NHS
Shropshire
Clinical Commissioning Group

Annual Report
2018/2019

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Introduction

from Shropshire Clinical Commissioning Group Chair and Accountable Officer

We are delighted to introduce our Annual Report for the year 2018/19, a year that has brought both significant challenges and opportunities and has seen continued positive strides forward for NHS Shropshire Clinical Commissioning Group (CCG).

During 2018/19 Shropshire CCG has continued its programme of financial recovery and transformation. Whilst we are disappointed that in 2018/19 we have not been able to achieve our control total our resolve to achieve this has not abated. We have continued to work closely with NHS England in relation to our Legal Directions and Special Measures requirements and have been able to fulfil the particular obligations these place on the CCG.

The wider local health and care economy faces a number of challenges in relation to financial sustainability, workforce and quality. Through 2018/19 we have actively engaged in our local Sustainability and Transformation Partnership to focus on these challenges and to work collectively to support the system to return to a sustainable footing. Against this challenging backdrop we are heartened by a number of significant achievements in the transformation and improvement of services for the local population, which are set out in this report.

In particular 2018/19 has seen the culmination of many years of work to reconfigure local acute hospital services – the Future Fit Programme – the landmark decision by the Future Fit Committee regarding a preferred option for delivery paves the way for an exciting phase of long overdue development and investment into our hospitals to ensure the best quality care for local residents.

Alongside this, the development of the Shropshire Care Closer to Home programme, including the pioneering Frailty Intervention Team, demonstrates the CCG's ambition to improve and transform local services to ensure the needs of the local population are met in the most efficient and effective way.

In addition, the CCG continues with its stringent Financial Recovery Plan which seeks to return the CCG to a recurrent balance over a number of years. Despite the setback of not reaching our financial control total for 2018/19 we will maintain our determination to address this challenge and re-double our efforts in this regard. This work continues to be clinically led by Shropshire GPs and has been developed with our health and social care partners.

Our Financial Recovery Plan remains based on improving health outcomes for patients, seeking better value for money from the services that we commission, and ceasing work that has limited or no clinical value for patients. Our focus remains to help our community lead healthier lives, commissioning high-quality care when it is needed, whilst ensuring that we have sustainable health services going forward. We continue working closely with the providers from which we commission services as well as patients and the public to ensure these plans are robust, evidence-based and work for our population.

As the CCG begins implementing its priorities for 2019/20, we would like to thank our staff, as well as our local partners, for their ongoing hard work and commitment in meeting the health needs of Shropshire patients.

Dr Julian Povey
Chair

Mr David Stout
Accountable Officer

Performance Report

Performance Overview

About us

NHS Shropshire Clinical Commissioning Group (CCG) is responsible for commissioning or 'buying' health and care services for people in the Shropshire CCG area.

We are authorised by NHS England to spend a £455m budget to ensure high-quality, sustainable healthcare for our population. We are a clinically-led organisation, comprising 41 GP practices, and we provide healthcare services for patients who are registered with a GP in Shropshire.

Map of Shropshire

Our Population

The activities undertaken by the CCG in 2018/19 were done so in consideration of the implications of our population make-up. 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, and 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.

Similarly, 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, inequalities in health persist in Shropshire and the increase in life expectancy, and reduction in overall mortality, have not had an equal impact across all sections of the population.

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, 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 or hospital services
- Community services
- Prescribing
- Mental health services
- Ambulance services
- Continuing healthcare
- Nursing home care

Local Challenges

Higher than expected intervention in MSK

NHS RightCare provides a suite of intelligence and tools to assist 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. Shropshire CCG has undertaken fresh benchmarking of performance against comparator CCGs and found that although we are still an outlier the gap is reducing as a result of the re-launch of the Shropshire Orthopaedic Outreach Service (SOOS) during 2018/19.

More information about how the CCG is responding to this challenge can be found in the "Our Achievements" section on page 24.

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 are 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 19.

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 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 to find ways 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).

The action we are taking to improve A&E performance, particularly our continued commitment to the NHS Future Fit programme and the work during 2018/19 to bring the programme to a decision regarding a preferred option is a significant positive step forward. In addition our 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 32.

Working in Partnership

We know that pressures on social care are of particular concern in Shropshire. Plans supported by the Better Care Fund programme have better enabled 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 as well as their 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 & 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 will also work 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 document but particularly within the Better Care Fund section (page 23) the Sustainability and Transformation Partnership section (page 22) and the Out of Hospital Transformation section (page 19).

Quality

During 2018/19 serious safety concerns have emerged at Shrewsbury and Telford Hospitals NHS Trust (SaTH) and the CCG has continuously sought reassurance that policies, practices and systems are in place and are being implemented.

Concerns and requests for assurance have not only been escalated to the SaTH Executive but to the external regulators via the NHS England Quality Surveillance Group and in other forms of notification. A tripartite meeting took place with the Trust in May 2018, 'Safe Today' calls commenced in July 2018 and a Risk Summit with regulators and the Trust took place in September 2018. The CCG has been proactively engaged and influential in the monthly oversight group which was established by NHS Improvement following the Risk Summit.

In collaboration, the Quality and Safeguarding Teams across Shropshire and Telford & Wrekin CCGs forged closer working relationships with the Trust's Quality and Safeguarding Team and will continue to work as key partners with the Trust, supporting them to improve the quality of their services so they meet the aspirations of both the public and ourselves.

Further information regarding how the CCG supports Improvements in quality can be found in the Improving Quality section (page 35).

Financial Performance

The CCG is required to meet national and local targets with respect to its expenditure and reported position. 2018/19 has proved to be a particularly challenging year and therefore, disappointingly, we have been unable to meet all of these targets. Performance is summarised below:

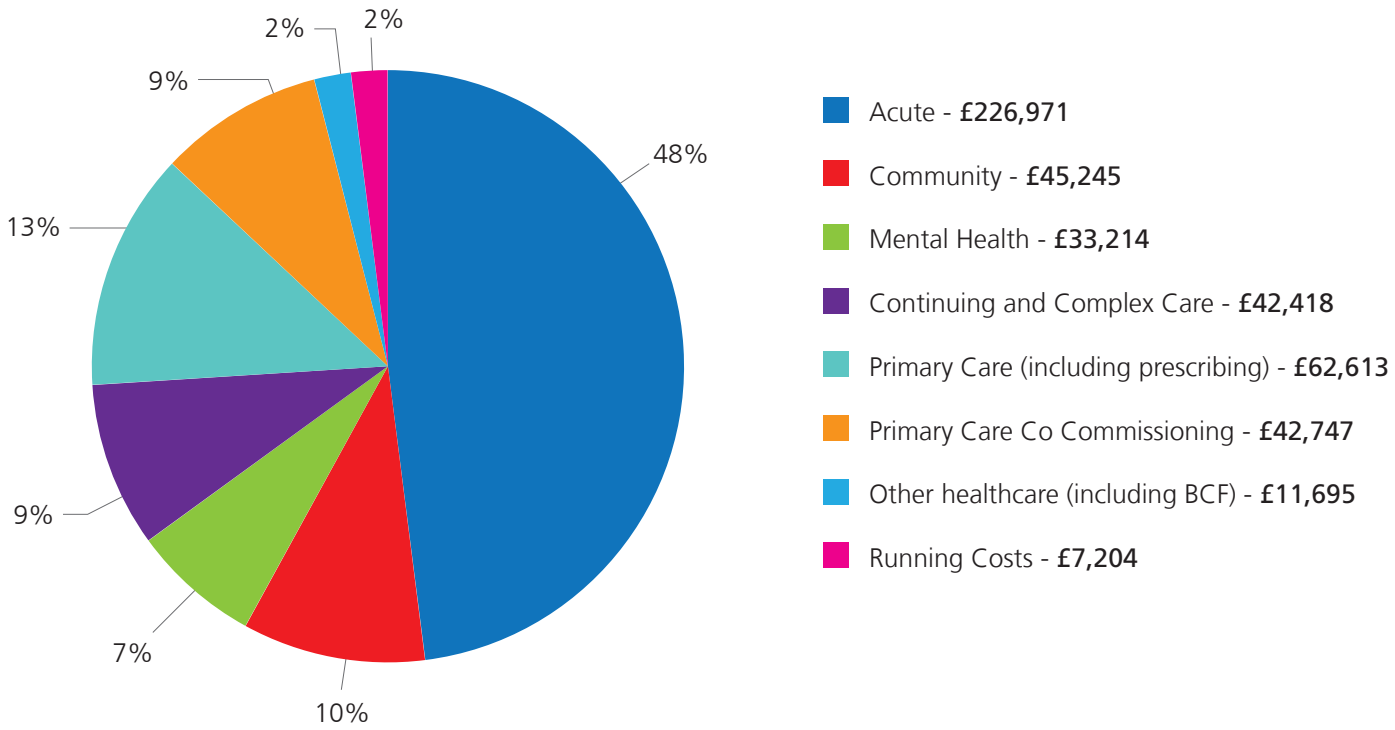
2018/19 Financial Performance Measure	**Target**	**Actual**
Statutory Duties:		
Expenditure not to exceed income (the CCG is in deficit but has a 'control total' in year deficit position set at the start of the year)	£456.422m	£473.481m
Capital resource use does not exceed the amount specified in Directions	Nil	Nil
Revenue resource use does not exceed the amount specified in Directions	£455.048m	£472.107m
Revenue administration resource use does not exceed the amount specified in Directions	£6.774m	£7.082m
Non- Statutory Duties:		
Better Payment Practice Code: NHS	95%	97.4%
Better Payment Practice Code: Non NHS	95%	98.3%
Cash draw down target	Achieved	Achieved
QIPP (Quality, Innovation, Productivity and Prevention)	£20.5m	£16.2m

It should be noted that the CCG has accrued an accumulated deficit of £59.6m to date. Once the 2018/19 deficit of £17.1m is added to this figure, the deficit carried forward to 2019/20 becomes £76.7m.

The CCG is striving to meet its statutory duty to not spend more than it has been allocated and is refreshing its medium term financial plan that aims to both return the CCG to recurrent financial balance and repay the deficit that it has accumulated.

A breakdown of actual expenditure is included below for information:

2018/19 Expenditure (£'000)



Information in relation to going concern is included in the Annual Accounts.

Assurance on How Well We Are Performing

To help NHS England, patients and the public identify how well CCGs are performing in their role as commissioners of health services there is an Improvement and Assessment Framework (IAF) against which CCGs are assessed.

We are accountable to our local population as well as the NHS for planning and delivering comprehensive and high quality care that meets the needs of our local population. We have quarterly assurance meetings with NHS England to assess how we are performing.

The IAF aligns with NHS England's Mandate and planning guidance with the aim of unlocking change and improvement in a number of key areas. This approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online.

The framework is intended as a focal point for joint work and support between NHS England and CCGs. It draws together the NHS Constitution, performance and finance metrics and transformational challenges. It also plays an important part in the delivery of the Five Year Forward View.

Details regarding the CCGs position in relation to IAF as well as our achievements in relation to our wider performance measures are set out in the following section.

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 2018/19 against a number of these targets and plans to build on this solid foundation in 2019/20.

We track the progress of our service providers, including our local hospitals, community services and mental health services, against a number of national outcome measures. This ensures that patients' rights within the NHS Constitution are maintained.

We measure our progress using a performance dashboard that shows up to 12 months' achievements. The Governing Body also receives monthly performance reports.

During 2018/19 there have been some areas where performance has not been as good as we would have expected. While the CCG performs well against similar CCGs, during 2018/19, the CCG has not met performance targets in respect of Accident & Emergency waiting times and ambulance emergency response times to category 1 calls. The Referral to Treatment (RTT) target for waiting times for elective treatment has improved but has only been achieved in some months. RTT waiting times were met by Shrewsbury and Telford Hospital through most of the year until late winter and were met by The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust by the end of the year. Key issues remain where our patients attend out of county hospitals and providers. We will continue to work with our service providers to improve performance. This is done through remedial action plans, regular reviews and the use of new pathways to improve performance.

The following table highlights our performance against the constitutional targets during 2018/19:

Standard	Performance
Referral to Treatment (RTT) for non-urgent consultant led services, incomplete patients to start treatment within a maximum of 18 weeks from referral.	At the end of March 2019 we achieved 90.5 per cent of patients waiting under 18 weeks for treatment. This was made up of 90.5% achievement at SaTH, 94.2% at RJAH; 97.3% at ShropCom and 85.1% at all other providers. The CCG achieved the target level in October and November 2018.
The total numbers waiting to be no more than the number in March 2018 by the end of the year.	The total count of people waiting at March 2019 was 19,284 against a target of 17,708. Increased emergency demand in the winter months at SaTH impacted on elective capacity which impacted on the achievement of this number and the under achievement against the 18 week waiting time standard.
Number of 52 week RTT pathways (incompletes): zero tolerance of over 52 week waits.	At the end of March 2019, published figures showed one Shropshire patient had been waiting over 52 weeks for treatment at Gloucester Hospitals Trust. All local providers achieved zero 52 week waiters.
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 been achieved regularly throughout the year and were 99.4 per cent at March 2019.

<table>
<tr><th>Standard</th><th>Performance</th></tr>
<tr><td>A&E waits: patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department.</td><td>Acute providers were monitored against a trajectory agreed with NHS Improvement outlining the performance level to which they would achieve the national standard for 2018/19. This recovery has not been achieved, despite significant work and initiatives put in place by both the CCG and SaTH and support from the national Emergency Care Improvement Programme (ECIP) to improve performance. Further recovery plans are in place and are being monitored by the local A&E Delivery Board. Performance at SaTH remains a significant challenge with 72.8 per cent of all A&E attendances waiting less than four hours in March 2019.

Improvement plans at SaTH are focused around improving patient flow in hospitals to achieve earlier discharge, to reduce the need for patients to be admitted and identifying better arrangements to support frail and elderly patients.

