Case Management pilot is live in eight GP practices and will run for nine months. Additional resources have been requested from Providers to deliver the increased activity to community teams. An investment business case is being developed in January 2020. Phase 3 models are signed off and impact assessments are underway, due to be completed by end October. The STP governance structure has been agreed and a Shadow ICS Board is being put in place from February 2020

- Communication and Engagement

Risk to Delivery	Mitigating Actions
There is a risk that we will fail to effectively engage and communicate with our members, the public, partners and stakeholders and our staff.	There is a rolling programme of communication and engagement with both staff and member practices in light of the Governing Body's approval to move to a Single Strategic Commissioning Organisation with T&W CCG. The volume of transformation work being undertaken by the CCG is significant and capacity remains an issue. Work plans and priorities are kept under continuous review and adjustments made where necessary to maximise capacity and responsiveness. Working arrangements with T&WCCG have been reviewed and a joint interim structure is now in place to ensure capacity is maximised and duplication reduced, along with work to maximise communication and engagement capacity and expertise in the Future Fit/ STP team.

- CCG Workforce Resilience and Trust

Risk to Delivery	Mitigating Actions
There is a risk that the current financial situation will impact negatively on existing staff resilience and retention levels and prevent successful recruitment in the future	Further to the approval by the Governing Bodies for the creation of a Single Strategic Commissioning organisation, SCCG and T&WCCG have procured an OD partner and dedicated HR input to support this work. An Organisational Development Plan has been developed and an implementation plan is being finalised. Workstream meetings have begun to meet more formally to manage the specific task realting to the transition workstream. OD work with staff has commenced.

	The CCG's statutory and mandatory training compliance is being monitored and reminders have been given to staff in this regard.

- Provider Workforce

Risk to Delivery	Mitigating Actions
There is a risk that providers' ability to deliver services and remain financially viable is not sustainable.	CCG continued to attend the Local Workforce Action Boards (LWAB) to engage regarding the national workforce issues impacting on the ability locally to recruit and retain staff. STP workforce group and LWAB in place which coordinates apprenticeship schemes/staffing passport and back office functions to maximise staff flow and competencies. Primary Care Strategy developed, linked to the quality agenda. Work ongoing with providers and Health Education England.

- Stakeholder and Patient Support and Trust

Risk to Delivery	Mitigating Actions
Failure to maintain stakeholder (including membership) and patient/public trust and support leading to negative organisational reputation because of the following reasons: 1) financial performance challenges 2) leadership challenges 3) organisational culture challenges 4) NHSE CCG assurance - 'needs improvement'.	The volume of transformation work being undertaken by the CCG is significant and capacity remains an issue. Current demands are enhanced due to supporting major programmes of transformation and redesign and forthcoming consultations in relation to MLU and Care Closer to Home, as well as an increased level of public and press interest regarding the CQC interventions regarding maternity and A&E services at SaTH. Work plans and priorities are kept under continuous review and adjustments made where necessary to maximise capacity and responsiveness. Working arrangements with T&WCCG have been reviewed and a joint interim structure is now in place to ensure capacity is maximised and duplication reduced, along with work to maximise communication and engagement capacity and expertise in the Future Fit/ STP team Staff training opportunities are being continuously monitored. Mental Health Awareness training planned for staff.

- Legal Directions

Risk to Delivery	Mitigating Actions
There is a risk that we will fail to have NHS England Legal Directions revoked within an agreed time frame.	Work regarding financial recovery continues with regular meetings to focus on the delivery of QIPP and associated work streams. Continued dialogue with NHSE regarding progress.

- Impact of Social Care Funding Challenges

Risk to Delivery	Mitigating Actions
There is a risk of individuals escalating into acute hospital care or not being able to be discharged from acute hospital care, thus impacting adversely on the capacity and capability of health services.	Delivering Care Closer to Home to reduce demand failure in the acute setting. Demonstrator site procurement for admission avoidance in Shrewsbury area in progress. Ongoing dialogue with Shropshire Council regarding service cessation impacts. The STP governance structure has been agreed and a Shadow ICS Board is being put in place from February 2020.

- Management of 0-25 Health and Wellbeing Service

Risk to Delivery	Mitigating Actions
Risk of lack of assurance of quality and safety of current service, in particular for a number of legacy patients.	In response to concerns raised by a visit of the Intensive Support Team, a comprehensive action, communication and governance plan was developed by the contract lead Provider and has now been delivered. The CYP LTP group continues to meet quarterly. The original workforce development plan has been delivered and the remaining issue related to skilled capacity for ASD diagnostic assessments is being resolved by commissioning additional capacity. The providers are on trajectory to reduce these long waiters and continues to be managed through the MPFT Strategic Commissioning Board. A new model of acre has been agreed and now implemented to deliver this service in the future within appropriate waiting times.

- Management of response to Covid 19

Risk to Delivery	Mitigating Actions
Failure to manage with partners the local health system response to Covid 19 pandemic.	EPRR processes in place and tested. National and regional daily Covid-19 calls involving SRO and AO. Business Continuity plans in place and have been enacted. Critical services identified, non critical scaled down. CCG SRO dedicated to leading CCG response – internal and external, with partners in local authority. Redeployment of clinical staff to frontline NHS services enacted. Most staff working from home where possible.

Other Sources of Assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the Clinical Commissioning Group to ensure we deliver our policies, aims and objectives.

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. For those items where the risk becomes a reality an Issues Log has been introduced. There is appropriate monitoring of issues and the courses of action being employed to mitigate them.

Our Risk Management Policy, which was updated in 2017/18, 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.

Members of the Audit Committee chair, or are members of, all the sub committees. In the Audit Committee they can therefore discuss the operation of the each sub committee and the governance processes in place. Each meeting of the Audit Committee considers “other sources of assurance” as part of the overall assessment of the systems in place at the CCG.

Annual Audit of Conflicts of Interest Management

The CCG receives a considerable amount of public funds to spend on healthcare for our population. We therefore must ensure that individuals acting on our behalf, whether this is a GP, staff member or a contractor, act with impartiality when making decisions on how our budget is spent, and that they do not use their role in the CCG to further their own private interests or those of anyone known to them.

The statutory guidance on managing conflicts of interest for CCGs was revised by NHS England in February 2017. During 2017/18 the CCG revised its Conflict of Interest Policy and has continued in 2019/20 to ensure a robust application of these requirements. As part of these requirements it is necessary for the CCG 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.

During 2019/20 our internal auditors have carried out an audit of our conflict of interest arrangements to assess whether we have 'effective arrangements in place to manage conflicts of interest'. The internal audit concluded that we provided significant assurance and there were no recommendations.

Data Quality

Our Constitution sets out the role of the Chair in ensuring the CCG's Governing Body has adequate support and is provided efficiently with all the necessary data on which to base informed decisions. It also sets out the Chief Finance Officer's responsibility to ensure the accuracy and security of the CCG's financial data.

The CCG has a number of other policies and processes in place that support the maintenance of the high quality data required for the CCG to fulfil its functions effectively.

Information Governance

The NHS Information Governance (IG) Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a Data Security and Protection Toolkit and the annual submission process provides assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance (IG) systems and processes in place to help protect data and information and to ensure it is used for appropriate purposes and in appropriate ways.

We are registered with the Information Commissioner's Office (ICO).

During the same period we refreshed our systems and processes to reflect the new General Data Protection Regulation regime that took effect. We employed the services of a Data Protection Officer (DPO) and issued updated IG & Data Security and Protection Policies. We also issued a new IG Staff Handbook and a new IG Staff Code of Conduct and updated the CCG's Privacy Notice which is displayed on the website via the required 2-click approach. We have also issued staff with an Employee Privacy Notice. This remains the current position for 2019/20.

We continue to apply the standards required under the applicable Data Security and Protection Toolkit, the new version of the IG Toolkit that all organisations must complete, including training staff in complying with our policies and meeting the requirements.

Shropshire CCG has reported a total of seven incidents during 2019/20. Please note that one was from late 2018/19 so wasn't captured in last year's Annual Report. All of these were graded as level 0 - very low risk and therefore not reported to the ICO.

Business Critical Models

We have an appropriate framework and environment to provide quality assurance of all models, plans and strategies (business critical or otherwise).
Models and plans (i.e. Operational Plan, Quality, Innovation, Productivity and Prevention Programmes etc.) have included statistical, economic and financial information as part of their quality assurance processes and all are subject to periodic review.

Our framework ensures that all models are planned. It also includes the identification and treatment of associated risks, determines capacity, capability and control and the involvement and participation of specialist staff in both the development and implementation of such models. This is in keeping with the principles outlined in the MacPherson Report (March 2013).

Emergency Preparedness Resilience and Response (EPRR)

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

The CCG's Business Continuity Plan was updated during 2019/20 and therefore remains current. The CCG maintains a Director on-call rota 24 hours a day, 365 days a year, to ensure capability to respond to critical or major incidents both affecting its ability to conduct its own business but also affecting the local health economy as a whole.

The CCG is category 2 responders and works closely with other agencies and NHS England in relation to the EPRR agenda. Refresher emergency planning training has been available to all on-call Directors during the year. The CCG has participated in a local EPRR exercise and has run its own internal communication exercise.

During 2019/20 NHS England undertook an assurance exercise of CCGs in relation to EPRR. Shropshire CCG was able to maintain the full assurance it gained in the previous year. This is the highest level of assurance. The CCG will continue to improve and develop its EPRR capability and will continue to test its EPRR plans during 2020/21 with a view to maintaining this assurance level.

Third Party Assurances

Third part assurances are received annually from Midlands and Lancashire CSU for particular financial functions which are part of a Service Level Agreement.