Significant improvement in A&E performance is likely to remain problematic as one of the main underlying issues is workforce, which cannot be solved quickly. The local system continues to work with NHS Improvement and SaTH to address workforce, patient flow and performance issues. Difficulties in achieving the A&E performance target are found elsewhere in the NHS at present.</td></tr>
<tr><td>Cancer waiting times: First outpatient appointment for patients referred urgently with suspected cancer by a GP</td><td>Performance against the range of cancer targets has been impacted by increased demand in some tumour types (notably Urological cancer) and by problems in staffing capacity in a number of cancer types and in diagnostic capacity. Figures for the end of March 2019 are shown below.
<table>
<tr><th>Description</th><th>Target %</th><th></th><th>Cumulative 18/19</th><th>Number of Months Achieved (out of 10)</th></tr>
<tr><td rowspan="3">Cancer urgent referral to first outpatient appointment (14 day referral)</td><td rowspan="3">93%</td><td>Achieved</td><td>86.4%</td><td rowspan="3">2</td></tr>
<tr><td>Total Referrals</td><td>16273</td></tr>
<tr><td>Breaches</td><td>2213</td></tr>
<tr><td rowspan="3">Proportion of patients with breast symptoms referred to a specialist who are seen (14 day referral)</td><td rowspan="3">93%</td><td>Achieved</td><td>68.76%</td><td rowspan="3">0</td></tr>
<tr><td>Total Referrals</td><td>1053</td></tr>
<tr><td>Breaches</td><td>329</td></tr>
<tr><td rowspan="3">Cancer diagnosis to treatment waiting times (31 day first treatment)</td><td rowspan="3">96%</td><td>Achieved</td><td>98.05%</td><td rowspan="3">11</td></tr>
<tr><td>Total Referrals</td><td>2201</td></tr>
<tr><td>Breaches</td><td>43</td></tr>
<tr><td rowspan="3">31 days for subsequent cancer treatment (surgery)</td><td rowspan="3">94%</td><td>Achieved</td><td>94.56%</td><td rowspan="3">8</td></tr>
<tr><td>Total Referrals</td><td>441</td></tr>
<tr><td>Breaches</td><td>24</td></tr>
<tr><td rowspan="3">31 days for subsequent cancer treatment (drugs)</td><td rowspan="3">98%</td><td>Achieved</td><td>99.86%</td><td rowspan="3">12</td></tr>
<tr><td>Total Referrals</td><td>728</td></tr>
<tr><td>Breaches</td><td>1</td></tr>
<tr><td rowspan="3">31 day standard for subsequent cancer treatments (radiotherapy)</td><td rowspan="3">94%</td><td>Achieved</td><td>97.29%</td><td rowspan="3">10</td></tr>
<tr><td>Total Referrals</td><td>737</td></tr>
<tr><td>Breaches</td><td>20</td></tr>
<tr><td rowspan="3">Urgent referral to treatment waiting times (62 day referral to treatment) Not including rare cancers -</td><td rowspan="3">85%</td><td>Achieved</td><td>77.67%</td><td rowspan="3">0</td></tr>
<tr><td>Total Referrals</td><td>1187</td></tr>
<tr><td>Breaches</td><td>265</td></tr>
<tr><td rowspan="3">Extended 62 day cancer treatment - screening (part a)</td><td rowspan="3">90%</td><td>Achieved</td><td>90.45%</td><td rowspan="3">8</td></tr>
<tr><td>Total Referrals</td><td>178</td></tr>
<tr><td>Breaches</td><td>17</td></tr>
<tr><td rowspan="3">Extended 62 day cancer treatment - consultant upgrade (part b)</td><td rowspan="3">(tbc)</td><td>Achieved</td><td>87.53%</td><td rowspan="3">n/a</td></tr>
<tr><td>Total Referrals</td><td>481</td></tr>
<tr><td>Breaches</td><td>60</td></tr>
</table></td></tr>
</table>

Standard	Performance
Category 1 ambulance calls: Category 1 calls to have an average emergency response within seven minutes and to reach 90% of calls within 15 minutes.	We have not achieved the standard locally during 2018/19 for Category 1 calls. Difficulty in achieving these targets is true for many of the more rural CCGs within the West Midlands. In Call categories 2, 3 and 4, the standards have been achieved and the performance in Shropshire is generally better for these than many other parts of the West Midlands.
Mixed sex accommodation breaches (minimise breaches).	During 2018/19, 144 breaches have been reported up to the end of March 2019. This is largely as a result of changes to data reporting at SaTH where it relates to Critical Care.
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.	There have been five occasions at SaTH in 2018/19, up to the end of March 2019 where a patient has had an operation cancelled and not re-booked within 28 days.
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.	Figures published at the end of Q4 show 99 per cent compliance on this measure.

CCG Improvement and Assessment Framework (IAF)

- The CCG is assessed across a range of system indicators on the impact it is having on improving health and providing better care in the local area
- We have continued to make good progress with regard to the IAF indicators
- At the most recent assessment, we were in the top quartile nationally for 13 of the indicators
- Only five of the indicators showed the CCG in the lowest quartile nationally
- A&E performance remains the most significant challenge for the CCG and the local system.

Better Health

	Area	Indicator	Period	Target	05N: NHS Shropshire CCG
Better Health	Child obesity	**102a:** Percentage of children aged 10-11 classified as overweight or obese	2014-15 to 2016-17		31.1%
	Diabetes	**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	2017-18		38.7%
		103b: People with diabetes diagnosed less than a year who attend a structured education course	2017-18 (2016 cohort)		2.81%
	Falls	**104a:** Injuries from falls in people aged 65 and over	17-18 Q3		979
	Personalisation and choice	**105b**: Personal health budgets	18-19 Q2		8
	Health inequalities	**106a:** Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	18-19 Q1		871

Better Health

Better Health	Antimicrobial resistance	**107a:** Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	2018 09	0.965	0.995
	Carers	**107b:** Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	2018 09	10%	4.34%
		108a: The proportion of carers with a long term condition who feel supported to manage their condition	2018		0.63

Key: **Bandings**

- Highest performing quartile
- Interquartile range
- Lowest performing quartile

Better Care

	Area	Indicator	Period	Target	05N: NHS Shropshire CCG
Better Care	Provision of high quality care	**121a:** Provision of high quality care: hospital	17-18 Q2		60
		121b: Provision of high quality care: primary medical services	17-18 Q2		69
		121c: Provision of high quality care: adult social care	17-18 Q2		64
	Cancer	**122a:** Cancers diagnosed at early stage	2013	53.52%	48.2%
		122b: People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	17-18 Q3	85%	86%
		122c: One-year survival from all cancers	2012		70.6%
	Mental health	**123a:** Improving Access to Psychological Therapies – recovery	17-18 Q3	50%	54.9%
		123b: Improving Access to Psychological Therapies – access	17-18 Q3		3.45%
		123c: People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	2018 08		83.9%
		123i: Delivery of the mental health investment standard	17-18 Q3		
	Learning disability	**124a:** Reliance on specialist inpatient care for people with a learning disability and/or autism	17-18 Q3		67
	Maternity	**125d:** Maternal smoking at delivery	17-18 Q3		11.7%

	Area	Indicator	Period	Target	05N: NHS Shropshire CCG
Better Care	Dementia	**126a:** Estimated diagnosis rate for people with dementia	2018 08		70.3%
		126b: Dementia care planning	2014-15		79.5%
	Urgent and emergency care	**127b:** Emergency admissions for urgent care sensitive conditions	17-18 Q2		1729
		127c: Percentage of patients admitted, transferred or discharged from A&E within 4 hours	2018 09	95%	78.3%
		127e: Delayed transfers of care per 100,000 population	2018 08		4.1
		127f: Population use of hospital beds following emergency admission	17/18 Q2		428

	Area	Indicator	Period	Target	05N: NHS Shropshire CCG
Better Care	Primary care	**128b:** Patient experience of GP services	2015		
		128c: Primary care access – proportion of population benefitting from extended access services	2018 07		51%
		128d: Primary care workforce	2016 09		1.12
		128e: Count of the total investment in primary care transformation made by CCGs compared with the £3 head commitment made in the General Practice Forward View	17-18 Q3		
	Elective access	**129a:** Patients waiting 18 weeks or less from referral to hospital treatment	2018 07	92%	90.6%
	NHS Continuing Healthcare	**131a:** Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	17-18 Q3		4.49%
	Diagnostics	**133a:** Percentage of patients waiting 6 weeks or more for a diagnostic test	2018 08		1.06%

Other Items of Strategic Importance

NHS Future Fit programme

Securing the future of hospital services for people in Shropshire, Telford & Wrekin and mid Wales.

Launched in January 2014, the programme aimed to develop safe, accessible and sustainable acute hospital services across Shropshire and Telford & Wrekin for the next 20 years, and beyond. It emerged from the Department of Health 'Call to Action' public survey in November 2013, which found that local people accepted the need for significant change and believed a new pattern of services would be more efficient, joined up and better used.

NHS Future Fit focused on hospital services provided by the Shrewsbury and Telford Hospital NHS Trust (SaTH) which in many cases are fragile. The plans consider people's physical, mental and social needs, as well as other things, such as the support they get from the local community, transport, and how we can use technology as part of our services.

In June 2014, a clinical design model report was published, based on the ideas of clinical professionals across Shropshire, Telford and Wrekin, and mid Wales, and incorporating evidence of what works elsewhere. This new model was collectively created by 300 doctors, nurses, other health professionals, social care workers and patients.

In January 2019, members of the Joint Committee of Shropshire and Telford & Wrekin CCGs unanimously agreed plans to transform the county's two hospitals, securing their future for the half a million people across Shropshire, Telford & Wrekin and mid Wales who access their services.

This final decision regarding the future configuration of the local hospitals will make sure that Shropshire continues to have two vibrant hospitals and that the wide range of services they provide for people across Shropshire, Telford & Wrekin and mid Wales are kept in the county. It will also mean that the Hospital Trust can provide better care for patients and develop both hospital sites to deliver state of the art facilities in which staff will be proud to work and patients will choose to be treated.

The changes agreed by the Joint Committee will mean that patients receive the best care in the right place at the right time, in better facilities with reduced waiting times. It will increase the prospects of attracting the very best doctors and nurses to work at our hospitals whilst maintaining the right level of highly skilled clinicians across both our hospital sites. The new model of patient care also takes into account the expected changes in our population over the coming years and how the best care can be provided for everyone. Robust plans will now need to be developed that will include a phased building programme over the next five years.

The CCGs are extremely grateful to the thousands of people who took part in the consultation and we look forward to continuing to involve patients and the public over the coming years as the scheme develops over the next few years.

Moving into 2019/20 the Hospital Trust will focus on the implementation of the Future Fit model of care, summarised below, which has been developed by members of the public and over 300 clinicians, GPs and social care professionals:

The Princess Royal Hospital in Telford will become a dedicated Planned Care site and the Royal Shrewsbury Hospital in Shrewsbury will become a specialist Emergency Care site.

Outpatient services, 24-hour urgent care, tests and midwife-led services will be available at both hospitals.

A significant step forward for the programme came in March 2018 when the Department of Health and Social Care announced that the programme would receive, subject to successful public consultation and an approved final business case, £312m capital funding for the Future Fit programme to assist with the future reconfiguration of hospital services, the largest capital investment in the NHS in Shropshire in the last 70 years.

The decision regarding the configuration of services follows a significant amount of work over the last five and a half years by the Future Fit Programme on behalf of Shropshire and Telford & Wrekin CCGs. This has involved developing the options, undertaking impact assessments and commissioning independent reviews. During 2018/19 a formal public consultation was undertaken, asking people for their views on the proposed model and the two options to deliver that model. This brought about an unprecedented response rate from more than 3% of local people served by the hospitals.

A suite of post consultation documentation was produced which set out the robust assurance process that has been followed. It also included the feedback from the public consultation, details of the conscientious consideration phase and the plans that have been developed to help lessen the impact the proposals may have on travel and transport and on seldom heard groups. These documents can be found on the dedicated Future Fit website.

What does this mean for services?

Emergency care

The chosen delivery option will allow specialist doctors to treat the most serious cases on the Emergency Care site, which is proven to be safer, provide better results for patients and reduce the amount of time people have to stay in hospital.

Planned care

By having a separate Planned Care site, patients will wait less time for their appointments and beds would be protected for planned operations, meaning that it is highly unlikely operations will be cancelled due to emergency admissions. In addition, patients will be able to access 24 hour urgent care services at both hospitals. This means that almost 80% of patients will continue to go to the same hospital as they do now for emergency and urgent care.

The following services will be provided at the Royal Shrewsbury Hospital:
- 24-hour Emergency Department
- Critical Care Unit
- Ambulatory Emergency Care Unit
- Emergency surgery and medicine
- Complex planned surgery
- Women and children's consultant-led inpatient services

The following services will be provided at the Princess Royal Hospital:
- Planned inpatient surgery
- Day case surgery
- Breast inpatient services
- Medical wards

Most people will still receive care and treatment in the same hospital as they do now, as the following services will be provided at both hospitals:
- 24-hour Urgent Care Centre (the majority of patients who attend our A&E departments will receive care and treatment here)
- Adult and children's outpatient services
- Day Case Renal Unit
- Tests (diagnostics)
- Midwife-led unit
- Antenatal Day Assessment Unit
- Early Pregnancy Assessment Service (EPAS)
- Maternity outpatients and scanning

More information can be found on the NHS Future Fit website.

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; 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 national Five Year Forward View, which advocates collaborative whole system solutions, the intentions and aspirations described in the NHS Long Term Plan, as well as locally supporting the Future Fit model.

The programme of transformation of out of hospital services has been officially named "Shropshire Care Closer to Home". The collaborative journey of the design and development of new or redesigned services commenced at the end of 2017 followed by a series of events and workshops that took place throughout 2018 involving GPs and primary care colleagues, provider organisations, the voluntary and care sector, patient representatives and members of the public.

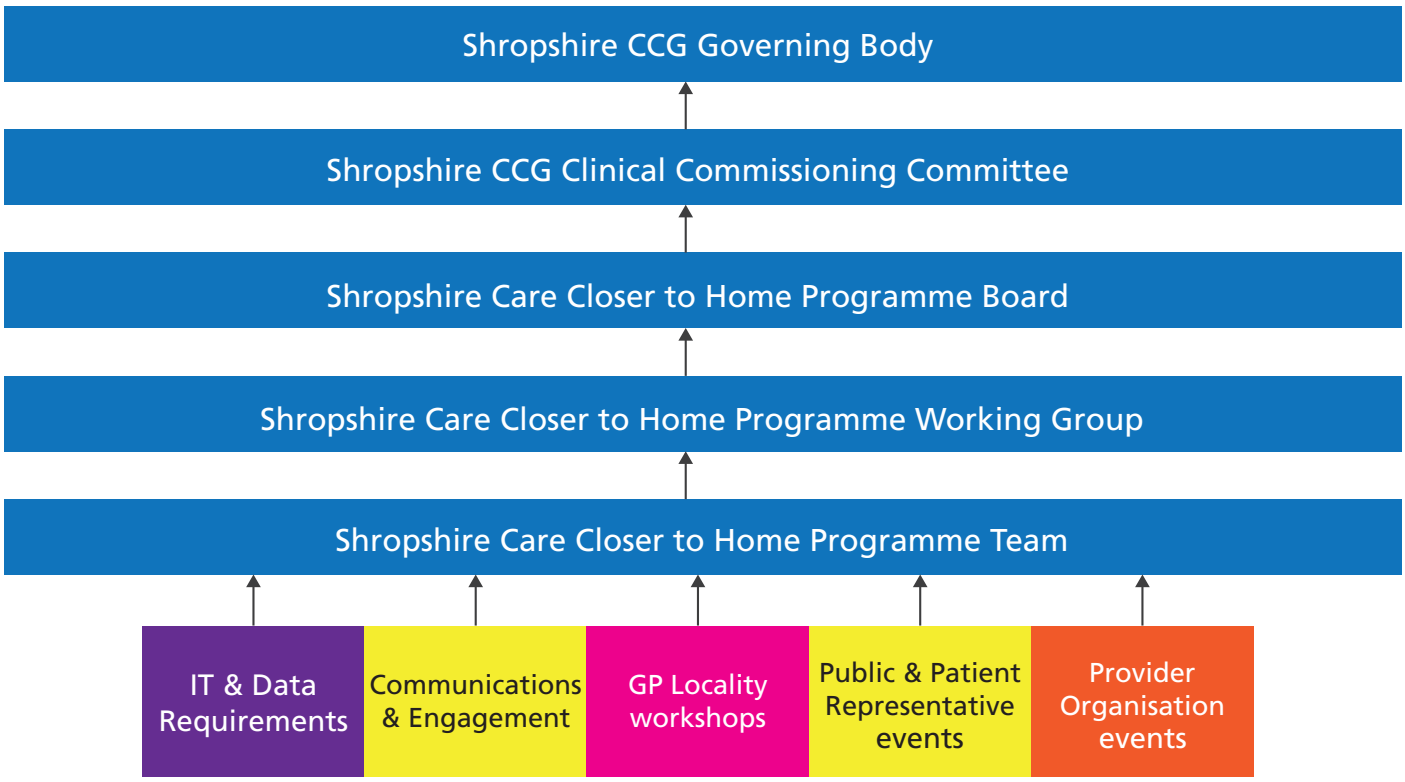
The vision for Shropshire Care Closer to Home is:

"Using all available resources to commission integrated health and care services that are clinically effective and cost-efficient and as close as possible to where people with the greatest need live."

Our approach:

"We are going to be collaborative and will involve all our partners throughout the process. We shall communicate what we are doing, why we are doing it, when it will be done and how people can get involved as we go. We shall be transparent and open throughout the process and explain the rationale for our decisions at all times."

A formal governance and reporting framework as illustrated below was established, along with a dedicated Programme Team who co-ordinate the delivery of the programme plan.



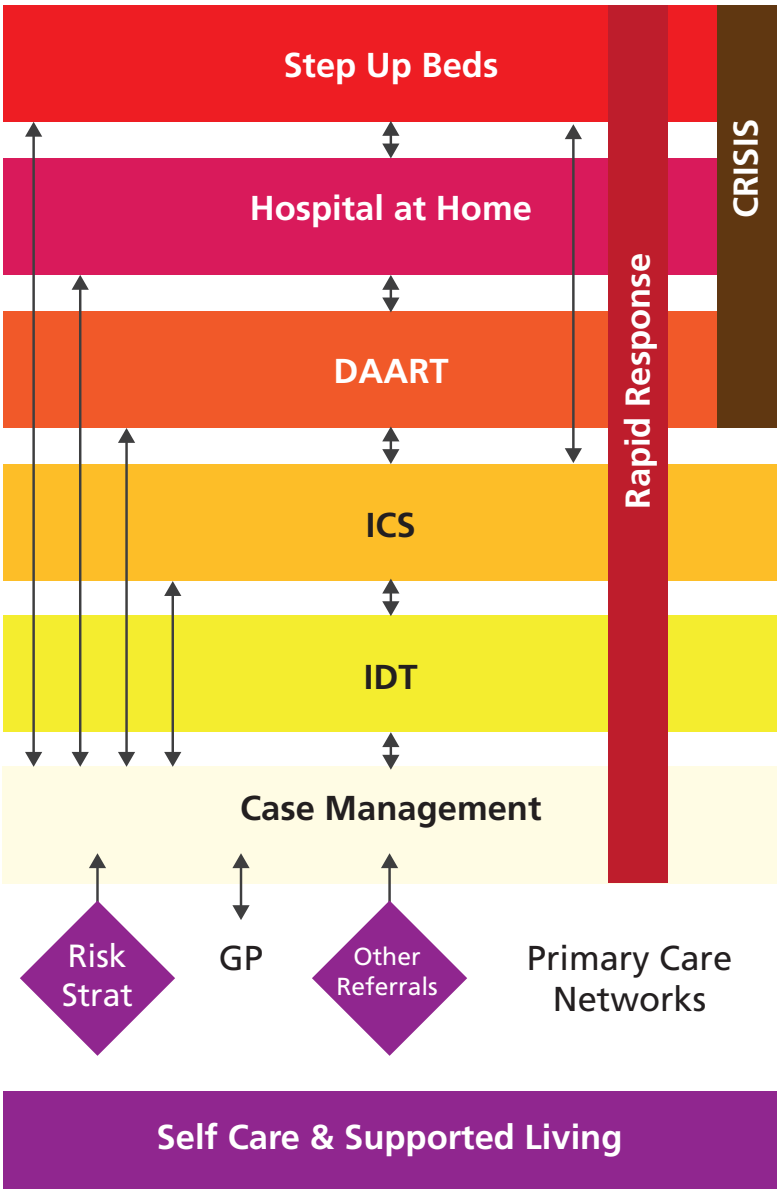
The scope of Shropshire Care Closer to Home includes multiple layers of community based services including:

- Earlier identification of people in need so that they can be supported much sooner
- Provision of an holistic person-centred Care Plan, delivered by an integrated team of health and social care professionals
- Focus on proactive and preventative care and support
- Development of semi-acute services in the community including Hospital at Home, DAART (Diagnostics, Assessment, Access to Rehabilitation & Treatment), Rapid Response, Crisis and Step Up Community Beds, building on from the work of the CCG in 2017. These will provide additional layers of new services providing care and treatment that you may have previously had to go to hospital for. These more acute areas of community based care will link with the developments being planned around Minor Injuries Services and the Urgent Care transformation agenda.

The high-level service map below illustrates the various services planned within the model of Shropshire Care Closer to Home and how they all relate to each other. To the patient, it will be one seamless journey between services navigated by a designated Case Manager who will be the dedicated point of contact for the patient, carers and family.

Shropshire Care Closer to Home

Service Map



In parallel with the design and development of new services, there is also a significant amount of IT work taking place to ensure the requirements are in place to enable optimum functionality of the services. This includes data sharing agreements, two-way flow of information between all provider organisations, a process called risk stratification which helps us to identify people in need before they deteriorate, and the development of a shared Care Plan to be used by anyone involved in the care of that person, meaning as a patient you only ever have to tell your story once.

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

Phase 1 Frailty Front Door (presently operational) – A dedicated multi-disciplinary team, called the Frailty Intervention Team based in the Emergency Department who are responsible for the early identification, treatment, risk assessment and planning for frail and long term condition patients. This improvement will facilitate appropriate triage of patients to either the acute/community/home setting and reduce the risk of an unnecessary admission into the general hospital. This team liaises and works with existing teams in the community such as intermediate care and care co-ordinators etc. DAART is a key focus for this process in terms of linking into existing acute frailty expertise, resources and skills, providing a responsive ambulatory care function.

Phase 1 has been running in the Emergency Department of Royal Shrewsbury Hospital for over a year now, with great results, e.g. reducing length of stay and reducing the number of patients over 75 admitted onto the main wards and teams are now being recruited ready to launch the same service in the Emergency Department of Princess Royal Hospital in Telford.

Phase 2 Risk Stratification and integrated Case Management built around general practices with a core locally available multidisciplinary team including a co-ordinating Case Manager, district nurses, care co-ordinators, allied health professionals, social workers, therapists, dementia support workers, matrons, and the voluntary and care sector. This element of the service will identify the case management cohort of service users, develop personalised care plans, provide the day-to-day care and support including wider services as necessary. For stable service users this will be the default range of services. It will provide a named lead for each service user to generate emergency care plans and to design the escalation services necessary to manage any exacerbation. The community matrons are key in the education and competence building of wider staff.

The collaboratively co-designed model of risk stratification and Case Management was approved the CCG Clinical Commissioning Committee in August 2018. A dedicated group that reports into the Programme Board is now planning the implementation of eight pilot demonstrator sites to test out the models in a practical way, in both rural and urban locations. The 6 month pilots will be followed by robust evaluation, with any learning used to refine the model, before commencing wider rollout across the county.

Phase 3 Semi-acute services in the community. New services including Hospital at Home, DAART, Rapid Response, Crisis Intervention and Step Up Community Beds. Where care needs to escalate beyond the core teams, service users will move into a Hospital at Home element of the service. This will incorporate the step-up element of the intermediate care team and community beds with an enhancement to medical cover arrangements (which could include in-reach from acute consultants or alternative medical governance models) and access to IV Antibiotics etc. within the community. The specialist frailty and long term conditions teams will be part of this element of the service, both in terms of care delivery to manage exacerbations and also in an educational role to cascade skills into the core teams. A Rapid Response Team will be established to enable intervention at pace across the Hospital at Home and Crisis functions. This team will make full use of the re-specified DAART and community bed provision.

The first draft Phase 3 models are now designed and developed, and will be shared throughout a series of involvement and engagement workshops in February and March 2019 to ensure continued collaborative input. A decision will be made by the CCG Clinical Commissioning Committee during early summer 2019 on the agreed models that will then go on the same journey of being tested out in pilot demonstrator sites prior to wider rollout.

The assumptions within the programme on case management are based on the evidence from the United States, reflecting the fact that case management programmes have been established there for longer. For example, the Promoting Action for All-inclusive Care for the Elderly (PACE) case management programme has been associated with reduced hospital utilisation and nursing home use. When compared with a control group, older people enrolled in the PACE programme showed a 50 per cent reduction in hospital use and were 20 per cent less likely to be admitted to a nursing home.

The initial focus of the Shropshire Care Closer to Home model is aimed at people aged 65 and over, and this is due to this being the predominant proportion of the local population who could benefit from these services at this time. It is recognised however that you can be frail, and require care and support and be under 65, so this is only the starting point. The programme will continue to be developed into 2019/20.

Sustainability and Transformation Partnership

Shropshire CCG is one of the local members of the Sustainability and Transformation Partnership (STP) for Shropshire, Telford & 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 it's 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.

The STP is an evolving programme, but it is anticipated that it will take an increasingly prominent role in planning and managing system-wide efforts to improve services. During 2018/19 this has included:

- Ensuring a system-wide approach to operating plans that aligns key assumptions between providers and commissioners
- Working with local clinical leaders to implement service improvements that require a system-wide effort; for example, implementing primary care networks or increasing system-wide resilience ahead of next winter
- Identifying system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions
- Undertaking a strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused or underutilised estate
- Taking further steps to enhance the capability of the system including stronger governance and aligned decision-making and greater engagement with communities and other partners, including, local authorities.

During 2018/19 the Shropshire, Telford & Wrekin STP successfully secured Sir Neil McKay as its independent STP Chair, leading to a comprehensive review of the programme to carry it into 2019/20.

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 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 Five Year Forward View.

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 over-sight and governance sitting with the Health & Well Being Board (HWBB).

Better Care Fund in Shropshire

The total 2018 -19 budget for the Shropshire BCF is £27.3million the minimum contributions from the CCG and the Local Authority – this does not include the iBCF value.

Shropshire CCGs contribution is a total of £20million which is made up of services commissioned and funded by Shropshire CCG (£12.2m), 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 2018/19 the Shropshire Better Care Fund (BCF) focused on the following themes:

- Reducing non elective hospital admissions in the over 65s
- Residential home admissions
- Reablement
- Reducing delayed transfers of care
- Eight high impact changes.

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

Our Achievements in 2018/19

MSK Triage and Assessment Service

An MSK Triage and Assessment Service was commissioned by Shropshire CCG from 1 April, 2018. The service is delivered by The Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust (RJAH) and has been rolled out across the county. The service has successfully shifted a significant number of consultant-led hospital outpatient attendances to the community, allowing for care closer to a patient's home. RJAH and Commissioners have worked closely together over the last 12 months to mobilise the new service. In 2019/20 further work on the MSK pathway will again be prioritised in order to maximise outcomes for our patients in Shropshire.

Community Optometry Services

In 2018/19 Shropshire CCG requested tenders for Community Optometry Services. This contract has been awarded to Community Health and Eye Care with a service commencement date from 1 April 2019. Services included under the new contract include Minor Eye Conditions (MECS), Pre-operative Cataracts, Post-operative Cataracts, Repeat Measures and Children's Pathway. These services were previously delivered by individual Optometry Practices across Shropshire, by awarding the contract to one provider allows commissioners to have more control over the quality of services provided to the local population by our optometry providers in Shropshire.

Termination of Pregnancy Services

Shropshire CCG and Telford & Wrekin CCG jointly awarded a new contract for Termination of Pregnancy Services to the British Pregnancy Advisory Service (BPAS) following a competitive procurement process. The new service began on 1 December 2018 and BPAS have established a clinic at Radbrook Surgery in Shrewsbury and another at Bishton Court in Telford where patients can access Early Medical Abortions (EMAs). Patients are offered choice of location to access their treatment with surgical terminations carried out at sites across the country, the closest to Shropshire being Chester or Cannock Chase.

Stroke

Working in partnership with SaTH, Shropshire Community Health Trust (SCHT) and Telford & Wrekin CCG, commissioners are supporting the Stroke Improvement Plan. Following the NHSE review of SaTH Stroke Services an action plan for improvement was implemented. Led by SaTH, the plan has a number of key targets which have seen improvements and developments to meet the requirements of the Sentinel Stroke National Audit Programme.

In 2018:

- over 90% of patients spent at least 90% of their stay on a stroke unit
- there has been a significant improvement in the number of patients that have received a scan within an hour of attendance by or at an emergency service
- More patients are being reviewed by a stroke consultant within 24 hours of admission
- A significant number of patients are being discharged early, where they are receiving rehabilitation by the Early Supported Discharge Team.

In 2019, commissioners began working with our local providers to review the Stroke Rehabilitation Pathway, with an aim to be more systematic with discharge processes, to ensure patients are discharged in a timely way and receive rehabilitation in the most appropriate setting or service.

Fracture Liaison Service

The plan to implement the Fracture Liaison Service (FLS) within SaTH is moving forward. On the basis of the groundwork completed in 2018/19, the aim is to launch the service within the second quarter of 2019/20. Based on a case finding model, the service will identify patients that have attended hospital with a fragility fracture, supporting those patients with a subsequent diagnosis of osteoporosis to manage their treatment and to encourage positive lifestyle changes, which will see a reduction in the risk of future fragility fractures for these people.

Frailty

The Frailty Intervention Team, known as FIT, was originally started as an idea by Shropshire CCG and The Shrewsbury and Telford Hospital NHS Trust (SaTH), to help local elderly people avoid being admitted onto a hospital ward where they risk lengthier stays and recovery periods.

Working together with the Shropshire Community Health NHS Trust and Shropshire Council a new team combining health and social care professionals was formed. The FIT is a fast track service to get frailer patients over 75 quickly assessed, treated and discharged safely back to their own homes or as close as, where research shows patients make a better, and quicker, recovery.

The team is based next to the Emergency Department at the Royal Shrewsbury Hospital, run by SaTH, and includes social workers, doctors, advanced nurse practitioners, physiotherapists, occupational therapists and a community matron.

Since its launch a year ago, over 100 patients a week who come into assessment areas like the Emergency Department (ED), Acute Medical Unit (AMU) and Clinical Decision Unit (CDU) are added to the team's case load, with around a quarter discharged instead of admitted onto the wards.

This means that their length of stay is less than 72 hours and the vast majority, over 80 per cent, are discharged straight home.

The hospital has seen a ten per cent reduction in patients aged over 75 being admitted onto the wards.

Dr Finola Lynch, GP and frailty lead at Shropshire CCG, said:

"For an older person sometimes going into hospital is absolutely the right thing to do - but sometimes it isn't. We know that once a person reaches the age of 80, ten days in hospital is the equivalent of losing ten years of muscle strength.

"As we get older our ability to recover from seemingly minor events like a urinary tract infection or a fall decreases; they hit us harder and we need more time to get back to normal. We're far more likely to recover fully if we can go home or be as close to home as possible, so that we're near friends and family and the surroundings that make us feel safe and supported.

"FIT is based on frailty models delivered elsewhere but what's different about it is the particular involvement of the social workers and community matron, who not only support the patient's discharge but can prevent them from hitting the Accident and Emergency (A&E) department again by supporting them in the community.

"We believe this is the first time a team of its kind has been brought together to deliver this type of care. The way we work together has been seen as a great piece of partnership working by NHS England. FIT really puts Shropshire on the map and showcases the innovative care that our health and social care colleagues are doing together."

A video called Roy's Story was commissioned and produced by NHS England. It features Roy, aged 90, who lives with wife Doreen 83, and shows how FIT helped him after he had suffered a fall.