Processes are in place to ensure that the CSU Internal Audit function shares its own audit findings of these functions with the CCG's internal auditor who includes a precis of the findings in the Head of Internal Audit Opinion which is part of this statement.

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

Control Issues

Building on issues identified via our Month Nine Governance Statement the following significant control issues were identified. We took remedial actions to reduce the impact and likelihood of the risks:

Financial position

"The CCG has recorded a £47.3m deficit against the submitted plan of £22.9m deficit. Whilst this means that the planned position was not achieved this did comply with the reforecast position agreed with NHSEI at month 9. Financial measures have been in place throughout the year to control spend where possible including but not limited to restrictions to discretionary spend; agreeing year end settlements with our main acute providers and increased oversight and scrutiny of the QIPP programme. We recognise that the worsening in the CCG's underlying position will impact on future financial plans and we will continue to engage financial grip and control measures in order to mitigate the risk of further deterioration. We plan to give particular attention to our medium term recovery plan placing particular emphasis on improving our QIPP development and reporting and transforming our contracting arrangements to create strong incentives for system change. ." As a result, the External Auditor is expected to issue a section 30 referral to the Secretary of State.

Quality of main acute provider

There has been variable assurance on standards of quality at the main acute provider during 2019/20 following Care Quality Commission inspections in November 2018 and subsequent inadequate rating and special measures.

The CCG has undertaken ongoing review with robust contractual performance monitoring relating to the delivery of quality standards via the monthly CQRM, active participation in the NHSE/I chaired Safety and Oversight Assurance Group (SOAG) with Shropshire CCG, all system partners and stakeholders.

Further escalation has been made to QSG at each meeting, to address significant concerns relating to patient safety and experience and concern relating to the robustness of assurances given to the CCGs, where the Trust remains at Risk Summit level of escalation.

NHSE/I Risk Summits have been held in December 2019, January and February 2020. Action plans for service improvement across all requisite areas have been in place and monitored through CQRM, SOAG with CQC with limited impact on quality improvement to date acknowledged by the regulatory bodies in February 2020.

Provider directors have attended the Governing Body meetings throughout the year to present their actions in relation to maternity, workforce and mortality directly. The assurance process is through Quality Committee to Board.

The CQRMs are in place for all providers to review contractual assurances and delivery; there are two SaTH CQRMs - one specially for maternity at this time given the national scrutiny in this area.

Outputs from these are shared in the Quality Committee reports which then go to the Governing Body for attention.

All SIs are reviewed in accordance with our policy and aligned to the national process. The CCG's process has recently been reviewed by internal auditors, which received significant assurance.

In addition the CCG, together with NHS Telford and Wrekin CCG, have had a peer review by West Midlands Quality Review Team in February 2019 which did not identify and specific issues related to quality oversight and assurance processes in place.

Continuing Health Care

Continuing health care and individual commissioning remain a significant challenge. Much work has been carried out in year with a clear action plan in place to deliver the required improvements to systems and processes for demand, activity and market management including financial oversight and delivery.

The action plan developed by the CHC team to strengthen system and process for individual commissioning has been received by the Audit, Finance and Performance and Quality Committees with a clear reporting process in place to each committee with oversight remaining at GB committee level. It is evident that the actions in place are beginning to produce the required outcomes to improve delivery and assurance.

Impact of the current COVID-19 pandemic

A further significant control issue is that the impact of the current COVID-19 pandemic is unknown. 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. Clinical staff have been redeployed to frontline services to support the anticipated significant challenge that COVID-19 is likely to have. Non clinical CCG staff are being redeployed into identified critical services or trained to provide back-up to these services when it is anticipated we will have staff shortages. The CCG in partnership with NHS Telford and Wrekin CCG and other key stakeholders is leading the local health resilience partnership (LHRP) response to the emergency across Shropshire and Telford and Wrekin.

Review of Economy, Efficiency, and Effectiveness of the Use of Resources

Ensuring value for money is an important principle for us. It is outlined in our Constitution and the Local Audit and Accountability Act 2014, which states that 'the [Clinical Commissioning] Group has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources'.

The CCG continues to strive to abide by this principle despite the challenging financial climate in which it is operating. However, we have been unable to meet our control total for 2019/20.

To ensure we remain focused on the delivery of safe, sustainable local healthcare, and appropriate access for patients, we continue to by following these key principles:

- We ensure that quality of care and patient safety is our first priority at all times as seen from our close review and involvement with the monitoring of quality at SaTH
- Any savings made are done through programmes which improve patient outcomes, efficiency of provision, reduced duplication with the aim of 'getting it right first time' for patients
- Areas of restricted access (in line with the CCG's Value Based Commissioning Policy) are only adopted once signed off by the local clinicians across primary, secondary and tertiary care, alongside patient groups, and at all times are based on recognised clinical evidence
- We adhere to our responsibilities as a commissioner for supporting innovation and pathway redesign for improved patient outcomes
- The Governing Body adheres to its principle of showing strong credible leadership across the local health economy

Delegation of Functions

There are occasions where we delegate some functions to outside organisations in order to help achieve our business objectives.

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

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

In 2015/16, we were approved to take on delegated responsibility for commissioning GP services from NHS England. In response to this we set up a Primary Care Commissioning Committee. During 2016/17, we put in place arrangements to ensure there was more capacity and capability to manage these new responsibilities.

The CCG continues to work in partnership with the Local Authority to implement the Better Care Fund Plan and to continue to monitor and review its work streams to ensure the best value is gained from the fund, both in service outcome and financial terms.

Risks associated with any delegated functions are managed through an appropriate Executive Director, with oversight, management and challenge from the Governing Body and relevant Governing Body Committee. This includes any aspects of whistleblowing, which we take seriously.

Counter Fraud Arrangements

We adhere to the standards set by the NHS Counter Fraud Authority in order to combat economic crime within the NHS. Counter Fraud arrangements are contracted by the CCG from CW Audit Services who provide the services of an Accredited Counter Fraud Specialist, contracted to undertake counter fraud work proportionate to the CCG's identified risks.

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

The Chief Finance Officer who is a member of the CCG 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 in 2019/20 the CCG has appointed a Counter Fraud Champion in line with requirements for CCGs.

Head of Internal Audit Opinion

The purpose of my annual 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. This Opinion will in turn assist the Governing Body in the completion of its Annual Governance Statement.

My overall opinion is that:

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

The basis for forming my opinion is as follows:

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

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

The design and operation of the Assurance Framework and associated processes

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

The CCG is planning to create a new Board Assurance Framework (BAF) next year, once updated joint objectives will have been considered with Telford and Wrekin CCG, as part of the move towards a new organisation. It was therefore a sensible and pragmatic decision by both CCGs not to invest time this year in getting the two CCG's BAFs in full alignment.

It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2019/20 Annual Governance Statement and

provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The system of internal control based on internal audit work undertaken

My Opinion also takes into account the range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. An internal audit plan for 2019/20 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 (*for those at draft report stage) is summarised below:

Full Assurance	• Conflicts of Interest Management
Significant Assurance	• Looked After Children • Financial Systems (Debtors, Ledger and Payroll) • Contract Monitoring – SaTH • Contract Monitoring – MPFT • Primary Care Commissioning
Moderate Assurance	• Budget Setting • Financial Systems (Accounts Payable) • Financial Reporting and Delivery

- Provider Serious Incidents- follow up – May 2019
- Data Protection & Security Toolkit – Action Required position statement
- Board Assurance Framework – Level A.

Details of the reviews were Moderate Assurance was provided are set out below:

Moderate Assurance Reviews

Budget Setting

We noted some improvements in certain aspects of Budget Setting. For the first time the CCG had managed to identify schemes that totalled the entire QIPP value by the start of the financial year and these schemes were all classed as recurrent. The CCG reported all budgets had been signed off.

A high level procedure document was introduced to combine/streamline the work of the CCG with Telford and Wrekin CCG. We also considered that the Finance Teams and Chief Officers should be congratulated for their forward thinking on their combined working with Telford and Wrekin CCG.

The 2019/20 final plan submission was made in line with NHSE requirements. The CCG and NHSE were unable to agree on a control total, with further efficiencies of £10.6m required in the final control total offer made by NHSE which was subsequently rejected by the CCG. If the control total had been accepted it would have resulted in a QIPP of £30.4m. The Governing Body approved the use of the financial plan for operational purposes but was made aware of the ongoing discussion. A letter was issued from NHSE on 28th June 2019 stating they were willing to use the most recent plan submission to assess performance for the remainder of the financial year, thus ending discussions.

The review noted some significant challenges regarding the CCG's QIPP, which the CCG was aware of and was recognising in their BAF. To achieve their control total the CCG required full delivery of what was the largest QIPP target ever for the CCG. The review acknowledged that the CCG faced a battle to achieve such a large QiPP in full in the year.

Work identified some QIPP business case documents which were lacking sufficient detail when reviewed as part of the QIPP development and approval testing and that these issues may affect the delivery of those schemes.

Financial Reporting

The review identified that the CCG was reporting its current year to date position accurately. It was also established that forecasts were derived from extrapolations of the year to date position, adjusted as appropriate for known issues/challenges. However, some elements of forecasting, in particular the Acute directorate and the SaTH contract was being impacted by uncertainty.

As at M7 the CCG reported that it was off-plan by £11.9m year to date, a significant rise compared to the same reporting period in 2018. This was mainly due to continued over-performance in major acute contracts, rising expenditure within Complex Care and under-delivery in the QIPP programme.

Given the level of overspend, no potential for any Commissioner Sustainability Funding (CSF) due to non agreement of a control total with NHSE when budget setting and a further £22.1m of unmitigated risk, it was highlighted at that time that the CCG faced an immense challenge in achieving their target.

Financial Systems –Accounts Payable

The review identified that the CCG continued to make improvements within Financial Systems and had generally sound controls in place in relation to the activities linked to the financial ledger and payroll. In particular we identified improvements in activities linked to accounts receivable moving the assurance level in this area to Significant.

The review noted that the level of dispute with Shropshire Council had reduced since last year however there continued to be challenges within accounts payable linked to Complex Care/CHC costs.

A dispute with NHS Property Services was noted and it was recognised that a number of organisations were in the same position with that organisation.

Other

Looked After Children (LAC) Review – Significant Assurance

Much had improved since our last report; data was now being captured by the provider, relationships were being built with partners, performance was challenged at CQRM and Shropshire

Community Health NHS Trust (SCHT) had, alongside the CCG developed a new national template. Across both Telford and Shropshire we saw and were described appropriate relationships with partners in relation to LAC.

The data at the time of review showed the challenge in relation to delivery of assessments and the rising number of LAC. We identified some improvements that could be made to data quality. It was noted that all of those we met expressed concern over instances when children had been placed in area from out of area but the relevant local authority or then subsequently the CCG had not been informed. We were advised this issue was being picked up nationally.

Provider Serious Incidents – Follow Up - May 2019

Whilst we found that the CCG's arrangements to manage the Serious Incident Process had improved since the last audit, there were areas where full implementation of our previous recommendations would further strengthen arrangements.

We noted that a policy has been approved and consistency in relation to the Route Cause Analysis (RCA) being used by providers had improved.

This alongside joint workshops has helped to reduce the volume of SIs in the cycle of poor quality RCA's being rejected. Timeliness had improved but this still remained an issue in relation to both the production of RCA's by Providers and the response to these by the CCG.

We noted that NHS England (NHSE) had undertaken a review of the CCG's SI review process. Their attendance at a SIRG meeting provided NHSE with assurance of the process taken upon review of SI RCAs.

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 is then required to update the status against agreed actions. This is a self-assessment and is supplemented by our independent follow-up reviews where this is deemed necessary, for example, following the issue of a limited or moderate assurance report.

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.

To avoid over burdening staff who are responding to the COVID 19 Critical incident we have not included details of the small number of deferred recommendations as at 31 March 2020.

We will continue to monitor the implementation of these plans over the coming months as appropriate.

Reliance on third party assurances

Midlands and Lancashire (M&L) Commissioning Support Unit (CSU) Report on Internal Controls Type II Finance and Payroll Service Auditor Report for the period 1 April 2019 to 31 March 2020 were received and reviewed. The report provides Reasonable Assurance overall, with qualified opinion assigned to two control objectives. These objectives and the reason for the qualification were reviewed. Following this review, we can confirm that there are no issues or concerns we wish to highlight within this opinion.

On 8 April 2020 CQC published their latest report on Shrewsbury and Telford Hospital NHS Trust. The" inadequate rating" was assessed as remaining in place with no assessment areas improving and two areas rated by CQC worse than the last inspection.

The review undertaken between November 2019 and January 2020 resulted in four out of five areas

judged as inadequate the remaining area was rated as requiring improvement.

Review of the Effectiveness of Governance, Risk Management and Internal Control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed. The Assurance Framework is reviewed regularly by the Governing Body, Audit Committee and Directors and I am satisfied that it reflects the key challenges faced by the CCG.

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

- The Governing Body
- The Audit Committee
- Performance Information
- 360 Degree Assurance
- Contract Monitoring information
- Sub committees of the Governing Body
- Feedback from staff and patients

Conclusion

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 2019/20. However during the year good 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 Shropshire 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.

Mr David Evans
Accountable Officer
24 June 2020

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee was established in accordance with our Constitution.

The Committee makes determinations about pay and remuneration for employees of the CCG, people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS Pension Scheme. In doing so, the Committee seeks assurance from the Chief Finance Officer and the Accountable Officer that decisions made by the Committee take into consideration the financial envelope within which the CCG is managed. This includes:

- Determining the remuneration and conditions of service of the Senior Team
- Considering severance payments of the Accountable Officer and other senior staff, seeking HM Treasury approval as appropriate.

Policy on the Remuneration of Senior Managers

The remuneration of the Accountable Officer and Executive Directors serving on our Governing Body is determined by 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. The Remuneration Committee also determines the remuneration of the GP practice members of our Governing Body. The rates payable are determined locally. Midlands and Lancashire Commissioning Support Unit provide independent advice and support to the CCG and the Remuneration Committee in relation to employment and remuneration matters.

Senior Manager Remuneration (including salary and pension entitlements)

Remuneration Report Disclosures (These tables are subject to audit by our external auditor)

The tables below set out the salaries, allowances, and pension benefits of senior managers serving on the Governing Body during the year. As Lay Members do not receive pensionable remuneration, there are no entries in respect of pensions for Lay Members. Where individuals are paid by agencies, the figure includes the agency's cost.

Table 1 Salaries and Allowances 2019/20

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Bird	Matthew	Locality Chair - South	01/04/19 to 31/03/20	20-25	-	-	-	217.5-220	240-245
Clarke	Dawn	Executive Nurse Director	01/04/19 to 31/05/19	10-15	-	-	-	10-12.5	25-30
Davies	Julie	Director of Performance & Delivery	01/04/19 to 31/12/19	70-75	900	-	-	55-57.5	130-135
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	10-15	300	-	-	7.5-10	20-25
Evans	David	Accountable Officer - Joint post with Telford & Wrekin CCG	01/10/19 to 31/03/20	35-40	-	-	-	0-2.5	35-40
Fortes-Mayer	Gail	Director of Contracting & Planning	01/04/19 to 31/12/19	70-75	-	-	-	112.5-115	185-190
Fortes-Mayer	Gail	Interim Director	01/01/20 to 31/03/20	20-25	-	-	-	37.5-40	60-65
Morris	Christine	Executive Nurse Director - Joint post with Telford & Wrekin CCG	01/06/19 to 31/12/19	30-35	-	-	-	27.5-30	60-65
Morris	Christine	Interim Executive Director of Quality - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	10-15	-	-	-	10-12.5	25-30
George	Priya	GP Member	01/04/19 to 31/03/20	20-25	-	-	-	0-2.5	20-25
James *	Stephen	GP Governing Body Member/Clinical Chief Information Officer	01/04/19 to 31/03/20	55-60	600	-	-	0-2.5	55-60
Leaman *	Alan	Secondary Care Clinical Member	01/04/19 to 31/03/20	15-20	-	-	-	0-2.5	15-20
Lewis *	Katy	Joint Locality Chair - North	01/04/19 to 31/03/20	20-25	-	-	-	0-2.5	20-25
Lynch	Finola	GP Governing Body Member/Deputy Clinical Chair	01/04/19 to 31/03/20	55-60	-	-	-	52.5-55	55-60
Matthee	Michael	Joint Locality Chair - North	01/04/19 to 31/03/20	25-30	-	-	-	0-2.5	25-30
Morris	Kevin	Practice Representative	01/04/19 to 31/03/20	50-55	-	-	-	27.5-30	50-55
Pepper	John	GP Governing Body Member	01/04/19 to 31/03/20	20-25	-	-	-	0-2.5	20-25
Porter *	Sarah	Lay Member - Transformation	01/04/19 to 31/03/20	15-20	-	-	-	0-2.5	15-20
Povey *	Julian	Chair (Clinical)	01/04/19 to 31/03/20	105-110	900	-	-	0-2.5	105-110
Shepherd	Deborah	Locality Chair - Shrewsbury & Atcham	01/04/19 to 31/03/20	60-65	-	-	-	40-42.5	60-65
Skidmore	Claire	Chief Finance Officer & Deputy Accountable Officer	01/04/19 to 31/12/19	85-90	-	-	-	65-67.5	155-160
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	15-20	-	-	-	10-12.5	25-30
Smith	Alison	Director of Corporate Affairs - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	10-15	-	-	-	2.5-5	15-20
Sokolov	Jessica	Medical Director	01/04/19 to 31/12/19	75-80	-	-	-	25-27.5	100-105
Sokolov	Jessica	Executive Director of Transformation - Joint post with Telford & Wrekin CCG	01/01/20 to 15/03/20	15-20	-	-	-	2.5-5	20-25
Stout	David	Interim Accountable Officer	01/04/19 to 30/09/19	70-75	1,500	-	-	0-2.5	70-75
Tilley	Samantha	Director of Corporate Affairs	01/04/19 to 31/12/19	70-75	800	-	-	120-122.5	195-200
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	10-15	300	-	-	20-22.5	30-35
Timmis *	Keith (Andrew)	Lay Member - Performance	01/04/19 to 31/03/20	15-20	-	-	-	0-2.5	15-20
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CCG	16/03/20 to 31/03/20	0-5	-	-	-	0-2.5	0-5
Vivian *	Meredith	Lay Member - Patient & Public Involvement	01/04/19 to 31/03/20	15-20	-	-	-	0-2.5	15-20
Wilde	Nicola	Director of Primary Care	01/04/19 to 31/12/19	70-75	800	-	-	97.5-100	170-175
Wilde	Nicola	Interim Director	01/01/20 to 31/03/20	20-25	300	-	-	32.5-35	55-60

Explanation of Joint Arrangements with Telford & Wrekin CCG

At the beginning of 2019/20 Shropshire CCG had its own separate Board structure. When the Executive Nurse Director post became vacant at the end of May 2019, the CCG took the opportunity with Telford & Wrekin CCG to redefine this as a joint post as a first step towards joint working. In October 2019 the Interim Accountable Officer (David Stout), stepped down and David Evans (Accountable Officer at Telford & Wrekin CCG), became the Joint AO for both CCGs which was the first stage in the Management of Change process. In December 2019 the next stage of the process was the creation of joint Director posts across both CCGs and these became effective from 1st January 2020.