The video can be viewed on YouTube.

The FIT is just one part of Shropshire Care Closer to Home (SCCtH), a much wider programme of work being developed by the CCG, and its partners, the details of which are set out earlier in this report. This aims to proactively case manage and deliver care to patients with long-term conditions at risk of repeated admissions so that they can better manage their health and avoid lengthy hospital stays.

Dr Lynch explained:

"Imagine a team like FIT but close to or wrapped around general practices, patients could be referred into this team who can then quickly assess and manage that patient. This may include care delivered in the community, even in their homes, rather than on a ward. Ironically the hospital has started what the community desperately needs.

Shropshire has a significant older population with those over 85 expected to increase by nearly 40 per cent by 2025. Currently community care is delivered too inconsistently across the county and our older, frailer patients are too often hitting A&E with issues that could have been sorted out earlier back in the community."

Reducing Length of Stay and Improving Timely Discharge

Working in partnership with Shrewsbury and Telford Hospital NHS Trust, Shropshire Council and related community providers, there has been a consistent and significant reduction in Delayed Transfers of Care (DTOC) in 2018/19 with two out of three service providers below the national target of 3.5%. Key performance indicators contributing to this improvement are:

Indicator	18/19 start position	18/19 year end position
Patients with Length of Stay over 7 days in SATH	320	290
Average Length of Stay on the SATH Medically Fit for Discharge (MFFD) List	6.3 days	4.7 days
Average Length of Stay in NHS commissioned care home rehabilitation beds	30.3 days	19.6 days
Delayed Transfers of Care (DToC) National target <3.5%	SATH 1.8% RJAH 5.3% SCHT 4.7%	1.6% 6.8% 1.7%

In addition during 2018/19 Shropshire Community Health NHS Trust has maintained the significant reduction in length of stay in the community hospital rehabilitation beds at 17 days.

Integrated Urgent Care – NHS111/ Out of Hours

In 2018/19 the national policy for integrated urgent care across NHS111 and GP Out of Hours was further developed locally. Prior to July 2018, Shropdoc (our local GP Out-of-Hours provider) provided the full Integrated Urgent Care Model with NHS111, which included the call handling and triage service, and the GP Out-of-Hours service for Shropshire. In line with national policy, the call handling and triage element of the contract transferred to NHS111 from July.

If NHS111 assesses that a patient needs to talk to our GP Out of Hours service they will transfer the patient's details to Shropdoc. Face-to-face appointments, GP telephone consultations and mobile visits continue to be provided by Shropdoc; however, from October 2018 it was re-launched under a new service model, still delivered by Shropdoc, but in a delivery partnership with Shropshire Community Health NHS Trust.

The main benefit of these new arrangements is that for the first time patients have access to a range of services by dialing a single free-to-call number (111) making it easier to get the right service. This supports the wider campaign encouraging patients to 'Choose Well' and helps to keep emergency departments (EDs, or also known as A&E) and 999 services for those who really need them.

Referral Assessment Service

We want every Shropshire patient to be able to choose where they are treated, within the guidelines set out in the NHS Constitution. We also want our providers to receive appropriate referrals that are supported by good quality information. We make this happen through our Referral Assessment Service (RAS).

When someone is referred by their GP for a hospital outpatient appointment, the doctor informs the RAS Team, who will contact the patient, explain the next steps and talk through their options to find the one that suits them best.

In 2018/19, RAS implemented the 'paper switch off' process for Shropshire, whereby all referrals for a consultant led outpatient appointment have to be made via the national e-referrals system.

RAS was chosen by NHS England to be the booking service for patients who are resident throughout England but are registered with a Welsh GP. This service has been successfully operating in 2018/19 and continues to expand so that it will eventually cover all such patients once the practices have signed up.

Given all the above, RAS forms an important part of the Shropshire health economy and it helps all partners to meet government targets for referral to treatment (RTT) times, while promoting patient choice within clinically safe and robust systems.

Cancer Services

We work with our main provider of cancer services, Shrewsbury and Telford Hospital NHS Trust (SaTH) to continue to improve processes and performance for various types of cancer. Whilst during 2017/18 SaTH were able to meet all of the cancer waiting times targets, in 2018/19 this has been much more challenging. We continue to work together to bring performance back up to the required standard.

Further to our work with SaTH, we are very pleased to be able to work with Macmillan Cancer Support to provide some local services, whereby patients who have had cancer are supported in the community once they have finished their treatment.

Women's and Children's Services

Local Maternity System

The Local Maternity System (LMS) is a partnership arrangement in place for the delivery of the recommendations from the national review of maternity services 'Better Births'. The key achievements to date delivered through the LMS include:

Maternity Voices Partnership

A Maternity Voices Partnership (MVP) has been established which brings together those working in and with maternity services and those who have received maternity services, working together to improve services. The Maternity Voices Partnership has been involved in a range of projects including improving information for women and their families, informing the design of perinatal mental health services and helping to design the finishing touches for the refurbished Midwife-Led Unit in Shrewsbury.

Perinatal Mental Health

In partnership with Telford & Wrekin CCG and Staffordshire CCGs, Shropshire CCG was successful in securing additional funding to jointly commission a specialist perinatal mental health service. From 2019/20 all CCGs will receive additional funding to increase specialist perinatal mental health provision, but Shropshire CCG has already started implementation of the new service through their joint commissioning arrangement.

Reducing Stillbirth, Neonatal Death and Brain Injury

A number of initiatives have been launched in order to raise awareness of risks in pregnancy and to improve the health of pregnant mothers. These include enhanced smoking cessation initiatives, an awareness raising campaign with regards to reduced fetal movements and the introduction of a new app to enable pregnant women with diabetes to more effectively manage their condition during pregnancy.

Midwifery-Led Services Review

Further engagement work has taken place throughout 2018/19 in order to inform the final proposals for the future of midwifery-led care in the county. The proposed model of care will improve outcomes for women and their families through a more sustainable service model that better responds to the needs of women and their families.

Mental Health

Adult Mental Health

Achieving parity of esteem for people with mental health needs is one of the NHS's core priorities and has been a key driver of transformational agenda for implementing the Mental Health Five Year Forward View. Currently, one in four people will experience a mental health problem in their lifetime and the cost of mental ill health to the economy, NHS and society is estimated to be £105 billion a year.

The introduction of the access and waiting time standard for early intervention in psychosis (EIP) services and improving access to psychological therapy (IAPT) services heralded the start of a new approach to deliver this improved access and embed standards akin to those for physical health. The EIP standard is not just a new approach for mental health but is a clear national priority for the NHS.

The national Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed treatment of adult anxiety disorders and depression in England. Nationally, over 900,000 people now access IAPT services each year, and the NHS Long Term Plan continues its commitment to expanding services further, alongside improving quality. IAPT services provide evidence based treatments for people with anxiety and depression (implementing NICE guidelines).

The target for 2020 is for 25% of adults with a common mental disorder to be treated in IAPT services and Shropshire CCG has been working towards this target during 2018/19. By March 2019, Shropshire CCG reached the required level of 19% of patients being treated in IAPT services, but is below the overall target. We plan to recover this position by investing more in IAPT in 2019/20 to 'catch up' with the trajectory lag to reach 25% at the beginning of 2020, and maintain this position thereafter. A further target is for 50% of patients who enter therapy to move into a 'recovery' phase. The CCG has performed well against this target averaging 55.3% at year end. Shropshire CCG agreed with Telford & Wrekin CCG that the long term conditions component of their IAPT model is extended across Shropshire to provide psychological support to people with long-term conditions to people in Shropshire. This will be further extended to build capacity and ensure that psychological therapies are available for people with long term conditions in 2019/20 and thereafter.

The target for Early Intervention in Psychosis (EIP) is for 50% of patients referred to be seen within two weeks; and in 2018/19 we have consistently exceeded this target in Shropshire, with our rolling three month % target being between 61.5% and 100%.

Improving mental health services has been a priority for the Shropshire CCG. We have met the requirements of the Mental Health Minimum Investment Standard (MHMIS) with an increased expenditure on mental health care in line with the CCGs uplift and investing in children and young people's mental health services in particular. We have continued to invest in new services including; Shropshire Sanctuary, Designs in Mind, advocacy services and secured new investment in perinatal mental health services. The perinatal services will provide a much needed service for new mothers, their babies and families to cope with and gain emotional support at a critical period.

The CCG has seen continued good performance against national indicators for early intervention in psychosis; dementia diagnosis and crisis care. Mental Health Liaison Teams in Shropshire and Telford Hospital (SATH) and Princess Royal Hospital (PRH) have, between them, continued to deliver 24-hour mental health cover to the hospital emergency departments.

Children's Mental Health

In 2015, the Government challenged CCGs to ensure that 32% of children requiring mental health services for support and treatment accessed it and Shropshire CCG has achieved this. The national ambition is that by 2020, 35% of those children who have a diagnosable mental health condition will receive the support that they need. The focus is increasingly on ensuring that children benefit not only from access to services but from outcomes which will have a positive long-lasting impact on their lives.

In June 2018 NHS Improvement's Intensive Support Team visited the BeeU service and identified a number of areas for improvement. These were: existing caseload, evidence based pathways; service identity; workforce; system wide governance and data and information quality. A detailed recovery action plan is in place and is being monitored closely with supporting regulatory oversight.

The Children's Mental Health Commissioners continue to work as one team across the STP footprint. A refreshed CYP Long Term Plan has been approved by the new STP Mental Health Group with a commitment to refresh this quarterly throughout 2019 to capture service improvements and to ensure full transparency of progress. The plan focuses on prevention, targeted intervention, evidence based interventions and help in crisis. The voices of children and young people informed the original vision and developments during 2018/19 and thereafter will continue to do so, including involvement in the development of new pathways. The vision is to make sure that children's mental health needs are identified early and they receive effective early support to reduce the likelihood of problem escalation.

Employment Support

'Enable' continues to deliver the Individual Placement Support (IPS) programme to help people experiencing mental illness back into work. The service is nationally recognised and continues to deliver excellent outcomes for people. The NHS Long Term Plan advocates an increase in people accessing the IPS programme and we will look at ways to achieve this over the next two years. Additional partnership working, as part of The Five Year Forward View, has enabled increased employment of workers within the service to support people back to work.

Crisis Care

The CCG continues to prioritise Crisis Care with the following developments achieved in-year 18/19:

- We continued to support mental health advocacy.
- We support secondary prevention enabling participation in design and fabrication offering practical support and confidence building.

We remain an outlier for Section 136 assessments, and have commenced a review of the successful Shropshire Sanctuary which was commissioned to provide police with an alternative place to take people who they would have otherwise detained under the Mental Health Act. The usage of the Sanctuary has increased with extended opening times, and we intend to fully review our urgent care pathways including the possible use of 'street triage' in partnership with the police and ambulance services.

In 2018 Shropshire Sanctuary was able to support 683 visitors in crisis. Highest referrals came from the police (317), ambulance (185) and the Crisis Team (119). This service has proven to be valued by people receiving care as well as by those involved in the pathways leading to it.

Shropshire Wellbeing Hub

Based upon the solid partnership working that led to the Sanctuary being commissioned, local third-sector providers have teamed up to help enrich what they offer to the people of Shropshire. Shropshire MIND, Enable, Designs in Mind and Shropshire Independent Advocacy Service (SIAS) have expressed a desire to form an alliance across the county.

Although not commissioned by the CCG, the Samaritans have also agreed to contribute to the well-being hub alliance. Whilst this informal arrangement has not been formally signed off due to changes in commissioning personnel at the CCG, we believe this offer of support provides an excellent foundation for ongoing and future opportunities for providing non-clinical holistic person centred support in a wide range of locations, even those who live in remote, hard to reach areas. We continue to support the aspiration to deliver 24 hour, 7 days a week, 365 days a year support option for people of all ages experiencing mental distress.

Dementia

In Oswestry and Ludlow we have seen the continuation of the Dementia Companion service which will be evaluated to identify the success and learning in the first year of running. This service is designed to provide people diagnosed with dementia the opportunity to receive support and guidance early on in their dementia journey.

Dementia Companions help people living with dementia and their carers plan for their dementia journey and develop ways of coping with the condition as things progress. This is largely aimed at enabling the people living with the condition to live life as well as can be achieved.

As part of the model set out within the Shropshire Dementia Strategy, we have enabled a number of GP based assessment clinics so that people can access help and support in familiar surroundings.

Next steps for development of dementia support will be exploring ways of integrating dementia specific competencies into our developing Out of Hospital model. The dementia ward at Redwoods Hospital reduced its overall bed capacity by providing additional support to people at home, and was able to use these beds as part of 'winter pressures' for people admitted to SATH with confusion, delirium or dementia as the primary cause.

The CCG received an outstanding rating for dementia with 70.2% of the estimated number of people with dementia receiving a recorded diagnosis compared with the national target of 66.7%. In addition, 80% of patients with dementia have had a care plan review in the preceding 12 months which is at the upper end of national performance.

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.

We have also been working on a joint prescribing formulary with our neighbour Telford & Wrekin CCG and our two main Hospital Trusts, SATH and Robert Jones to ensure that we all have the same approach to making the best use of medicines for our patients.

Prescription Ordering Direct (POD)

In June 2017 the CCG launched the pilot Prescription Ordering Direct (POD) service in five practices; for patients to order their repeat medication. Following the successful pilot this has been widely rolled out in 2018 and now covers 17 practices with around 25,000 patients using this service to order their repeat prescriptions each month. Where previously the ordering of repeat medication was managed by the GP surgery or the Community Pharmacy, POD is a dedicated telephone line that patients ring to speak to a trained call-handler who will discuss the patient's prescription needs to ensure that they only order the medication that they need when they need it. This helps to reduce the amount of prescription waste. POD has saved over £1 million in 2018/19 which will be reinvested in new medicines and patient care.

Since POD was launched, we have had several positive comments from patients using the service; here are just a few of them:

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. Subsequently, the Medicines Management Team has developed a number of resources to support patients in safely self-managing simple conditions such as coughs and colds, sore throats and simple upset stomachs with medicines that can be bought at their local pharmacy. In November 2018 as part of SelfCare Week the team ran a patient awareness campaign in a number of supermarkets across Shropshire.

Shropshire CCG spent over £1 million on prescriptions for medicines for minor conditions in 2018/19, which could otherwise be purchased over the counter from a pharmacy. The costs to the NHS for many of the items used to treat minor conditions are often higher than the prices for which they can be purchased over the counter as there are hidden costs such as the costs of your GP appointment and a fee to the pharmacy dispensing a prescription. In many cases, people can take care of their minor conditions if they are provided with the right information; thereby releasing GPs to focus on patients with more complex and/or serious health concerns. Our aim is to continue to educate patients on self-care and encourage practices and pharmacy to promote self-care.

Antibiotic Stewardship

Antimicrobial resistance is a national and global threat to health as no new antibiotics have been developed in the past 30 years and increasing bacterial resistance to those antibiotics in current use means infections are becoming harder to treat. There are currently 25,000 deaths a year in Europe caused by infections that have no effective antibiotic treatment. A key priority for medicines management is to optimise antimicrobial prescribing practice to reduce both inappropriate antibiotic use, and health care associated gram negative blood stream infections. In 2018/19 we have focused on improving antibiotic prescribing across Shropshire in urinary tract infections where we have seen significant improvements in the use of antibiotics.