For those staff appointed jointly with Telford & Wrekin CCG, the total cost of their remuneration across both CCGs is shown below. This is in respect of the period of joint working only:

SURNAME	FIRST NAME	POST	TOTAL REMUNERATION (Bands of £5,000)
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG	25-30
Evans	David	Accountable Officer - Joint post with Telford & Wrekin CCG	70-75
Morris	Christine	Interim Executive Director of Quality - Joint post with Telford & Wrekin CCG	90-95
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG	30-35
Smith	Alison	Director of Corporate Affairs - Joint post with Telford & Wrekin CCG	25-30
Sokolov	Jessica	Executive Director of Transformation - Joint post with Telford & Wrekin CCG	30-35
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG	25-30
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CCG	0-5

Table 2 - Salaries and allowances 2018/19 (audited information)

SALARIES AND ALLOWANCES 2018/19 (audited information)

Surname	First Name	Tilte	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Allen	Shailendra	Locality Chair - South	01/04/18 to 01/08/18	15-20				2-2.5	15-20
Bird	Matthew	Locality Chair - South	01/01/19 to 31/03/19	5-10					5-10
Clarke	Dawn	Executive Nurse Director	01/04/18 to 31/03/19	95-100	1.3			27.5-30	125-130
Davies	Julie	Director of Performance & Delivery	01/04/18 to 31/03/19	95-100	1.5			27.5-30	130-135
Fortes-Mayer	Gail	Director of Contracting & Planning	01/04/18 to 31/03/19	95-100	2.1			157.5-160	260-265
Freeman	Simon	Accountable Officer	01/04/18 to 26/03/19	140-145	2.2			22.5-25	165-170
Hutton	William	Lay Member - Audit Chair	01/04/18 to 31/03/19	15-20	2.6				15-20
James	Stephen	GP Member/Clinical Director - Primary Care	01/04/18 to 31/03/19	55-60	1.1				55-60
Leaman	Alan	Secondary Care Clinical Member	01/01/19 to 31/03/19	0-5					0-5
Lewis	Katy	Joint Locality Chair - North	01/01/19 to 31/03/19	5-10					5-10
Lynch	Finola	GP Member/Clinical Director - Communication & Engagement	01/04/18 to 31/03/19	50-55				17.5-20	70-75
Lyttle	Timothy	Locality Chair - North	03/04/18 to 04/10/18	10-15				15-17.5	25-30
Mathee	Michael	Joint Locality Chair - North	01/01/19 to 31/03/19	5-10					5-10
Morris	Kevin	Practice Representative	01/04/18 to 31/03/19	50-55				2.5-5	55-60
Pepper	John	Clinical Director -Medical	01/04/18 to 31/03/19	45-50				187.5-190	230-235
Porter	Sarah	Lay Member - Transformation	01/04/18 to 31/03/19	15-20	0.1				15-20
Povey	Julian	Chair (Clinical)	01/04/18 to 31/03/19	105-110	2.0				105-110
Rysdale	Edward	Secondary Care Clinical Member	01/04/18 to 30/09/18	0-5					0-5
Shepherd	Deborah	Locality Chair - Shrewsbury & Atcham	01/04/18 to 31/03/19	50-55				12.5-15	65-70
Skidmore	Claire	Chief Finance Officer & Deputy Accountable Officer	01/04/18 to 31/03/19	115-120	0.3			30-32.5	150-155
Sokolov	Jessica	GP Member/Clinical Director - Womens & Children	01/04/18 to 02/12/18	35-40					35-40
Sokolov	Jessica	Medical Director	03/12/18 to 31/03/19	30-35				2.5-5	35-40
Tilley	Samantha	Director of Corporate Affairs	01/04/18 to 31/03/19	85-90	1.0			70-72.5	160-165
Timmis	Keith	Lay Member - Performance	01/04/18 to 31/03/19	15-20					15-20
Vivian	Meredith	Lay Member - Patient & Public Involvement	01/04/18 to 31/03/19	15-20					15-20
Wilde	Nicola	Director of Primary Care	01/04/18 to 31/03/19	95-100	1.0			77.5-80	175-180

Table 3 - Pension Benefits 2019/20 (These tables are subject to audit by our external auditor)

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

Surname	Forename		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2020 £'000	Cash Equivalent Transfer Value at 1 April 2019 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Bird	Matthew	Locality Chair - South	7.5-10	25-27.5	10-15	35-40	211	47	163	0
Clarke #	Dawn	Executive Nurse Director	0-2.5	0-2.5	25-30	75-80	-	-	-	0
Davies	Julie	Director of Performance & Delivery	2.5-5	0-2.5	20-25	35-40	388	289	92	0
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG								
Fortes-Mayer	Gail	Director of Contracting & Planning	5-7.5	5-7.5	40-45	60-65	618	432	175	0
Fortes-Mayer	Gail	Interim Director								
Parker	Claire	Director of Partnerships - Joint post with Telford & Wrekin CCG	0-2.5	0-2.5	0-5	0-5	0	0	0	0
George	Priya	GP Member	0-2.5	7.5-10	0-5	10-15	69	52	16	0
James *	Stephen	GP Governing Body Member/Clinical Chief Information Officer	-	-	-	-	-		-	0
Leaman *	Alan	Secondary Care Clinical Member	-	-	-	-	-	-	-	0
Lewis *	Katy	Joint Locality Chair - North	-	-	-	-	-	-	-	0
Lynch	Finola	GP Governing Body Member/Deputy Clinical Chair	2.5-5	0-2.5	15-20	35-40	262	191	67	0
Matthee *	Michael	Joint Locality Chair - North	-	-	-	-	-	-	-	0
Morris	Kevin	Practice Representative	0-2.5	0-2.5	15-20	40-45	359	296	56	0
Pepper	John	GP Governing Body Member	0-2.5	0-2.5	5-10	20-25	182	173	4	0
Porter *	Sarah	Lay Member - Transformation	-	-	-	-	-	-	-	0
Povey *	Julian	Chair (Clinical)	-	-	-	-	-	-	-	0
Shepherd	Deborah	Locality Chair - Shrewsbury & Atcham	0-2.5	0-2.5	10-15	25-30	241	183	53	0
Skidmore	Claire	Chief Finance Officer & Deputy Accountable Officer	2.5-5	0-2.5	35-40	80-85	565	424	131	0
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG								
Sokolov	Jessica	Medical Director	0-2.5	0-2.5	10-15	25-30	238	187	46	0
Sokolov	Jessica	Executive Director of Transformation - Joint post with Telford & Wrekin CCG								
Stout	David	Interim Accountable Officer	0-2.5	0-2.5	50-55	150-155	1,177	1,181	0	0
Tilley	Samantha	Director of Corporate Affairs	7.5-10	10-12.5	25-30	60-65	476	300	169	0
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG								
Timmis *	Keith (Andrew	Lay Member - Performance	-	-	-	-	-	-	-	0
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CC	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Vivian *	Meredith	Lay Member - Patient & Public Involvement	-	-	-	-	-	-	-	0
Wilde	Nicola	Director of Primary Care	5-7.5	5-7.5	25-30	60-65	571	399	162	0
Wilde	Nicola	Interim Director								

* Not in the NHS Pension scheme in this employment
# Pension has now been taken so CETV figures are no longer applicable

Table 4 - Pension Benefits as at 31 March 2019 (audited information)

PENSION BENEFITS AS AT 31 MARCH 2019 (audited information)

Surname	Forename		pension at pension age	pension lump sum at	at pension age at 31	age related to accrued	Transfer Value at 31	Transfer Value at 1	Equivalent Transfer	contribution to
Allen	Shailendra	Locality Chair - South	0-2.5	0-2.5	5-10	15-20	130	110	16	0
Clarke	Dawn	Executive Nurse Director	0-2.5	2.5-5	25-30	80-85	649	550	82	0
Davies	Julie	Director of Strategy and Service Redesign	0-2.5	0-2.5	15-20	35-40	353	289	55	0
Fortes-Mayer	Gail	Basic Salary - Director	5-7.5	10-12.5	40-45	65-70	618	432	172	0
Freeman	Simon	Accountable Officer	0-2.5	2.5-5	25-30	80-85	626	533	78	0
Lynch	Finola	GP Member/Clinical Director - Communication & Engagement	0-2.5	0-2.5	10-15	30-35	236	191	39	0
Lyttle	Timothy	Executive Medical Director	0-2.5	0-2.5	5-10	15-20	124	95	26	0
Morris	Kevin	Locality Chair - North	0-2.5	0-2.5	15-20	40-45	337	296	32	0
Pepper *	John	Clinical Director -Medical	7.5-10	20-22.5	5-10	20-25	173	0	173	0
Shepherd	Deborah	Executive Medical Director	0-2.5	0-2.5	10-15	25-30	219	183	30	0
Skidmore	Claire	Basic Salary - Director	0-2.5	0-2.5	35-40	80-85	529	424	93	0
Sokolov	Jessica	GP Member/Clinical Director - Womens & Children	0-2.5	0-2.5	10-15	30-35	218	187	26	0
Tilley	Samantha	Basic Salary - Director	2.5-5	2.5-5	20-25	55-60	405	300	95	0
Wilde	Nicola	Basic Salary - Director	2.5-5	5-7.5	25-30	60-65	523	399	112	0

Compensation on Early Retirement or for Loss of Office **(**These tables are subject to audit by our external auditor)

Shropshire CCG does not have any to report during 2019/20.