Care Home Team

The Medicines Care Home Team further expanded this year to include: a Technician Lead, Clinical Pharmacist, three Pharmacy Technicians and a Specialist Dietitian and we are currently in the process of adding two new clinical pharmacists to the team. The team continues to work closely with partner organisations such as the Shropshire Community Health NHS Trust, Shropshire Partners in Care and all of our Shropshire Care Homes to provide education and dissemination of our good quality prescribing messages.

The team's focus is on reviewing prescribing in care homes to both improve well-being and reduce risks of side effects for the residents. The Think Food in Care Homes Pathway promotes a food based approach to treat malnutrition and new hydration guidance has also been developed. The care home lead offers a point of access for care homes and domiciliary care agencies to gain advice and support in medicines management. They also provide RCN accredited training promoting a person-centred approach to medicines and organise an additional rolling programme of training for managers, nurses and healthcare assistants.

Primary Care

During 2018/19, 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 a three-way merger in Whitchurch/Ellesmere between Ellesmere Medical Practice, Bridgewater Medical Practice and Claypit Street Medical Practice to form Churchmere Medical Group, the CCG now has 41 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.

The main focus for 2018/19 has been 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:

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 was to ensure that GP and other clinical appointments were available in the evenings and at weekends. The CCG has worked closely with groups of practices and the Out of Hours provider to enable this to be successfully implemented in the CCG. This has led to additional routine appointments being delivered in numerous locations across the county in the evenings and at weekends. In devising this new service, the CCG engaged widely with our member practices and with our patients through Patient Group meetings and a widely publicised Patient Survey. This engagement helped ensure that our local service was deliverable by our practices and that it met the needs of our patients.

Recent data collections have indicated that utilisation of these appointments have gradually increased over the period October 2018-March 2019 to over 90% for the evening appointments and over 70% for the weekend providers. The CCG is fully compliant with the mandatory parts of the Seven Core Requirements and is working with regional NHS England colleagues to ensure that it implements the other requirements as soon as they become technologically possible.

The CCG has been working with the providers to undertake a further Patient Survey around the extended access service during February and March 2019 and will report the results to Primary Care Commissioning Committee in June 2019.

The Primary Care Team has been 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 ten fellowships for trainee and newly-qualified doctors, the provision of a series of retention workshops for GPs, the development of a GP locum support framework, the funding of a Physicians Associate Internship scheme and significant investment in training and upskilling for nurses and health care assistants. In addition the Primary Care Team is working very closely with the record number of GP trainees to ensure that, as far as possible; as many of these remain in the area once they are qualified. The key upcoming workforce challenge is to support 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. The CCG's Quality Team has also been pivotal in driving the delivery of the ten point nursing action plan as part of the collaborative working.

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 2018/19, 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 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 2019 and 2020 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; 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.

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 2018 the national GP Patient Survey reported that practices in Shropshire had higher than average patient satisfaction rates with an overall rating of 89% (the same as 2017), with the addition of extended access appointments in October 2018, the CCG is expecting to see an improvement on this in 2019.

The Primary Care Team has again reviewed all of the Locally Commissioned Services that the CCG commissions from practices and which sit outside the main General Medical Services Contract. The recommendations will be implemented in 2019/20.

In the latter half of 2018/19, 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. Delivery of these priorities will be the main focus for 2019/20.

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 2018/19. We have:

- Continued the roll out of the CCG's paperless approach, building on the paperless Governing Body and Committees introduced in 2017/18
- Participated in the development of and signing a local Social Value Charter with other local public sector partners to demonstrate our commitment to local sustainability
- Identified opportunities to reduce car usage; encourage active travel and promote low carbon models of care; encourage the use of remote communication in place of face-to-face meetings and use of flexible working.

Improving quality

Improvement in the quality of services

Quality may be defined as the continuous improvement in effectiveness, experience and safety of health and social care services for the people of Shropshire provided within available resources.

Our commitment to quality is central to the CCG's values and our focus is on continually improving the quality of services and to be alert to the needs of all our population, particularly those who are most vulnerable. Embracing the NHS England 'Sign up to Safety' culture, our focus is on improving quality, safety and the individuals experience of care in all the services we commission, including children's services, mental health and learning disabilities. Our focus is on improving the consistency of care and reducing variability of outcomes.

Patients want to know they are receiving the very best quality of care. To achieve this the CCG utilises several sources of data to triangulate patient safety, patient experience and clinical outcomes.

This work may involve reviewing multiple sources of information received by the CCG such as complaints data, the public voice through events, performance incidents, infection rates, staff levels or other specific investigations. My NHS provides an important source of data that is taken into account when reports are prepared. The Quality Committee made recommendations on the findings of these reviews and oversight of corrective actions. This work is the subsequently reported to the Governing Body.

The CCG commissions services from a number of providers and is associate commissioner, working in partnership with the lead CCG for others. The quality and safety of provided services is assured through quality schedules, commissioning for quality and innovation indicators (CQUIN), monitoring of the quality impact of cost improvement schemes and site visits.

My NHS Data

Provider	Care Quality Commission (CQC) Inspection ratings	A&E performance	Mortality rate (in hospital and up to 30 days after discharge)	Recommended by staff	Percentage of patients waiting less than 18 weeks	Friends and Family Test score: Inpatient
Royal Shrewsbury Hospital	Inadequate	**72.13%** Patients seen within 4 hours	OK Number of deaths within the expected range	OK Within expected range with a value of **59%**	**93%** of patients waiting less than 18 weeks from referral	**97%** Patients recommend this hospital. **609** responses
The Princess Royal Hospital	Inadequate	**72.13%** Patients seen within 4 hours	OK Number of deaths within the expected range	OK Within expected range with a value of **59%**	**93%** of patients waiting less than 18 weeks from referral	**99%** Patients recommend this hospital. **815** responses
The Robert Jones and Agnes Hunt Orthopaedic Hospital	Good	Patients seen within 4 hours	N/A Not available for independent or specialist hospitals	Among the best with a value of **93%**	**90%** of patients waiting less than 18 weeks from referral	**99%** Patients recommend this hospital. **599** responses
Shropshire Community Hospitals: Bridgnorth Hospital Bishops Castle Ludlow Hospitals	N/A No rating	**99.97%** Patients seen within 4 hours	N/A Not available for independent or specialist hospitals	OK Within expected range with a value of **74%**	**95%** of patients waiting less than 18 weeks from referral	N/A No relevant data available
MPFT Redwoods	N/A Not yet rated	N/A No A&E at this hospital	N/A Not available for independent or specialist hospitals	OK Within expected range with a value of **70%**	**98%** of patients waiting less than 18 weeks from referral	N/A No relevant data available
Nuffield Health, Shrewsbury Hospital	Good	N/A No A&E at this hospital	N/A Not available for independent or specialist hospitals	N/A No relevant data available	**90%** of patients waiting less than 18 weeks from referral	**95%** Patients recommend this hospital. **58** responses

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. Further information about the priorities of the Quality Committee and the work it has carried out during 2018/19 can be found in the Governance Statement at page 52.

Transforming Care Partnership (TCP)

NHS England has set out a detailed programme of work to transform care for people with learning disabilities (LD). This guidance is framing our initiatives and those of the wider system.

We have continued to support the Transforming Care Partnership to move people out of inpatient units into accommodation closer to, or at, home. This is a three-year plan to reduce the reliance on hospital beds by 50% across the economy by the end of 2019. Co-production and engagement with families, carers, adults and young people with LD underpins the work being developed.

In 2019 key developments include:

- The implementation of a robust and dynamic risk register and the continued implementation of effective Care and Treatment Review (CTR) and CETR processes, which are keeping children, young people and adults out of secure hospitals
- There is an Enhanced Community Learning Disability (LD) Team, through increase of the Crisis Support Team/ Intensive Support Teams and development of an LD Forensic Support Team
- There has been effective CYP and transition pathway development focusing on prevention and we have been working with the police, social care, education and other health services to identify early those with behaviours which challenge.

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. Shropshire and Telford & Wrekin are the best performing CCGs in Midlands and East, having the lowest number of unallocated cases and the highest number of completed cases. Of the cases reviewed, 58% were considered to have received good or excellent care. Appropriate reasonable adjustments have been made to care, and monitoring from GP's and other services have been repeatedly cited as the reason for this good care. An action plan is in place to address recommendations that have arisen.

Assuring Quality and Safety

The CCG has been instrumental in escalating safety and quality concerns to all its providers to ensure that timely and appropriate action is taken.

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

Concerns and requests for assurance have not only been escalated to the SaTH Executive but to the external regulators via the NHS England Quality Surveillance Group and in other forms of notification. A tripartite meeting took place with the Trust in May 2018, 'Safe Today' calls commenced in July 2018 and a Risk Summit with regulators and the Trust took place in September 2018. The CCG has been proactively engaged and influential in the monthly oversight group which was established by NHS Improvement following the Risk Summit.

In collaboration, the Quality and Safeguarding Teams across Shropshire and Telford & Wrekin CCGs forged closer working relationships with the Trust's Quality and Safeguarding Team and will continue to work as key partners with the Trust, supporting them to improve the quality of their services so they meet the aspirations of both the public and ourselves.

Friends and Family Test

Quality of care includes the compassion, dignity and respect with which patients and service users and their carers are treated. It can only be improved by understanding satisfaction with their experience.

Feedback from the NHS Friends and Family Test (FFT) is therefore very important. The FFT was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed.

Safeguarding Children

The CCG takes safeguarding very seriously. The recent Ofsted/CQC Joint Targeted Area Inspection of the multi-agency response to sexual abuse in the family in Shropshire report published in January 2019 (which can be found on the Ofsted website) stated that:

> "Shropshire CCG senior leaders show strong commitment to improving outcomes for vulnerable children. The governance offers oversight of safeguarding arrangements and the performance of services they commission in provider services. The safeguarding expectations for 2018/19 provider contracts have been further refined to offer increased assurance and a greater level of consistency across the commissioned services".

The report also noted the very clear and strong commitment to improving outcomes for vulnerable children, and that the CCG and two health providers have worked together successfully to establish processes that ensure the availability of background information concerning children referred to the local authority.

The Director of Nursing and Quality and Safeguarding Children Designated Nurse continues to work as part of the Safeguarding Children Board and the Designated Nurse has been part of multi-agency audits that demonstrate good multi-agency working.

There have sadly been a small number of cases that need to be reviewed to understand lessons learned, (serious case reviews and learning reviews). The Designated Nurse has worked with providers to ensure that all serious case review learning is embedded in practice by monitoring services, supervising named nurses, and carrying out inspections.

Looked After Children/Children in Care

We have worked hard with our providers to support a plan to deliver Statutory Health Passports to 16-17yr old care leavers and a plan is in place to support this. The commissioning arrangements of Looked After Children in Shropshire will continue to be reviewed to ensure safe, effective care for this group.

Safeguarding Adults

The CCG and all of our partner agencies in the Keeping Adults Safe in Shropshire Board (KASISB) have maintained the commitment to ensuring that "safeguarding is everyone's business." The CCG does this by working with our providers to try and improve the health services they deliver and when they become aware of concerns about abuse or neglect they talk to the adults about the safeguarding actions needed.

This year KASISB organised a day devoted to exploring how services can support people with issues of self-neglect as we know this is a major cause of harm. We arranged for leading experts to come to Shropshire to share best practice ideas and the video about this, as well as other guidance is available from the Shropshire Adult Safeguarding Board's website.

We have also supported a summit about exploitation so we can better understand problems vulnerable people face with issues ranging from scammers to the growing threat from "county lines" drug based crime in our market towns. This information is also available from the website.

The CCG and its partners have also established a safeguarding forum for our care homes to support the work they do to safeguard their residents and have provided details about new schemes to better understand pressure ulcers and safeguarding, the best use of medicines and related learning - all of which are available on the Shropshire Partners in Care website.

Healthwatch

We have maintained strong links with Healthwatch in Shropshire, the independent consumer champion created to gather and represent the views of the public. A Healthwatch representative has a seat as an observer at our Governing Body and on our Quality Committee and other Healthwatch representatives are involved in project groups to support the review, development and implementation of CCG programmes and projects. Healthwatch provides the CCG with regular patient insight information from their monthly 'Hot Topics' reviews as well as via their Enter and View and Sit and See schemes.

Engaging People and Communities

The views of our patients and wider public are important to us to help us work together to shape existing and future services.

We know that as a CCG we cannot deliver and develop services working in a silo and we need to be pro-active to seek out and listen to the views and feedback from 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 at the CCG is carried out utilising a range of methods and activities, from surveys through to information events, to foster and develop a collaborative approach whereby people are working together.

An open two way dialogue for feedback and ideas from the public we serve, on the services they use and need, is vital for a sustainable health economy.

A key focus this year has been for the CCG to have face-to-face open dialogue and to start conversations with its key stakeholders and the public and this is highlighted in practice below.

Future Fit Consultation

As a result of the major public consultation on the NHS Future Fit Programme on the hospital services at the Royal Shrewsbury Hospital and the Princess Royal Hospital, engagement has been at the fore of CCG business this financial year.

As part of a full consultation, a diverse and wide ranging programme of engagement and involvement activity took place. Some of the highlights included informal pop ups around the County in carefully sourced accessible locations as a means to develop open conversations with the public.

Following on from this were structured touring roadshows covering key topics highlighted by the engagement work with cross-agency representation from partners providing clinical and non-clinical support. Visitors had the opportunity to speak directly to hospital consultants currently delivering services about any concerns or questions they had, not only about the overarching programme, but how it could impact on them. A total of 13 roadshow events were held which were attended by more than 1,000 people.

This was supported by a range of information resources including EASY read and multilingual versions of consultation documents and summary briefings.

Detailed information about the Programme and in particular the consultation can be found on the dedicated NHS Future Fit website.

futurefit
Shaping healthcare together

We presented at **28 council meetings** to more than **260 people**

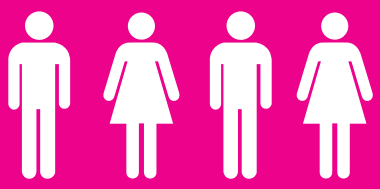
More than **3,100 people** visited our 74 pop-up displays

We consulted for

We held more than **150 meetings with seldom heard groups**

We had more than **24,000 visitors** to our consultation website

Around **900 people** attended our 13 public events



We created a suite of accessible consultation materials, including **Welsh, Easy Read, Large Print** and **screen-reader-friendly**

We received **18,858 responses** - equivalent to more than 3% of the population served by the two hospitals

Engaging with our Stakeholders

We undertook a specific suite of activities for our stakeholders, which not only included our health and social care partners, but stretched across voluntary and third sector organisations. For Future Fit, links were established with the Voluntary and Community Sector Association to help increase reach through a total of 222 meetings. This was an evolving piece of work and was further developed to reach specific interest groups who had tailored engagement for more than 150 meetings.

From this extensive stakeholder mapping exercise, work is continuing to support further engagement work by helping to identify known stakeholders in our area who may be interested in other programmes of work. This work has been invaluable in developing our stakeholder engagement database and resources for utilisation in future programmes.

Care Closer to Home

Co-design has been a key consideration and a principle adopted for the Shropshire Care Closer to Home transformation project. A number of key stakeholder events have been held to look at the different phases of the programme and to help develop models of care with feedback from a cross-section of key stakeholders. This work will be ongoing into 2019/20.

The Midwife-Led Unit Review

Engagement is an ongoing activity for the CCG in relation to this programme of work and as the review moves towards public consultation it has updated stakeholders and discussed with them in an open and transparent way what new models of care could be. This has included briefings, not just for people who have an interest in the service and have used it, but has also included tailored specific engagement work for staff with face-to-face briefings.

Primary Care - Getting the Messages Out

As an important part of local communities across Shropshire, links have been developed with the practice network through the creation of weekly practice newsletters and a monthly GP publication with updates on news from the CCG. Procedures have also been put in place to share important and urgent news across the practices in a timely and appropriate manner.

Ready-to-use resources have also been developed for practices in support of national and local awareness campaigns such as the introduction of 111 in Shropshire where screen savers, information display posters, and web content were supplied to each practice.

Engagement Campaigns

General engagement work has been taking place across the range of CCGs day-to-day activities. This encompasses the CCG's self-care campaign. Each month a designated health topic was featured on seasonal issues, such as hay fever through to common complaints such as head lice, with advice and signposting in conjunction with the Medicines Optimisation Team. This was supported by tailor-made information resources, such as patient information screen displays, which were shared and cascaded across the primary care practices.

The highlight of this campaign was a touring roadshow where the Medicines Optimisation Team visited 15 public venues with pop up displays and information on health tips and advice on how common illnesses can be treated with over the counter medication, as well as general health advice.

Engagement in CCG Governance

From a governance position engagement now has a higher profile in relation to participation and representation of the views of our communities in the CCG's committees, boards and groups. This has been led by the CCG's lay member for patient and public involvement, ensuring it has a high profile on the governing body.

The CCG now has a process in place and guidance for its commissioners on the recruitment of patient representatives, which has successfully generated interest from very strong candidates who have an opportunity to get involved in the work of the CCG. The CCG had broadened its reach in terms of the ways it seeks to engage members of the community.

In addition, the CCG continues its link with Shropshire Patients' Group and hosts its monthly meetings as well as supporting the patient group with regular updates, guest speakers, and newsletter editorial.

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 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. Some examples of where some positive changes have been seen are as follows:

The Prescription Ordering Direct (POD) service enables patients to order repeat prescriptions over the telephone speaking to trained call-handlers at the CCG. The POD scheme was gradually rolled out across Shropshire during the year with most practices continuing to offer the options of dropping off prescriptions in person or ordering them on-line. Some patients choosing to use the POD service did initially experience long waiting times particularly during Monday and Tuesday mornings and contacted the CCG with their concerns.

The CCG responded to these concerns by increasing staff numbers in POD (particularly during peak times) and extending opening hours. These actions have significantly reduced both the call waiting times and the length of time spent on the phone with the call handler. Additionally, an extra broadband line was installed to increase bandwidth capacity.

There has been a gradual reduction during the year of the number of complaints about Continuing Health Care and Complex Care funding. Several long overdue complaints were closed and systems have been put in place by the new Business Manager to prevent similar situations arising. Following feedback from patients and their relatives, the frequency of communication from staff has been increased so that there are regular updates provided for each case.

Should a complainant feel dissatisfied with their response, they are offered the opportunity to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) for independent review. Four cases have been referred to the PHSO during 2018/19. One was rejected and the others are still being considered. A further case referred in 2017/18 is still under investigation. Two other cases referred in 2017/18 were not pursued further by the PHSO during 2017/18. No cases referred to the PHSO during 2018/19 have been upheld.

Patient Advice and Liaison Service

Patients and the public engage with us on a daily basis and contact the CCG through a number of channels on different issues. These are dealt with by our Patient Advice and Liaison Service (PALS) which captures, records, and puts forward resolutions for the complaints, issues and comments it receives.

Patient Experience

During 2018/19, we received:

- Complaints - 128
- MP Letters - 64
- Patient Advice and Liaison Service (PALS) Enquiries - 279

A total of 475 Insight issues have been recorded

Focus on Patient Experience

Patient stories presented at our public Governing Body meetings provide valuable insight into the experiences of patients and also allow Governing Body Members to reflect on ways in which we are able to influence improvements in services.

In April 2018 the Governing Body heard about an elderly residential patient accessing phlebotomy and out of hospital services. This resident, in her 90's had severe learning disabilities, was profoundly deaf, unable to communicate verbally and could not walk due to a deterioration in her hip joints.

Consideration of the case was facilitated by the CCG's Lay Member for Patient and Public Involvement and highlighted how, despite the best intentions of the GP, in terms of clinical effectiveness and patient safety, access to services had become fragmented with the resultant negative impact for all concerned.

The Governing Body was asked to reflect on its level of influence to ensure that services were commissioned to meet the needs of all service users in an efficient, timely and caring patient centred way, to avoid the potential for poor patient/carer experience as highlighted in this account. The Governing Body was also asked to support the approach of routinely seeking and considering patient experience feedback as an integral part of any service re-design.

In March 2019 the Governing Body considered the issue of frailty and in particular reviewed a film specially commissioned by NHS England featuring the newly developed Frailty Intervention Team. The film focuses on the input of the team to Roy and his family and the impact it has had.

Roy is 90 and lives with his wife Doreen, who is 83. After falling whilst gardening and breaking his hip, Roy's mobility became very limited. He also suffers from Chronic Obstructive Pulmonary Disease (COPD) and is prone to numerous chest infections.

Being regularly admitted to hospital, Roy's daughter, Jayne, noticed that both his health and his mood had deteriorated.

"He wasn't getting any better at all and dad's mood was really low." says Jayne. **"It was really quite distressing to see his mood drop in the way that it did."**

The newly developed Frailty Intervention Team were able to step in and assist Roy and his family as part of the CCG's Care Closer to Home programme.

The Frailty Intervention Team became involved with Roy's care after he fell down the stairs at home. They visited him in hospital and have been supporting Roy in his home.

The team's remit of supporting people in their own home, involves managing long term conditions, prescribing, and applying advanced clinical practice, so that they can assess patients much more quickly.

Now, thanks to the team's involvement, Roy is treated at home instead of being admitted to hospital.

"It was fantastic to see the council and the NHS working together and joining up their efforts for the benefit of dad's health and wellbeing," said Jayne.

The urgent need to help avoid hospital admissions and provide care at home, or closer to home, led to the creation of the Frailty Intervention Team. Based next to the Emergency Department at the Royal Shrewsbury Hospital, and run by SaTH, the team is dedicated to frailty, and comprises social workers, a consultant geriatrician, specialist interest GPs, a community matron, nurses, physios and occupational therapists. Bringing together health and social care professionals means the Shropshire Community Health NHS Trust and Shropshire Council are also part of this exciting new approach.

Clinicians can more easily access and speak to each other, discuss patients and get them seen really quickly, which makes a huge difference. When a patient is discharged from hospital, they are usually seen within 48 hours of returning home and plans can be put in place to support them long term if needed, and make sure they are safe.

Roy's touching story, and the reduction in his hospital stays through this Care Closer to Home approach, shows that the CCG can successfully re-design its services for the benefit of patients.

Individual Funding Process – Support for Patients

We recognise that there will be times when a patient's needs cannot be met through existing commissioned services, so we have arrangements in place to consider these on an individual basis.

During 2018/19, a total of 101 such requests were considered by our Individual Funding Review panel, with patients offered a level of support, engagement and involvement to guide them through the process. The rationale of any decision taken must be reasonable, transparent and clearly defined and, aligned to these principles, a total of 22 requests were approved, 59 were not approved, and 20 are currently pending (awaiting further information and review).

Reducing Health Inequalities

We acknowledge the need to ensure that the most vulnerable groups have access to high quality services and we are committed to reducing health inequalities for our population. Shropshire CCG is committed to ensuring the population it serves is engaged in the design of the services commissioned.

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

Similarly, 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.

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.

The counties local Joint Strategic Needs Assessment is an important tool to inform this, and other elements of CCG work, as it enables us 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 early 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 fore front 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.

2018-19 has seen an 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 to 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, set out earlier in this report, demonstrates the CCG's approach 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 Midwifery-Led Unit Review and Shropshire Care Closer to Home.

Further details of this work can be found on the NHS Future Fit website.

Health and Wellbeing Strategy

Shropshire CCG is an active member of the local Health and Wellbeing Board (HWB). 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 neighbouring CCGs, the Health and Wellbeing Board, local authorities, local providers and, most importantly, local people and communities.

The Shropshire Better Care Fund has been a key enabler in the delivery and support of the joint working approach. As a health and social care community, Shropshire is moving forward at pace to ensure the best health and social care for our population

Accountability Report

Corporate Governance Report

Members' Report

Member profiles

Our CCG consists of 41 GP member practices that are working together to ensure the local population has high quality and sustainable healthcare services.

Member practices

1.	Marysville Medical Practice	22.	Albrighton Medical Practice
2.	Much Wenlock & Cressage Medical Practice	23.	Alveley Medical Practice
3.	Mytton Oak Medical Practice	24.	Belvidere Medical Practice
4.	Plas Ffynnon Medical Centre	25.	Bishops Castle Medical Practice
5.	Pontesbury Medical Practice	26.	Bridgnorth Medical Practice
6.	Portcullis Surgery	27.	Broseley Medical Practice
7.	Prescott Surgery	28.	Brown Clee Medical Practice
8.	Radbrook Green Surgery	29.	Cambrian Medical Centre
9.	Riverside Medical Practice	30.	Churchmere Medical Group
10.	Severn Fields Medical Practice	31.	Church Stretton Medical Practice
11.	Shawbury Medical Practice	32.	Claremont Bank Surgery
12.	Shifnal and Priorslee Medical Practice	33.	Cleobury Mortimer Medical Centre
13.	South Hermitage Surgery	34.	Clive Medical Practice
14.	Station Drive Surgery	35.	Craven Arms Medical Practice
15.	The Beeches Medical Practice	36.	Dodington Surgery
16.	The Caxton Surgery	37.	Drayton Medical Practice
17.	The Meadows Medical Practice	38.	Highley Medical Centre
18.	Wem and Prees Medical Practice	39.	Hodnet Medical Centre
19.	Westbury Medical Centre	40.	Knockin Medical Centre
20.	Whitehall Medical Practice	41.	Marden Medical Practice
21.	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.

As of 31, March 2019, the make-up of our Governing Body was as follows:

Dr Julian Povey – Chair
Mr William Hutton – Lay Member for Governance & Audit, Vice Chair
Dr Simon Freeman – Accountable Officer
Mrs Claire Skidmore – Chief Finance Officer and Deputy Accountable Officer
Dr Stephen James – GP Member
Dr Jessica Sokolov – Medical Director
Dr Finola Lynch – GP Member, Deputy Clinical Chair
Dr John Pepper – GP Member
Dr Priya George – 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
Mrs Nicky Wilde – Director of Primary Care
Ms Dawn Clarke – Director of Nursing, Quality and Patient Experience
Mrs Gail Fortes Mayer – Director of Planning and Contracting
Mrs Sam Tilley – Director of Corporate Affairs
Mr Keith Timmis – Lay Member for Performance
Mrs Sarah Porter – Lay Member for Transformation
Mr Meredith Vivian – Lay Member for Patient and Public Involvement
Professor Rod Thomson– Director of Public Health

The remuneration report contains details on all Governing Body Members in post during the 2018/19 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 2018/19, 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

During 2018/19, there was only 1 information governance incident reported, which following risk assessment, was deemed to be a non-reportable breach. There have been 0 breaches that were reportable to the ICO.

Further information regarding the CCG's approach to Information Governance is set out on page 83.

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 Stout to be the Accountable Officer of NHS Shropshire CCG from 1 April 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 2018/19, 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 arrangements 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 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 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 judgments required for determining that it is fair, balanced and understandable

David Stout
Interim Accountable Officer

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 2018/19. 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 focus 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:

- The organisation has maintained a stable Executive team and has been able to develop the position of Medical Director to ensure clinical input at an Executive level.
- The Governing Body has maintained both its Clinical and Lay Member input and during Q4 of 2018/19 undertook an independent effectiveness review to inform future practice.
- The CCG has reviewed and updated its Constitution to reflect improvements it has made to the way that it operates and to ensure it is operating in accordance with the latest NHS England guidance and best practice corporate governance.
- The CCG's finance function has been reviewed and a new team structure recruited to which provides sufficient capacity and capability to deliver a robust and strategic finance service. In particular this year we have worked to implement the recommendations made by Price Waterhouse Coopers in their review at the end of the previous financial year and we have made improvements in financial governance, systems and processes. Shropshire CCG has worked with Telford & Wrekin CCG to support the implementation of the Future Fit acute hospital reconfiguration programme. During 2018/19, following an extensive public consultation, a decision has been reached regarding a preferred option for service delivery. We are also pleased that Shrewsbury and Telford Hospital NHS Trust have been awarded £312m to support this development from the Treasury.
- The CCG continues to develop a number of key commissioning plans including a review of Midwifery Led Units and the development of the Shropshire Care Closer to Home programme.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS Shropshire 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.

David Stout
Interim Accountable Officer

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.

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states:
The main function of the Governing Body is to ensure that the CCG has made appropriate arrangements for ensuring that it 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. 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.

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 2018/19 the CCG has reviewed and updated its constitution to ensure it continues to reflect best governance practice.

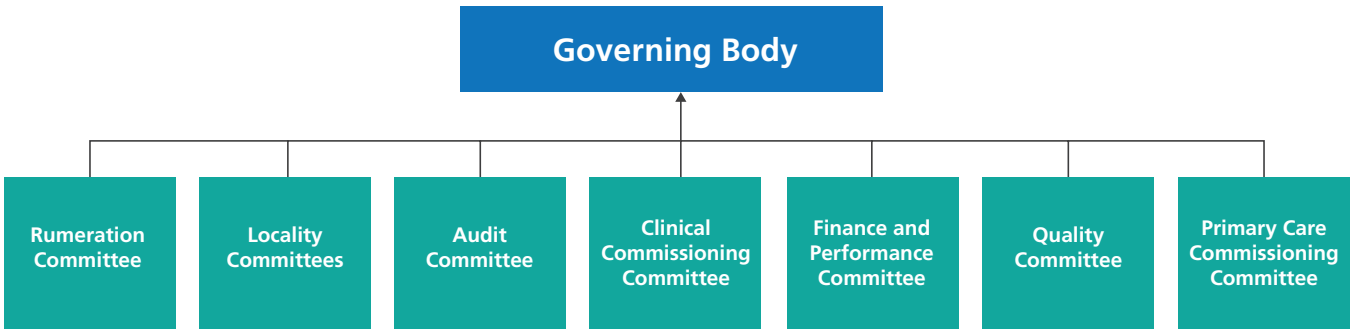
The CCG's Scheme of Reservation and Delegation sets out how the decision-making responsibilities of the CCG are shared between the membership and the Governing Body and its various committees.

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.