Payment to Past Members (These tables are subject to audit by our external auditor)

Shropshire CCG does not have any to report during 2019/20.

Pay Multiples (These tables are subject to audit by our external auditor)

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

The remuneration of the highest paid member of the Governing Body in the CCG in the financial year 2019-20 was £149,000 which included relocation costs of £8,000, (2018-19, £142,500). This was 4.58 times (2018-19, 3.89) the median remuneration of the workforce, which was £32,525 (2018-19, £36,644). The reduction in median remuneration compared to 2018-19 is due to the engagement of a number of senior temporary staff in 2018-19, which skewed the calculation when compared to 2019-20.

In 2019/20, one employee (2018-19, two) received remuneration in excess of the highest paid member of the CCG Governing Body. Remuneration ranged from £15,416 to £166,858 (2018/19, £15,461 to £166,858).

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

Staff Report

The CCG has employed a headcount of 196 staff during 2019/20. This is equivalent to 163.65 WTE.

Number of senior managers

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

Gender Analysis of CCG Workforce (based on staffing at 31 March 2020)

	Headcount by Gender				% by Gender		
Staff Grouping	**Female**	**Male**	**Unknown***	**Totals**	**Female**	**Male**	**Unknown**
Governing Body	12	11	1	**24**	50.00%	45.8%	4.2%
Other Senior Management (Band 8C+)	12	2	0	**14**	85.7%	14.3%	0.0%
All Other Employees	124	34	0	**158**	78.5%	21.5%	0.0%
Grand Total	148	47	1	**196**	75.51%	23.98%	0.51%

**Unknown Gender pertains to Governing Body Members without an entry in the CCG Electronic Staff Record (ESR) system*

Named Individuals categorised as Unknown are :

Rachel Robinson

Gender Analysis of CCG Workforce as at 31 March 2020 (WTE)

	FTE by Gender				% by Gender		
Staff Grouping	**Female**	**Male**	**Unknown***	**Totals**	**Female**	**Male**	**Unknown**
Governing Body	9.42	3.73	0.00	13.16	71.6%	28.4%	0.0%
Other Senior Management (Band 8C+)	8.82	2.00	0.00	10.82	81.5%	18.5%	0.0%
All other employees	107.07	32.60	0.00	139.67	76.7%	23.3%	0.0%
Grand Total	**125.32**	**38.33**	**0.00**	**163.65**	**76.58%**	**23.42%**	**0.0%**

*Unknown Gender pertains to Governing Body Members without an entry in the CCG Electronic Staff Record (ESR) system

Named Individuals categorised as Unknown are:
Rachel Robinson

Staff numbers and cost (These tables are subject to audit by our external auditor)

Staff composition – by pay band:

Senior Staff Analysis by Band at 31 March 2020 (Headcount)

Sum of Headcount	
Pay Band	**Total**
Band 2	3
Band 3	42
Band 4	17
Band 5	27
Band 6	25
Band 7	19
Band 8 - Range A	18
Band 8 - Range B	7
Band 8 – Range C	4
Band 8 - Range D	2
Band 9	2
*Gov Body (off payroll)	1
Medical Payscale	12
VSM	17
Grand Total	196

**Gov Body (off payroll) pertains to Governing Body Members without a pay record in the CCG Electronic Staff Record (ESR) system*

Named Individuals categorised as such are:
Rachel Robinson

Senior Staff Analysis by Band at 31 March 2020 (WTE)

Sum of FTE	
Pay Band	**Total**
Band 2	1.84
Band 3	37.34
Band 4	14.87
Band 5	22.17
Band 6	22.05
Band 7	17.80
Band 8 - Range A	17.00
Band 8 - Range B	6.60
Band 8 - Range C	3.80
Band 8 - Range D	2.00
Band 9	2.00
*Gov Body (off payroll)	0.00
Medical Payscale	3.63
VSM	12.55
Grand Total	**163.65**

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

Employee benefits 2019-20					
	Permanent Employees		Other		Total
	£'000		£'000		£'000
Employee Benefits					
Salaries and wages	5,595		976		**6,570**
Social security costs	561		-		**561**
Employer Contributions to NHS Pension scheme	1,045		-		**1,045**
Other pension costs	-		-		**-**
Apprenticeship Levy	15		-		**15**
Other post-employment benefits	-		-		**-**
Other employment benefits	-		-		**-**
Termination benefits	-		-		**-**
Gross employee benefits expenditure	**7,215**		**976**		**8,190**
Less recoveries in respect of employee benefits (note 4.1.3)	**-**		**-**		**-**
Total - Net admin employee benefits including capitalised costs	**7,215**		**976**		**8,190**
Less: Employee costs capitalised	**-**		**-**		**-**
Net employee benefits excluding capitalised costs	**7,215**		**976**		**8,190**

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 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 to the accounts.

Employee benefits 2018-19					
	Permanent Employees		Other		Total
	£'000		£'000		£'000
Employee Benefits					
Salaries and wages	4,877		1,786		6,663
Social security costs	525		-		525
Employer Contributions to NHS Pension scheme	656		-		656
Other pension costs	-		-		-
Apprenticeship Levy	13		-		13
Other post-employment benefits	**-**		**-**		**-**
Other employment benefits	**-**		**-**		**-**
Termination benefits	**-**		**-**		**-**
Gross employee benefits expenditure	6,071		1,786		7,857
Less recoveries in respect of employee benefits (note 4.1.2)	**-**		**-**		**-**
Total - Net admin employee benefits including capitalised costs	6,071		1,786		7,857
Less: Employee costs capitalised	**-**		**-**		**-**

Net employee benefits excluding capitalised costs	6,071		1,786		7,857

Sickness absence data

The sickness absence data for the CCG in 2019 was whole time equivalent (WTE) days available of 33888.78 and WTE days lost to sickness absence of 1718.12 and average working days lost per employee was 11.41 which was managed through the Absence Management Policy.

Staff Policies for Disabled Persons

Employing people with a disability is important for any organisation commissioning 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 and interview
- The adjustments that peole 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 on people with disabilities.

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 grounds of age, disability, gender/gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex, or sexual orientation. To support this commitment, the CCG requires all its staff to undertake regular mandatory training on equality, diversity and human rights and has an Equal Opportunities Policy.

The CCG seeks to involve and consult its staff via regular staff briefings with the Chair and Accountable Officer, a weekly "huddle" to keep staff up to date with live issues and to seek their feedback and regular communication mechanisms via a weekly staff electronic newsletter. This is further reinforced through regular one to ones, team meetings, staff consultation events and a staff newsletter. We are part of our regional Joint Staff Consultative Committee (JSCC), which provides a forum for Trade Union staff representatives to meet and contribute to service change and development and for issues to be discussed.

The CCG has a recruitment policy which is based on NHS best practice and we use the recruitment service of our CSU 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 seeks to ensure that all staff have an equal opportunity and access to training and development that their role requires through identification with their managers in appraisals and regular one to one meetings.

Trade union facility time

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

Percentage of pay bill spent on facility time

First Column	Figures
Provide the total cost of facility time	0
Provide the total pay bill	0
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0

Paid trade union activities

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

Expenditure on consultancy

Shropshire CCG spent £85k on consultancy services in 2019/20.

Off payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012 Clinical Commissioning Groups must publish information on their highly paid and/or senior off-payroll engagements.
The table below shows the existing arrangements as of 31 March 2020:

Table 1: Off-payroll engagements longer than six months

For all off-payroll engagements as at 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2020	4
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	4
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

Shropshire 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.

Table 2: New Off-payroll engagements

For all new off-payroll engagements between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	3
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	3
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements/senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2019 and 31 March 2020

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	**0**
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	22

Exit packages and severance payments (These tables are subject to audit by our external auditor)

Shropshire CCG does not have any to report during 2019/20.

Health and Safety

The CCG takes 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, which are then investigated and action taken to help mitigate incidents reoccurring.

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

Fraud

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

The CCG employs the services of assurance provider CW Audit Services to provide its local counter fraud specialists. 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 Chief Finance Officer 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 in 2019/20 the CCG has appointed a Counter Fraud Champion in line with requirements for CCGs.

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 £55k excluding VAT. The contract included the core audit work of the financial statements and work to reach a conclusion on the economy, efficiency and effectiveness in the CCG's use of resources (Value for Money conclusion).

Statement as to disclosure to auditors

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

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

Parliamentary Accountability and Audit Report

NHS Shropshire Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special

payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at Note 22. An audit certificate will be received from our auditors following submission of the Annual Accounts.

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services		-	-
Other operating income	2	(1,251)	(1,374)
Total operating income		**(1,251)**	**(1,374)**
Staff costs	4	8,190	7,857
Purchase of goods and services	5	514,911	464,874
Depreciation and impairment charges		-	-
Provision expense	5	599	-
Other Operating Expenditure	5	861	750
Total operating expenditure		**524,562**	**473,481**
Net Operating Expenditure		**523,311**	**472,107**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**523,311**	**472,107**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**523,311**	**472,107**
Comprehensive expenditure for the financial year ended 31 March 2020		**523,311**	**472,107**

The CCG's planned in-year deficit was £22.9m which was revised during the latter part of the year to £47.3m in agreement with NHSE/I. The final in-year deficit was £47.3m. The cumulative deficit is £124.01m, following the application of the cumulative deficit brought forward from previous years of £76.73 million. The External Auditors have made a referral to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 in this respect.

The Clinical Commissioning Group has a residual cash balance of £37k on 31 March 2020 that is within the tolerance required by NHS England. This balance can be seen in the Statement of Cash Flows.

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Current assets:			
Trade and other receivables	9	1,807	3,687
Cash and cash equivalents	10	37	88
Total current assets		**1,845**	3,775
Total assets		**1,845**	3,775
Current liabilities			
Trade and other payables	11	(36,646)	(31,315)
Provisions	12	(599)	-
Total current liabilities		**(37,245)**	(31,315)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(35,400)**	(27,540)
Financed by Taxpayers' Equity			
General fund		(35,400)	(27,540)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(35,400)**	(27,540)

The financial statements on pages 121 to 149 were approved by the Audit Committee on 24 June and signed on its behalf by:

David Evans
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2020

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(27,540)	0	0	**(27,540)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(27,540)**	**0**	**0**	**(27,540)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(523,311)			**(523,311)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	0	**0**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(523,311)**	**0**	**0**	**(523,311)**
Net funding	515,451	0	0	**515,451**
Balance at 31 March 2020	**(35,400)**	**0**	**0**	**(35,400)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(26,683)	0	0	**(26,683)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(26,683)**	**0**	**0**	**(26,683)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Impact of applying IFRS 9 to Opening Balances	0	0	0	0
Impact of applying IFRS 15 to Opening Balances	0	0	0	0
Net operating costs for the financial year	(472,107)	0	0	(472,107)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	0	0	0	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(472,107)**	**0**	**0**	**(472,107)**
Net funding	471,250	0	0	471,250
Balance at 31 March 2019	**(27,540)**	**0**	**0**	**(27,540)**

Statement of Cash Flows for the year ended
31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(523,311)	(472,107)
Depreciation and amortisation		0	0
Impairments and reversals		0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	9	1,880	387
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	5,331	465
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	12	0	(104)
Increase/(decrease) in provisions	12	599	0
Net Cash Inflow (Outflow) from Operating Activities		**(515,502)**	(471,358)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(515,502)**	(471,358)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		515,451	471,250
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**515,451**	471,250
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(51)**	(108)
Cash & Cash Equivalents at the Beginning of the Financial Year		**88**	197
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**37**	88

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 2019-20 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis, (despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014).

The CCG ended the financial year with an in-year deficit of £47,286k. This was an increase of £24,432k on the plan set at the beginning of the year.

The impact of the global pandemic COVID-19 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 however it is recognised that there has been a significant impact on how we operate. Our assessment of going concern is made on the basis that 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 3rd party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected.

Although the financial position of the clinical commissioning group and the issue of a Section 30 report by the Secretary of State for Health indicates some uncertainty over the CCG's ability to continue as a going concern, the Governing Body, having made appropriate enquiries, have reasonable expectations that the CCG will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Group Accounting Manual 2019/20, the Governing Body have prepared the financial statements on a going concern basis as they consider that the services currently provided by the CCG will continue to be provided in the foreseeable future. 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 following is clear evidence that the CCG meets the requirement highlighted above and as set out in section 4.11 to 4.16 of the Department of Health Group Accounting Manual 2019/20:

- NHS Shropshire CCG was established on 1 April 2013 as a separate statutory body;
- the CCG has been allocated funds by NHS England for the financial years 2019/20 and 2020/21;
- the CCG has an agreed Constitution that directs the governance of its activities;
- the CCG has been allocated indicative allocations to 2023/24;
- the CCG continues to drawdown on the allocated funds based on its cash requirements and in accordance with the arrangements put in place by NHS England; and
- detailed financial plans for 2020/21 were submitted to NHSE in March 2020 and have been submitted to the Governing Body in May 2020.

With both continuity of service and future financial provision assured, the CCG's financial statements have been prepared on the going concern basis. The temporary suspension of the NHS financial regime from 17 March 2020 as part of the COVID-19 response, does not undermine either the continuity of services or financial provision judgement, but strengthens it.

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 Charitable Funds

Under the provisions of IAS 27, Charitable funds held within the CCG are consolidated into the accounts of the CCG.

1.5 Pooled Budgets

The clinical commissioning group entered into a pooled budget arrangement with Shropshire Council under a Section 75 (NHS Act 2006) 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.

Notes to the Financial Statements

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

1.6.1 **Critical accounting judgements in applying accounting policies**

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

Going concern: These accounts have been prepared on a going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014). The grounds on which the directors of the CCG have applied the going concern basis and have a reasonable expectation that the CCG will continue in operational existence for the foreseeable future are set out in note 1.1.

1.6.2 **Sources of estimation uncertainty**

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

Provisions and accruals: Estimates used to calculate potential provisions and accruals (including accruals in continuing health and complex care) are based on expert advice from solicitors and other external professional agents combined with the experience of CCG managers.
Prescribing 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.

1.7 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.8 **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 the 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 Clinical Commissioning Group, as a commissioning organisation, does not receive any significant revenue from contracts. The majority of the CCG's revenue is from Departmental funding which is recognised within the year it is received as Grant in Aid funding as reflected in the Statement of Changes in Taxpayers' Equity.

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.

1.9 **Employee Benefits**

1.9.1 **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.

1.9.2 **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 though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

The Clinical Commissioning Group does not currently own property or plant and equipment. The following accounting policies will apply for any future purchases:

1.11.1 **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.

1.11.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

1.11.3 **Subsequent Expenditure**

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

1.12 **Intangible Assets**

1.12.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights.

The CCG did not hold any Intangible Assets in 2019/20.

1.13 **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.

Notes to the Financial Statements

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.

1.14 **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.

1.14.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The CCG has no finance leases as lessees or as a lessor
The CCG has no operating leases as a lessor

1.15 **Inventories**

The CCG does not hold any inventories.

1.16 **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.

1.17 **Provisions**

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.50% (2018-19: positive 0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.55% (2018-19:1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2018-19: 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 1.99% (2018-19: 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.

1.18 **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.

At the end of 2019-20 NHS Resolution held a provision of £0k for clinical negligence cases that are still to be settled.

Notes to the Financial Statements

1.19 **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 NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.20 **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.

1.21 **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.

1.21.1 **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.

1.21.2 **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.

Shropshire CCG did not hold any such financial assets during 2019/20.

1.21.3 **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.

Shropshire CCG did not hold any such financial assets during 2019/20.

1.21.4 **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.

1.22 **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.

1.22.1 **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 2019/20.

1.22.2 **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 2019/20.

Notes to the Financial Statements

1.22.3 **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.

1.23 **Value Added Tax**

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

1.24 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

NHS Shropshire CCG did not have any business involving exchange of foreign currency during 2019/20.

1.25 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.26 **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).

1.27 **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.

1.28 **Joint Operations**

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.28.1 **Better Care Fund**

The Better Care Fund (BCF) was implemented by the Department of Health during 2015/16. In Shropshire, the BCF has been developed as a conduit for integrated working across health and social care, based around the delivery of a set of national metrics and utilising a pooled budget arrangement. The BCF budget for Shropshire is £41m in 2019/20. Oversight of the BCF sits with Shropshire Health and Wellbeing Board in line with NHS England requirements. A detailed plan for Shropshire was developed with the involvement of key stakeholders and the fund is managed by both Shropshire Council and Shropshire CCG under a Section 75 arrangement.

Shropshire Council are the host for the fund under this agreement therefore the funds are recorded in the CCG accounts on a net accounting basis. The value of CCG funds held equates to £22m.

1.28.2 **Primary Care Commissioning**

On 17 March 2015, NHS England issued a delegation agreement to Shropshire CCG to assume delegated commissioning responsibilities for primary medical services. As a consequence, from 1 April 2015 the CCG took on delegated responsibilities for these functions. A Primary Care Commissioning Committee was set up to discharge the delegated responsibilities. In accounting for this expenditure, the CCG has worked closely with NHS England colleagues to assure integrity to the accounting records.

1.20 **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 2019-20. These Standards are still subject to HM Treasury FReM adoption.

● HM Treasury has announced that IFRS 16, Leases, as interpreted and adapted by the FReM is to be effective from 1 April 2021. This represents a further one year deferral.

Work carried out to date has identified that the CCG currently has 2 operating leases which will be re-classified as finance leases. The most significant of these is in relation to the lease held with NHS Property Services. Current calculations estimate that this would have the effect on the Statement of Financial Position of increasing non-current assets by £266k and increasing financial liabilities by £266k. The current estimated impact on expenditure is an annual increase of £135k representing depreciation and interest costs and guidance is awaited from NHSE/I regarding the funding of this.

● The IASB has deferred the effective date of IFRS 17, Insurance Contracts, to annual reporting periods beginning on or after 1 January 2023. IFRS 17 as interpreted and adapted by the FReM is to be effective from 1 April 2023.

● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019. The application of this standard has no financial impact on the CCG.

2 Other Operating Revenue

	2019-20 Total £'000	2018-19 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	-	-
Recoveries in respect of employee benefits	-	-
Total Income from sale of goods and services	**-**	**-**
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	**1,251**	1,374
Total Other operating income	**1,251**	**1,374**
Total Operating Income	**1,251**	**1,374**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the Clinical Commissioning Group and credited to the General Fund.

3. Contract Revenue

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

The CCG did not receive any income in 2019/20 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 2019/20 expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2019-20

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	5,595	976	**6,570**
Social security costs	561	-	**561**
Employer Contributions to NHS Pension scheme	1,045	-	**1,045**
Other pension costs	-	-	**-**
Apprenticeship Levy	15	-	**15**
Other post-employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	-	-	**-**
Gross employee benefits expenditure	**7,215**	**976**	**8,190**
Less recoveries in respect of employee benefits (note 4.1.3)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**7,215**	**976**	**8,190**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**7,215**	**976**	**8,190**

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.4.2.