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 2018/19. 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 2018/19 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 2018/19 is set out below:

Name	Title	Attendance
Dr. Julian Povey	Chair	9 of 10
Dr. Simon Freeman	Accountable Officer	9 of 10
Dr. Finola Lynch	GP Member	8 of 10
Dr. Steve James	GP Member	6 of 10
Dr. Jessica Sokolov	Medical Director	7 of 10
Mr. Kevin Morris	Practice Representative	9 of 10
Dr. Tim Lyttle	Locality Chair (North) (ceased in post 4 October 2018)	5 of 6
Dr. Shailendra Allen	Locality Chair (South) (ceased in post 1 August 2018)	3 of 4
Dr. Deborah Shepherd	Locality Chair (Shrewsbury and Atcham)	9 of 10
Mrs. Claire Skidmore	Chief Finance Officer and Deputy Accountable Officer	10 of 10
Dr. Julie Davies	Director of Performance and Delivery	9 of 10
Mrs. Samantha Tilley	Director of Corporate Affairs	9 of 10
Ms. Dawn Clarke	Director of Nursing Quality and Patient Experience	8 of 10
Mrs. Nicky Wilde	Director of Primary Care	7 of 10
Mrs. Gail Fortes Mayer	Director of Contracting and Planning	9 of 10
Professor Rod Thomson	Director of Public Health	8 of 10
Mr. William Hutton	Lay Member – Governance and Audit	10 of 10
Mr. Keith Timmis	Lay Member – Audit	10 of 10
Mrs. Sarah Porter	Lay Member for Transformation	9 of 10
Mr. Meredith Vivian	Lay Member for Public and Patient Involvement	9 of 10
Dr. Ed Rysdale	Secondary Care Clinical Member (ceased in post 30 September 2018)	5 of 6
Dr. Alan Leaman	Secondary Care Consultant (commenced in post 1 January 2019)	2 of 2
Dr. John Pepper	GP Member	10 of 10
Dr. Matthew Bird	Locality Chair (South) (commenced in post 1 January 2019)	2 of 2
Dr. Michael Matthee	Joint Locality Chair (North) (commenced in post 1 January 2019)	2 of 2
Dr. Priya George	GP Member (commenced in post 1 February 2019)	1 of 1
Observers		
Mr. Graham Shepherd	Observer - Shropshire Patient Group	9 of 10
Mrs. Jane Randall-Smith Ms. Vanessa Barrett Ms. Lynn Cawley	Observer - HealthWatch Shropshire	7 of 10
Mr. Jonathan Bletcher	NHS England Representative	7 of 10
Mrs. Samantha Bunyan	Head of Quality and Safety	1 of 1
Mr. David Stout	Incoming Interim Accountable Officer	1 of 1

The Governing Body held meetings in public throughout 2018/19, moving from monthly meetings to bi-monthly meetings in public from November 2018. Public attendance at the meetings has been encouraging, indicating a high level of local interest in the work of the CCG. The CCG has also commenced live streaming each of its public meetings during 2018/19.

As set out in the introduction, during 2018/19 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 2018/19 with a full complement of Governing Body Members.

Locality Committees

The CCG is a membership organisation, comprising the 41 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 their Practice Manager to represent the practice in all matters considered at the Locality Committee and to vote on decisions, when required. Whilst 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	4 of 7
Mr. Nicholas Storey	Practice Manager		7 of 7
Dr. TW Lyttle	General Practitioner	Churchmere Medical Group	7 of 7
Ms. Jenny Davies	Practice Manager		5 of 7
Dr. G Davies / Dr A Ayers	General Practitioner	Clive	6 of 7
Mrs. Zoe Bishop	Practice Manager		0 of 7
Dr. N Raichura	General Practitioner	Hodnet	5 of 7
Mrs. Christine Charlesworth	Practice Manager		4 of 7

Name	Title	Medical Practice	Attendance
Dr. J Davies	General Practitioner	Knockin	4 of 7
Mrs. Mary Herbert	Practice Manager		6 of 7
Dr. M Matthee (Co-Chair)	General Practitioner	Market Drayton	7 of 7
Mrs. Michele Matthee	Practice Manager		6 of 7
Dr. S Eslava / Dr G Ahmad	General Practitioner	Oswestry - Cambrian	4 of 7
Mr. K Morris	Practice Manager		5 of 7
Dr. S Lachowicz	General Practitioner	Oswestry - Caxton	6 of 7
Mr. James Bradbury	Practice Manager		7 of 7
Dr. Y Vibhishanan	General Practitioner	Oswestry - Plas Ffynnon	7 of 7
Ms. Sarah Williams	Practice Manager		7 of 7
Dr. A C W Clark	General Practitioner	Shawbury	6 of 7
Ms. Jane Coles / Joanne Clark	Practice Manager		1 of 7
Dr. C Rogers	General Practitioner	Wem / Prees	5 of 7
Mr. Richard Birkenhead	Practice Manager		7 of 7
Dr. K Lewis (Co-Chair)	General Practitioner	Westbury	6 of 7
Mrs. Helen Bowkett	Practice Manager		2 of 7
Dr. R Clayton	General Practitioner	Whitchurch – Dodington	5 of 7
Mrs. Elaine Ashley	Practice Manager		6 of 7
Mrs. Janet Gittins / Tom Brettell	Locality Manager	Shropshire CCG	7 of 7
Mrs. Sandra Stackhouse / Miss Heather Clark	Minute Recorder		7 of 7
Shrewsbury and Atcham Locality Committee			
Dr. D Shepherd (Chair)	General Practitioner	Locum GP	7 of 7
Dr. J Pepper	General Practitioner	Belvidere	7 of 7
Ms. Caroline Davis	Practice Manager		6 of 7
Dr. M Fallon	General Practitioner	Claremont Bank	5 of 7
Ms. Jane Read / Emily Marston	Practice Manager		5 of 7
Dr. E Baines	General Practitioner	Marden	7 of 7
Mrs. Zoe George	Practice Manager		7 of 7
Dr. J Visick / Dr. P Hine	General Practitioner	Marysville	7 of 7
Mrs. Izzy Culliss	Practice Manager		7 of 7
Dr. S Watton	General Practitioner	Mytton Oak	4 of 7
Mr. Adrian Kirsop	Practice Manager		7 of 7
Dr. R Bland	General Practitioner	Pontesbury	6 of 7
Ms. Heather Brown	Practice Manager		2 of 7
Dr. N Russell / Dr. H Callahan / Dr. B Roberts	General Practitioner	Radbrook Green	7 of 7
Ms. Angela Treherne	Practice Manager		1 of 7
Dr. D Clesham / Dr. P Rwezaura	General Practitioner	Riverside	5 of 7
Ms. Tracy Willocks (Vice Chair)	Practice Manager		6 of 7
Dr. D Martin	General Practitioner	Severn Fields	6 of 7
Mr. Tim Bellett	Practice Manager		3 of 7

Name	Title	Medical Practice	Attendance
Dr L Davis	General Practitioner	South Hermitage	7 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 / Ms. H Steel	Practice Manager		3 of 7
Ms. Joanne Beason	Practice Manager	Whitehall - Malling Health	7 of 7
Dr. K McCormack	General Practitioner	Worthen	4 of 7
Ms. Cheryl Brierley	Practice Manager		0 of 7
Mrs. Jenny Stevenson	Locality Manager	Shropshire CCG	7 of 7
Mrs. Sandra Stackhouse / Miss Heather Clark	Minute Recorder		7 of 7
South Locality Committee			
Dr. M Bird (Chair)	General Practitioner	Albrighton	7 of 7
Ms. Val Eastup	Practice Manager		6 of 7
Dr. D Abbotts	General Practitioner	Alveley	2 of 7
Mrs. Lindsey Clark	Practice Manager		4 of 7
Dr. A Penney	General Practitioner	Bishop's Castle	7 of 7
Ms. Sarah Bevan	Practice Manager		0 of 7
Dr. S Wright / Dr. G Potter	General Practitioner	Bridgnorth	6 of 7
Mrs. Sandra Sutton / Dude Newell	Practice Manager		5 of 7
Dr. M Babu	General Practitioner	Broseley	6 of 7
Ms. Nina Wakenell	Practice Manager		7 of 7
Dr. W Bassett	General Practitioner	Brown Clee	5 of 7
Ms. Vicki Brassington	Practice Manager		0 of 7
Dr. A Chamberlain	General Practitioner	Church Stretton	4 of 7
Ms. Emma Kay	Practice Manager		5 of 7
Dr. P Thompson / Dr. A Allsop	General Practitioner	Cleobury Mortimer	7 of 7
Mr. Mark Dodds	Practice Manager		4 of 7
Dr. J Bennett	General Practitioner	Clun	7 of 7
Mr. Peter Allen	Practice Manager		6 of 7
Dr. D Appleby	General Practitioner	Craven Arms	5 of 7
Mrs. Susan Mellor-Palmer	Practice Manager		7 of 7
Dr. S Allen	General Practitioner	Highley	4 of 7
Ms. Theresa Dolman / Mr. S Consul	Practice Manager		3 of 7
Dr. C Beanland	General Practitioner	Ludlow – Portcullis	6 of 7
Mrs. Rachel Shields	Practice Manager		6 of 7
Dr. G Cook	General Practitioner	Ludlow – Station Drive	2 of 7
Dr. J Bailey	General Practitioner	Much Wenlock & Cressage	5 of 7
Mrs. Sarah Hope	Practice Manager		5 of 7
Dr. P Leigh / Dr. M Brinkley / Dr. R Shore	General Practitioner	Shifnal & Priorslee	5 of 7
Ms. Sheila MacLucas	Practice Manager		1 of 7
Mr. Tom Brettell / Jenny Stevenson	Locality Manager	Shropshire CCG	7 of 7
Mrs. Sandra Stackhouse / Miss Heather Clark	Minute Recorder		7 of 7

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:

- Financial plan/QIPP
- Future Fit
- Shropshire Care Closer to Home – including the appointment of additional GP representatives to give more detailed input into this important programme of work
- Commissioning intentions
- Cardiology pathways
- Paediatric asthma pathways
- Maternity services
- Public health nursing
- Mental health and the BeeU service
- Musculoskeletal services including physiotherapy
- Prescribing updates
- Cross border issues

Significant developments this year have been changes in the chairmanship of the localities: the Chairs of both the North and South localities resigned in Summer 2018. New chairs have been elected: Drs Michael Matthee and Katy Lewis are joint Chairs for the North locality, and Dr. Matthew Bird is Chair for the South locality. Dr. Deborah Shepherd continues as Chair of the Shrewsbury and Atcham locality.

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 2018-2019, 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 scrutinised
- 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
Mrs. Dawn Clarke	Director of Nursing, Quality and Patient Experience	9 of 11
Mrs. Sara Bailey	Lead Nurse for Quality and Safety (ceased on post 31 July 2018)	1 of 3
Mrs. Samantha Bunyan	Head of Quality (commenced in post 26 November 2018)	4 of 5
Dr. Julie Davies	Director of Performance and Delivery	8 of 11
Dr. Jessica Sokolov	GP Member/ Medical Director	6 of 11
Dr. Ed Rysdale	Secondary Care Consultant (ceased in post 30 September 2018)	2 of 5
Dr. Alan Leaman	Secondary Care Clinician (commenced in post 1 January 2019)	3 of 3
Dr. Finola Lynch	GP Member	6 of 11
Mr. Meredith Vivian	Lay Member for Patient and Public Involvement	10 of 11
Mr. Keith Timmis	Lay Member for Performance	11 of 11
Mrs. Sarah Porter	Lay Member for Transformation	10 of 11
Observers		
Jayne Randall Smith Rachael Allen Lynn Cawley	Shropshire Healthwatch	3 of 4 1 of 1 4 of 6

Key Achievements/Areas of Focus for the Quality Committee

Serious Incidents

In 2018, the Quality Committee reviewed and ratified the Serious Incident Policy. This clarifies and improves the process of reviewing serious incidents, allowing better communication and understanding of providers' challenges, while working with them to resolve issues and improve care and quality.

Infection Prevention and Control

Reducing and preventing healthcare associated infections is fundamental to the safety and quality of care delivered to patients, and remains a high priority for Shropshire Clinical Commissioning Group.

This year Shropshire CCG was instrumental in developing the Shropshire and Telford Infection Prevention and Control Strategy (2018-21). The strategy provides a platform from which to ensure a whole-systems approach is taken to reducing the risk of healthcare associated infection.

Working collaboratively with partners throughout the year to maintain the low levels of Methicillin Resistant Staphylococcus Aureus (MRSA) blood stream infection and Clostridium Difficile infection. As a health community, robust root cause analysis has been applied to all cases and learning identified and disseminated to mitigate against reoccurrence.

The Infection Prevention and Control work programme within Primary Care and Nursing Homes was reviewed and re-prioritised.

Quality visits in care homes

Working in partnership with the 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 services care homes are providing.

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. Shropshire and Telford & Wrekin are the best performing CCGs in Midlands and East, having the lowest number of unallocated case and the highest number of completed cases. Of the cases reviewed, 58% were considered to have received good or excellent care. Appropriate reasonable adjustments being made to care and monitoring from GPs and other services have been repeatedly cited as the reason for this good care. An action plan is in place to address recommendations that have arisen.

Assuring Quality and Safety

The CCG has been instrumental in escalating safety and quality concerns to all its providers to ensure that timely and appropriate action is taken.

In light of serious safety concerns emerging at Shrewsbury and Telford Hospitals NHS Trust the Quality Committee have continuously sought reassurance that policies, practices and systems are in place and are being implemented.

Concerns and requests for assurance have not only been escalated to the SaTH Executive but to the external regulators via the NHS England Quality Surveillance Group and in other forms of notification. A tripartite meeting took place with the Trust in May 2018, 'Safe Today' calls commenced in July 2018 and a Risk Summit with regulators and the Trust took place in September 2018. The CCG has been proactively engaged and influential in the monthly oversight group which was established by NHS Improvement following the Risk Summit.

The Quality and Safeguarding Team, in collaboration with Telford & Wrekin CCG Quality and Safeguarding Team has forged closer working relationships with the Trust's Quality and Safeguarding Team and will continue to work as key partners with the Trust, supporting them to improve the quality of their services so they meet the aspirations of both the public and ourselves.

Safeguarding Children

The CCG takes safeguarding very seriously. The recent Ofsted/CQC Joint Targeted Area Inspection of the multi-agency response to sexual abuse in the family in Shropshire report published in January 2019 on the Ofsted website stated that:

> 'Shropshire CCG senior leaders show strong commitment to improving outcomes for vulnerable children. The governance offers oversight of safeguarding arrangements and the performance of services they commission in provider services. The safeguarding expectations for 2018/19 provider contracts have been further refined to offer increased assurance and a greater level of consistency across the commissioned services'.

The report also noted the very clear and strong commitment to improving outcomes for vulnerable children, and that the CCG and two health providers have worked together successfully to establish processes that ensure the availability of background information concerning children referred to the local authority.

The Director of Nursing and Quality and Safeguarding Children Designated Nurse continues to work as part of the safeguarding children safeguarding board and the Designated Nurse has been part of multi-agency audits that demonstrate good multi-agency working.

There have sadly been cases that need to be reviewed to understand lessons learned, (serious case reviews and learning reviews). The Designated Nurse has worked with providers to ensure that all serious case review learning is embedded in practice by monitoring services, supervising named nurses and carrying out inspections.

Looked After Children/Children in Care

We have worked hard with our providers to support a plan to deliver Statutory Health Passports to 16-17yr old care leavers and a plan is in place to support this. The commissioning arrangements of Looked After Children in Shropshire will continue to be reviewed to ensure safe, effective care for this group.

Safeguarding Adults

The CCG and all of our partner agencies in the Keeping Adults Safe in Shropshire Board (KASISB) have maintained the commitment to ensuring that "safeguarding is everyone's business." The CCG does this by working with our providers to try and improve the health services they deliver and when they become aware of concerns about abuse or neglect they talk to the adults about the safeguarding actions needed.

This year KASISB have scrutinise a day devoted to exploring how services can support people with issues of self-neglect as we know this is a major cause of harm. We arranged for leading experts to come to Shropshire to share best practice ideas and the video about this and other guidance is available from the Shropshire Adult Safeguarding Board's website.