4.1.2 Employee benefits 2018-19

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,877	1,786	6,663
Social security costs	525	-	525
Employer Contributions to NHS Pension scheme	656	-	656
Other pension costs	-	-	-
Apprenticeship Levy	13	-	13
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	6,071	1,786	7,857
Less recoveries in respect of employee benefits (note 4.1.3)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	6,071	1,786	7,857
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	6,071	1,786	7,857

4.1.3 Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in 2019/20 (nil in 2018/19).

4.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	153.73	12.28	**166.01**	133.66	29.89	**163.55**

4.3 Exit packages agreed in the financial year

The CCG has made no payments in respect of exit packages in 2019/20, (nil in 2018/19). The CCG has made no special payments in respect of employee departures in 2019/20, (nil in 2018/19).

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

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

5. Operating expenses

	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	2,989	2,428
Services from foundation trusts	90,473	85,807
Services from other NHS trusts	229,730	205,916
Services from Other WGA bodies	2	3
Purchase of healthcare from non-NHS bodies	78,120	64,429
Purchase of social care	-	-
Prescribing costs	52,182	49,793
General Ophthalmic services	392	363
GPMS/APMS and PCTMS	47,581	45,117
Supplies and services – clinical	1,121	1,081
Supplies and services – general	8,638	6,456
Consultancy services	85	1,031
Establishment	2,068	1,019
Transport	95	92
Premises	653	391
Audit fees	72	63
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	12	10
Other professional fees	640	751
Legal fees	35	85
Education, training and conferences	24	39
Total Purchase of goods and services	**514,911**	**464,874**
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	599	-
Total Provision expense	**599**	**-**
Other Operating Expenditure		
Chair and Non Executive Members	574	253
Grants to Other bodies	183	202
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	104	294
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Other expenditure	-	-
Total Other Operating Expenditure	**861**	**750**
Total operating expenditure	**516,372**	**465,624**

The above includes expenditure dealt with under the pooled budget arrangement for the Better Care Fund as set out in Note 16

There has been no increase in year in the assessment of partially completed spells.

Internal audit and counter fraud services are provided by CW Audit who are part of a Foundation Trust. The cost of these services was £44k in 2019/20, (included within other professional services).

External Audit Fees are inclusive of VAT and comprise:

Statutory audit fee 2019/20	£66k
Unaccrued element of 2018/19 statutory audit fee	£6k
Total External Audit Fees incurred in 2019/20	£72k

The auditor's liability for external audit work carried out for the financial year 2019/20 is limited to £2 million.

6 Prompt Payment Targets

6.1 Better Payment Practice Code

Measure of compliance	2019-20		2018-19	
	Number	**£'000**	**Number**	**£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	26,945	144,119	26,802	133,687
Total Non-NHS Trade Invoices paid within target	26,539	141,855	26,347	131,397
Percentage of Non-NHS Trade invoices paid within target	**98.49%**	**98.43%**	**98.30%**	**98.29%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,266	325,894	3,149	296,161
Total NHS Trade Invoices Paid within target	3,215	325,327	3,066	293,778
Percentage of NHS Trade Invoices paid within target	**98.44%**	**99.83%**	**97.36%**	**99.20%**

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	2019-20	2018-19
	£'000	£'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2019-20				2018-19			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense								
Minimum lease payments	-	253	6	**258**	-	223	5	**228**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**253**	**6**	**258**	**-**	**223**	**5**	**228**

Buildings lease payments relate to expenditure with NHS Property Services Ltd for the rental of office accommodation (£117k), and void & subsidy costs (£136k).

7.1.2 Future minimum lease payments

	2019-20				2018-19			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payable:								
No later than one year	-	-	-	**-**	-	-	4	**4**
Between one and five years	-	-	-	**-**	-	-	3	**3**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**-**	**-**	**-**	**-**	**7**	**7**

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. Similarly, the current lease for printer/photocopier is under review and a new lease has not yet been signed.

7.2 As lessor

The clinical commissioning group does not have any leasing arrangements as a lessor.

8 Property, plant and equipment

2019-20	Information technology £'000	Total £'000
Cost or valuation at 01 April 2019	114	114
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	(114)	(114)
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 2020	**-**	**-**
Depreciation 01 April 2019	114	114
Reclassifications	-	-
Reclassified as held for sale and reversals	-	-
Disposals other than by sale	(114)	(114)
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 2020	**-**	**-**
Net Book Value at 31 March 2020	**-**	**-**
Purchased	-	-
Donated	-	-
Government Granted	-	-
Total at 31 March 2020	**-**	**-**
Asset financing:		
Owned	-	-
Held on finance lease	-	-
On-SOFP Lift contracts	-	-
PFI residual: interests	-	-
Total at 31 March 2020	**-**	**-**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Total £'000
Balance at 01 April 2019	-	-
Revaluation gains	-	-
Impairments	-	-
Release to general fund	-	-
Other movements	-	-
Balance at 31 March 2020	**-**	**-**

8 Property, plant and equipment cont'd

8.1 Cost or valuation of fully depreciated assets

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

	2019-20	2018-19
	£'000	£'000
Land	-	-
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	114	-
Furniture & fittings	-	-
Total	**114**	**-**

8.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Buildings excluding dwellings	3	99
Dwellings	3	99
Plant & machinery	3	15
Transport equipment	7	10
Information technology	1	3
Furniture & fittings	3	15

The CCG does not currently hold any non-current assets. The asset lives given above reflect the policy in respect of the depreciation of such assets should the organisation purchase these in the future.

9.1 Trade and other receivables

	Current 2019-20 £'000	Current 2018-19 £'000
NHS receivables: Revenue	656	1,154
NHS receivables: Capital	-	-
NHS prepayments	-	50
NHS accrued income	651	1,708
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	642	990
Non-NHS and Other WGA receivables: Capital	-	-
Non-NHS and Other WGA prepayments	138	10
Non-NHS and Other WGA accrued income	92	67
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	(562)	(458)
VAT	188	165
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-
Interest receivables	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
Other receivables and accruals	2	1
Total Trade & other receivables	**1,807**	**3,687**
Total current and non current	**1,807**	**3,687**

9.2 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	**2019-20 Non DHSC Group Bodies £'000**	**2018-19 DHSC Group Bodies £'000**	**2018-19 Non DHSC Group Bodies £'000**
By up to three months	410	1	1,189	203
By three to six months	-	1	-	280
By more than six months	-	-	-	14
Total	**410**	**2**	**1,189**	**497**

9.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	**Other financial assets £'000**	**Total £'000**
Balance at 01 April 2019	(458)	-	**(458)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 3	(282)	-	**(282)**
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	178	-	**178**
Total	**(562)**	**-**	**(562)**

10 Cash and cash equivalents

	2019-20	2018-19
	£'000	£'000
Balance at 01 April 2019	88	197
Net change in year	(51)	(108)
Balance at 31 March 2020	**37**	**88**
Made up of:		
Cash with the Government Banking Service	37	88
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**37**	**88**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2020	**37**	**88**

11 Trade and other payables	**Current 2019-20 £'000**	Current 2018-19 £'000
Interest payable	-	-
NHS payables: Revenue	3,045	2,544
NHS payables: Capital	-	-
NHS accruals	2,735	2,898
NHS deferred income	-	-
NHS Contract Liabilities	-	-
Non-NHS and Other WGA payables: Revenue	5,914	7,249
Non-NHS and Other WGA payables: Capital	-	-
Non-NHS and Other WGA accruals	18,304	14,257
Non-NHS and Other WGA deferred income	-	1,395
Non-NHS Contract Liabilities	-	-
Social security costs	92	86
VAT	-	-
Tax	77	80
Payments received on account	-	-
Other payables and accruals	6,477	2,807
Total Trade & Other Payables	**36,646**	**31,315**
Total current and non-current	**36,646**	**31,315**

NHS payables include £1,824k in respect of partially completed spells (£1,824k in 2018/19).
Other payables include £472k outstanding pension contributions at 31 March 2020 (£508k in 2018/19).

12 Provisions

	Current 2019-20 £'000	**Non-current 2019-20 £'000**	Current 2018-19 £'000	Non-current 2018-19 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	190	-	-	-
Redundancy	209	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	200	-	-	-
Other	-	-	-	-
Total	**599**	**-**	**-**	**-**
Total current and non-current	**599**		**-**	

	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 2019	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Arising during the year	-	-	190	209	-	-	-	200	-	**599**
Utilised during the year	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	-	-	-	-	-	-	-	**-**
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 2020	**-**	**-**	**190**	**209**	**-**	**-**	**-**	**200**	**-**	**599**
Expected timing of cash flows:										
Within one year	-	-	190	209	-	-	-	200	-	**599**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2020	**-**	**-**	**190**	**209**	**-**	**-**	**-**	**200**	**-**	**599**

Restructuring and redundancy provisions have been created as a result of the proposal by Shropshire CCG and Telford & Wrekin CCG to come together as one Single Strategic Commissioning Organisation with effect from 1st April 2021. This involves a restructuring of roles & responsibilities and will have an impact on the associated staffing. Work has already been completed to form a new single structure for Directors and the redundancy provision reflects the estimated impact of this, (£190k). It is expected that these costs will be paid out in the new financial year. A Mutually Agreed Resignation Scheme (MARS), has been agreed and offered to other staff and the restructuring provision reflects the estimated cost of potential uptake and approval, (£209k). Although the process has been stalled due to COVID-19 it is still expected to be concluded before the end of the new financial year.

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 2020, with the probability of success and the financial value based on previous appeals heard. These are expected to be processed within the new financial year.

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them.
There are no such claims in 2019/20.

13 Contingent Liabilities

The CCG has identified a higher volume of prescription ordering activity in the latter weeks of March 2020 as a result of COVID-19. It is difficult to estimate the value of this increased activity at this time since prescribing figures for this period will not be available from NHS Business Services Authority until late May 2020.

14 Financial instruments

14.1 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 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 clinical commissioning group prime financial policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group and internal auditors.

14.1.1 Currency risk

The 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 clinical commissioning group has no overseas operations and therefore has low exposure to currency rate fluctuations.

14.1.2 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.

14.1.3 Credit risk

Because the majority of the clinical commissioning group's revenue comes from parliamentary funding, it 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.

14.1.4 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

14.1.5 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.

14 Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	Equity Instruments designated at FVOCI 2019-20 £'000	Total 2019-20 £'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	855	-	855
Trade and other receivables with other DHSC group bodies	544	-	544
Trade and other receivables with external bodies	644	-	644
Other financial assets	-	-	-
Cash and cash equivalents	37	-	37
Total at 31 March 2020	**2,080**	**-**	**2,080**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	Other 2019-20 £'000	Total 2019-20 £'000
Loans with group bodies	-	-	**-**
Loans with external bodies	-	-	**-**
Trade and other payables with NHSE bodies	257	-	**257**
Trade and other payables with other DHSC group bodies	16,418	-	**16,418**
Trade and other payables with external bodies	19,801	-	**19,801**
Other financial liabilities	-	-	**-**
Private Finance Initiative and finance lease obligations	-	-	**-**
Total at 31 March 2020	**36,476**	**-**	**36,476**

15 Operating segments

Per 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 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.

16 Joint arrangements - interests in joint operations

16.1 Interests in joint operations

	Amounts recognised in Entities books ONLY 2019-20				Amounts recognised in Entities books ONLY 2018-19			
Description of arrangement	**Assets**	**Liabilities**	**Income**	**Expenditure**	Assets	Liabilities	Income	Expenditure
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
The clinical commissioning group operates a pooled budget in respect of the Better Care fund with Shropshire Council. The principal activities are the commissioning of health and social care services	0	0	0	21,555	0	0	0	20,021

The total value of this pool for 2019/20 is £41m, £22m of this being the CCG's contribution (£20m for 2018/19).

A summary of the schemes relating to this expenditure is given below:

	2019-20	2018-19
	£'000	£'000
Assistive Technologies	1,613	1,645
Care navigation/Co-ordination	1,843	1,739
Carers Services	0	2
Enablers for Integration	3,666	3,619
Healthcare Services to Care Homes	140	266
Integrated Care Planning	2,992	1,921
Intermediate Care Services	3,233	2,783
Personalised Healthcare at Home	289	267
L A Schemes	7,779	7,779
Total	**21,555**	20,021

17 Related party transactions

During 2019/20 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
Mr Matthew Bird - Locality Chair (South Locality) - GP Partner at Albrighton Medical Practice	2,961	0	1	0
Dr Katy Lewis - Joint Locality Chair (North Locality) - GP Principle at Westbury Medical Centre	1,016	0	1	0
Dr Finola Lynch - GP Governing Body Member - Salaried GP at Bishops Castle Medical Practice	1,728	0	6	0
Dr Mike Matthee - Joint Locality Chair (North Locality) - GP Partner at Drayton Medical Practice	5,466	0	0	0
Dr Priya George - GP Governing Body Member - GP Partner at Drayton Medical Practice (figures as above). Husband is Consultant Radiologist at University Hospitals of North Midlands NHS Trust	5,123	0	387	0
Mr Kevin Morris - GP Governing Body Member - Managing Partner at Cambrian Medical Centre	4,248	0	0	0
Dr John Pepper - GP Governing Body Member - Partner at Belvidere Medical Practice	1,598	0	7	0
Dr Julian Povey - Chair - GP Partner at Pontesbury Medical Practice	3,038	0	0	0
Dr Julian Povey - Chair - Wife is Medical Director at Shropshire Community Health NHS Trust	44,468	0	112	145
Dr Jessica Sokolov - Director of Transformation - Father elected to Shropshire Council	22,650	161	1,842	10
Dr Jessica Sokolov - Director of Transformation - Father is Governor of West Midlands Ambulance Service	15,113	0	19	0
Mr Colin Stanford - Lay Member - Clinical Champion of Osteoarthritis Keele University	17	0	0	0
Ms Samantha Tilley - Director of Planning - Brother-in-Law is Operations Manager at Shrewsbury and Telford Hospital NHS Trust	163,329	254	69	13

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

NHS England
NHS Business Services Authority
NHS Property Services Limited

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 (disclosed in the section above), and Welsh Government Bodies.

Payments were also made to GP practices in 2019/20 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.

18 Events after the end of the reporting period

On the 4th May the CCG were notified by NHSE/I of a rate increase in relation to Funded Nursing Care payments for the financial year 2019/20, to be backdated from 1st April 2019. This represents an increase of 9% and the estimated financial impact for Shropshire CCG is £702k. The CCG have been advised by NHSE/I that a national provision has been made for this additional charge and that CCGs do not need to include a provision for this in their 2019/20 accounts.

NHS Shropshire CCG and NHS Telford & Wrekin CCG are applying to NHSE/I for approval to bring the two CCGs together to create one commissioning body across the Shropshire and Telford area. If approved this will be effective from 1 April 2021.

19 Third party assets

The clinical commissioning group did not hold any third party assets in 2019/20 (nil in 2018/19).

20 Financial performance targets

The Clinical Commissioning Group has a number of financial duties under the NHS Act 2006 (as amended).
Performance against those duties was as follows:

	2019-20 Target £'000	**2019-20 Performance £'000**	**2019-20 Variance £'000**	2018-19 Target £'000	2018-19 Performance £'000	2018-19 Variance £'000
Expenditure not to exceed income	477,276	524,562	47,286	456,422	473,481	17,059
Capital resource use does not exceed the amount specified in Directions	-	-		-	-	
Revenue resource use does not exceed the amount specified in Directions	476,025	523,311	47,286	455,048	472,107	17,059
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	6,955	7,157	202	6,774	7,082	308

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 £12.3m with an agreed deficit plan of £22.9m. The CCG is reporting an outturn of £47m deficit against this plan. The cumulative control total was £89m deficit with an agreed deficit plan of £99.6m. The cumulative outturn against this plan was £124m deficit.

The CCG was placed in special measures in 2016 in response to the CCG's deficit financial position.

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

	2019-20 £'000	2018-19 £'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

22.1 Losses

The clinical commissioning group did not record any cases of losses in 2019/20 (nil in 2018/19).

22.2 Special payments

The clinical commissioning group has made no special payments in 2019/20 (nil in 2018/19).

Independent auditor's report to the members of the Governing Body of NHS Shropshire Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Shropshire Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accountable Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the CCG's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the CCG's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

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

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

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the CCG's financial statements shall be prepared on a going concern basis, we considered the risks associated with the CCG's operating activities, including effects arising from macro-economic uncertainties such as Covid-19 and Brexit. We analysed how those risks might affect the CCG's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, we have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Other information

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020 and the requirements of the Health and Social Care Act 2012; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity required by the Code of Audit Practice

In our opinion, except for the effects of the matters described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported a deficit of £47.3 million against its total in year revenue resource limit in its financial statements for the year ended 31 March 2020, thereby breaching two of its duties under the National Health Service Act 2006, as amended by:

- paragraph 223H of Section 27 of the Health and Social Care Act 2012, to ensure that its expenditure in a financial year does not exceed its income; and
- paragraph 223l of Section 27 of the Health and Social Care Act 2012, to ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the NHS Commissioning Board, otherwise known as NHS England.

In addition, the CCG exceeded its revenue administration resource limit by £0.202m in the year ended 31 March 2020, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223J of Section 27 of the Health and Social Care Act 2012, to ensure that its revenue resource use in a financial year which is attributable to prescribed matters relating to administration does not exceed the amount specified by direction of the NHS Commissioning Board.

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except:

On 26 May 2020 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the CCG's breach of its breakeven duty and its administration resource limit.

On 26 May 2020 we made a written recommendation to the CCG under section 24 (schedule 7) of the Local Audit and Accountability Act 2014 in relation to the financial position of the CCG.

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

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 62 to 63, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects, NHS Shropshire Clinical Commissioning Group put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for adverse conclusion

Our review of the CCG's arrangements for securing economy, efficiency, and effectiveness in its use of resources identified the following matters:

- the CCG set a deficit budget of £22.9 million for 2019/20, which was £10.6 million in excess of the original target set by NHS England. Due to volatility in the demand for continuing healthcare and complex care, overspends on major acute care contracts and under-delivery of their efficiency savings programme, the CCG reported a deficit of £47.3 million in its financial statements for the year ended 31 March 2020
- the CCG's cumulative deficit grew to £123.9 million at 31 March 2020. The CCG has been unable to draft and deliver a plan for addressing this cumulative deficit and returning to financial balance. The CCG has budgeted for a deficit of £50.1 million in 2020/21, which is £27.4 million in excess of the target set for it by NHS England. If the CCG were to meet NHS England's target of a deficit of £22.7 million, it would need to identify total efficiency savings of £42.8 million, which would account for 8.8% of its resource limit. By 31 March 2020, the CCG had only been able to identify efficiency savings of £15.3 million, of which £3 million were deemed to be at risk of non-delivery.

These matters identify weaknesses in the CCG's arrangements for setting a sustainable budget and financial forecasting. These matters are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Shropshire Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

M C Stocks

Mark C Stocks, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

24 June 2020

Annual Report
2019/2020

NHS
Shropshire
Clinical Commissioning Group

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