We have also supported a summit about exploitation so we can better understand problems vulnerable people face with issues ranging from scammers to the growing threat from "county lines" drug based crime in our market towns. This information is also available from the website.

The CCG and its partners have also established a safeguarding forum for our care homes to support the work they do to safeguard their residents and have provided details about new schemes to better understand pressure ulcers and safeguarding, the best use of medicines and related learning- all of which is available from the Shropshire Partners in Care website.

Future planning for 2019-2020

Our values underpin equality, diversity and human rights as central to our service planning, employment practices and community engagement and involvement. The quality agenda is complex and far reaching and it must be scrutinised so that there are constraints which will need to be overcome. So it will be "how can it be done?" not "it cannot be achieved without additional resources."

To achieve this, we are currently reviewing and updating the 2018-2019 Quality Strategy and Delivery Plan to reflect the NHS England Long Term Plan and local changing priorities and quality risks in the system

Finance and Performance Committee

The Finance and Performance Committee scrutinises the CCG's financial plans and decisions, including reviewing monthly financial performance and identifying key issues and risks. The Committee oversees the delivery of Quality, Innovation, Productivity and Prevention (QIPP). It also 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
Mr. Keith Timmis	Lay Member – Performance	11 of 12
Mr. William Hutton	Lay Member – Audit	10 of 12
Mrs. Claire Skidmore	Chief Finance Officer and Deputy Accountable Officer	10 of 12
Dr. Julie Davies	Director of Performance and Delivery	10 of 12
Mrs. Gail Fortes-Mayer	Director of Contracting and Planning	5 of 7
Mr. Kevin Morris	GP Board Representative	10 of 12
Dr. Jessica Sokolov	Medical Director	7 of 9
Mr. Meredith Vivian	Lay Member – Patient and Public Involvement	9 of 12
Mrs. Sarah Porter	Lay Member for Transformation	10 of 12
Dr. Michael Matthee	North Locality Chair (North)	3 of 3

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.

Key Achievements / Areas of Work

The CCG's financial position has continued to be the main focus of the Finance and Performance Committee in 2018/19. The annual budget was agreed in May 2018 after a series of detailed discussions at the Committee and Governing Body. There was a high level of concern because members considered the control total for the year to be extremely challenging and expressed sceptiscism that it would be achieved.

The CCG has been in financial recovery for a number of years and each succeeding year it becomes more challenging to find sufficient new schemes to deliver savings or efficiencies that will bring us back to financial balance. The year commenced with limited flexibility in our reserves and therefore limited scope to deal with any adverse variance in activity from the levels included in the budget and contract plans.

The Committee has reviewed financial performance closely each month during the year, with a particular focus on the level of risk underpinning the year-end forecast. Although there have been improvements to the financial reports received by the Committee and Governing Body, the Finance and Performance Committee continues to seek further assurances about the assumptions and explanations for the forecasts. We have faced significant cost pressures, in particular from higher levels of activity from the acute providers and also the West Midlands Ambulance Trust. The increased activity for the Robert Jones and Agnes Hunt Hospital is also a concern as benchmarking information continues to show us that the level of orthopaedic work in Shropshire is significantly higher than expected, even taking into account the age of our population.

Our savings schemes have continued to deliver impressive results, but again we have failed to meet the target set for the year. The Committee has questioned the planning assumptions for schemes and the management processes that seek to deliver the work. A member of the Finance and Performance Committee has chaired the QIPP Programme Board this year to provide greater direct scrutiny of the processes and to provide additional challenge to the review of each scheme. There has also been significant additional staffing during the year focused on delivering QIPP. This resource is not available in the forthcoming year and the Committee has raised its concerns about the CCG's capacity, in terms of the number and skills of staff available, to continue to do the work to deliver a health service that is viable in the medium term.

Some of the greatest potential savings depend on bigger decisions at the STP level. The new independent chair of the STP has begun this process, but in the short term the CCG will continue to need to identify even higher levels of savings than we have achieved in recent years.

In addition to the financial issues, the Committee has viewed with concern the deterioration in a number of the key performance measures we are judged on. As in previous years, the data on A&E has been the main concern, with no evidence that the long-term deterioration in the four hour target will be stopped. A range of interventions and some positive news of consultant recruitment has been welcome, but the performance continues to be not only poor but among the lowest in the country. In addition to this, the Committee received regular reports on the deterioration in many of the cancer indicators. There have been significant problems in diagnostic performance, although the latest reports suggest the action plans put in place are turning this round.

The outlook for the 2019/20 year looks to be at least as challenging as 2018/19. Draft budget figures indicate an even larger gap between our resources and likely expenditure that will leave us with a much larger savings' target. The Committee will also be seeking assurance that we will finally see successful action on our performance challenges, particularly in A&E.

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 County 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
Mrs Sarah Porter	Lay Member for Transformation	11 of 12
Dr. Julie Davies	Director of Performance and Delivery	10 of 12
Mrs. Gail Fortes-Mayer	Director of Planning and Contracting	4 of 12
Dr. Simon Freeman	Accountable Officer	2 of 12
Dr. Steve James	GP Board Member	9 of 12
Dr. Julian Povey	CCG Chair	8 of 12
Dr. Ed Rysdale	Secondary Care Consultant (ceased on post 30 September 2018)	5 of 6
Dr. Alan Leaman	Secondary Care Clinician (commenced in post 1 January 2019)	2 of 3
Prof. Rod Thomson	Director of Public Health	3 of 12
Dr. Shailendra Allen	Locality Chair (South) (ceased on post 1 August 2018)	2 of 4
Dr. Tim Lyttle	Locality Chair (North) (ceased in post 4 October 2018)	4 of 6
Mrs. Claire Skidmore	Chief Finance Officer and Deputy Accountable Officer	1 of 12
Ms. Dawn Clarke	Director of Nursing, Quality and Patient Experience	6 of 12
Mr. Kevin Morris	Practice Representative	8 of 12
Dr. Finola Lynch	GP Member	8 of 12

Name	Title	Attendance
Dr Deborah Shepherd	Locality Chair (Shrewsbury and Atcham)	8 of 12
Dr. Jessica Sokolov	Medical Director	7 of 12
Mr. Meredith Vivian	Lay Member Patient and Public Involvement	10 of 12
Mrs. Nicky Wilde	Director of Primary Care	7 of 12
Dr. John Pepper	GP Member	6 of 12
Dr. Michael Matthee	Locality Chair (North) (commenced in post 1 January 2019)	1 of 3
Dr. Matthew Bird	Locality Chair (South) (commenced in post 1 January 2019)	1 of 3
Dr. Priya George	GP Member (commenced in post 1 February 2019)	1 of 2

Key achievements/areas of work

During 2018/19, the Clinical Commissioning Committee considered the following areas and provided recommendations on actions to the Governing Body:

- A number of areas of service review and development to help to address the financial and sustainability challenges faced including Optometry and Dermatology
- Adoption of National Guidelines for Self-Care
- Progress on reviewing and revising policy documents including Value Based Commissioning, IVF and Stoma
- Progress on all areas of the Shropshire Care Closer to Home programme including the establishment of an Alliance Agreement
- Revised service specification and Key Performance Indicators for Care Co-ordination Centre
- Support for Vulnerable Persons Resettlement Programme
- Develop arrangements for Urgent Treatment Centres
- Develop new pathways including Primary Care Headache Pathway and Physiotherapy Referral Pathway
- Local Transformation Plan for Children and Young People revised and published on website
- Commissioning of autism assessment service in Shropshire
- Commissioned new service for Menorrhagia Management as additional Locally Commissioned Service
- Agreed plan for Prescribing Development Scheme with targets over 3 years
- Development of Cancer Transformation Programme and refresh of Cancer Services Strategy
- Development of Individual Placement and Support scheme
- Continue to review the new MSK model of care including the service specification for Shropshire Orthopaedic Outreach Service.

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 Clinical Commissioning Group and the key duties of the Audit Committee broadly encapsulate these areas:

Integrated governance, risk management and internal control

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.

In particular, the Committee reviews the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Governance Statement), together with any appropriate independent assurances, prior to endorsement by the CCG
- The underlying assurance processes that indicate the degree of achievement of CCG objectives, the effectiveness of the management of principal risks and the appropriateness of disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as set out in the NHS Standards for Commissioners (Fraud, Bribery and Corruption).

In carrying out this work, the Committee uses the work of internal audit, external audit and other assurance functions, but is not limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This is evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

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. This is achieved by:

- Considering the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- Reviewing and approving the internal audit strategy, operational plan and more detailed programmes of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework
- Considering the major findings of internal audit work (and management's response)
- Ensuring co-ordination between the internal and external auditors to optimise audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Clinical Commissioning Group
- Conducting an annual review of the effectiveness of internal audit.

External Audit

The Committee reviews the work and findings of the external auditors and considers the implications and management's responses to their work. This is achieved by:

- Considering the performance of the external auditors, as far as the rules governing the appointment permit
- Discussing and agreeing with the external auditors, before the audit commences, on the nature and scope of the audit (as set out in the annual plan), and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- Discussing the external auditors' local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee
- Reviewing all external audit reports, including the report to "those charged with governance", agreeing the annual audit letter before submission to the CCG and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

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.

These include any reviews by the Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

Counter Fraud

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.

We adhere to the standards set by the NHS Counter Fraud Authority in order to combat economic crime within the NHS. We comply with the NHS Counter Fraud Authority Anti-Fraud Manual, and best practice guidance from the Chartered Institute of Public Finance and Accountancy and the Institute of Counter Fraud Specialists.

Security Management

The Committee satisfies itself that the CCG has appropriate security management arrangements in place. It approves the annual plan for security management and reviews associated work carried out.

Management

The Committee reviews reports and seeks positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

Financial reporting

The Committee monitors the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance. The Committee:

- 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, focusing particularly on:

    - The wording in the governance statement and other disclosures relevant to the terms of reference of the Committee
    - Changes in, and compliance with, accounting policies, practices and estimation techniques
    - Unadjusted misstatements in the financial statements
    - Significant judgements in preparing the financial statements
    - Significant adjustments resulting from the audit
    - Letter of representation
    - Qualitative aspects of financial reporting.

The Audit Committee membership and attendance is set out below:

Name	Title	Attendance
Mr. William Hutton	Lay Member – Governance and Audit (Chair)	6 of 6
Mr. Keith Timmis	Lay Member – Performance	6 of 6
Mrs. Sarah Porter	Lay Member – Transformation	5 of 6

Key Achievements / Areas of Work Governance

The Audit Committee is constituted from the Lay Members of the CCG with the above three as full Members. The fourth Lay Member, Meredith Vivian, attends as an observer when availability allows.

During 2018/19 the Audit Committee sought to streamline its work by reviewing the annual work plan and 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.

As a result of internal and external reviews of the Finance Function within the CCG, a consolidated Finance Improvement Plan was created and at the request of the Governing Body, the Audit Committee was tasked with monitoring progress. The plan and associated actions were reviewed at each meeting and following the completion of most actions as evidenced in a further independent review, the Audit Committee was able to close this down with outstanding issues handled as "business as usual" by the strengthened Finance Team.

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 raised part way through the year by NHS England, in relation to controls around the employment of Interim/Contract Staff, the Audit Committee requested that regular updates be provided to the Committee as a source of assurance that required procedures were being complied with.

The Audit Committee reviewed the Governing Body Assurance Framework at each meeting during the year. 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.

Following on from the extended Internal Audit work plan in 2017/18, the Audit Committee agreed to a slightly reduced level of work in 2018/19 at 175 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 towards the end of 2017/18.

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 in the previous year.

Any governance concerns from Governing Body Committees were discussed at each meeting through verbal input from the Lay Members who chaired/attended 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 175 days was agreed by the Audit Committee for 2018/19, 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, and are outlined below, with the specific level of assurance for each review:

Significant Assurance	• Conflict of Interest Management • QIPP • Financial Ledger • Payroll
Moderate Assurance	• Budget Setting • Continuing Healthcare - Health check • Financial Reporting & Delivery • Accounts Receivable • Accounts Payable • Contract Monitoring • Workforce Controls

In 2018/19, the improvement in findings from Internal Audit Reviews seen towards the end of 2017/18 continued with no audits attracting limited assurance (six in 2017/18). 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.

The Head of Internal Audit's overall opinion is that 'moderate assurance' can be given ('limited assurance' in 2017/18). This assurance is informed by their assessment of the design and operation of the underpinning Assurance Framework and supporting processes and an assessment of the range of individual opinions arising from risk-based audit assignments undertaken throughout the year. This assessment has taken account of the relative materiality of these areas and progress in terms of addressing control weaknesses.

Further detail, including the Head of Internal Audit Opinion, is included from page 86.

Counter Fraud

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

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

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

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

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

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

The Audit Committee agreed a work plan by CW Audit Services for counter fraud at the start of 2018/19, 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.

External Audit and Financial Reporting

The Audit Committee agreed the 2018/19 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.

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, and presented the findings to the Governing Body, including actions that were agreed to increase effectiveness. An Annual Report on the operation of the Audit Committee during 2017/18 was produced and presented to the Governing Body. A further report for 2018/19 will be produced after the close down of the year.

Remuneration Committee

The Remuneration Committee was established in accordance with our constitution.

The membership of the Committee continued 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.

The Remuneration Committee met seven times in 2018/19 and the membership, attendees and subsequent attendance is set out below:

Name	Title	Attendance
Mr. William Hutton	Lay Member for Governance and Audit	7 of 7
Mr. Keith Timmis	Lay Member for Performance	7 of 7
Mrs. Sarah Porter	Lay Member for Transformation	7 of 7
Mr. Meredith Vivian	Lay Member for Patient and Public Involvement	7 of 7
Dr. Julian Povey	Chair	4 of 4
Dr. Simon Freeman	Accountable Officer	7 of 7
Dr. Alan Leaman	Secondary Care Consultant (commenced in post 1 January 2019)	1 of 1
Mrs. Sam Tilley	Director of Corporate Affairs	5 of 5
Mrs. Lisa Kelly	HR Adviser	6 of 6
Adam Burgess Evans	Senior HR Advisor	1 of 1

During these meetings, the Remuneration Committee made decisions including Annual Pay Reviews for 2018/19 for non-Agenda for Change staff, remuneration of new Executive posts including the new Medical Director and the incoming Accountable Officer starting in 2019/20 and contractual employment mechanisms for GP staff.

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 2018/19 is set out below:

Name	Title	Attendance
Mr. Keith Timmis	Lay Member for Performance	9 of 9
Mrs. Sarah Porter	Lay Member for Transformation	5 of 9
Mr. Meredith Vivian	Lay Member for Patient and Public Involvement	8 of 9
Mrs. Claire Skidmore	Chief Finance Officer and Deputy Accountable Officer	5 of 9
Mr. Tony Uttley	Interim Deputy Chief Finance Officer	4 of 9
Dr. Ed Rysdale	Secondary Care Consultant (ceased in post 30 September 2018)	4 of 5
Mrs. Nicky Wilde	Director of Primary Care	9 of 9
Mr. Steve Ellis	Head of Primary Care	7 of 9
Mrs. Dawn Clarke	Director of Nursing	7 of 9
Mrs. Sam Tilley	Director of Corporate Affairs	7 of 9
Dr. Colin Stanford	Independent GP Member	6 of 9
Mrs. Rebecca Woods	NHS England	8 of 9
Mrs. Amanda Alamanos	NHS England	5 of 9
Dr. Finola Lynch	GP Member	6 of 9
Mr. Kevin Morris	Practice Representative	5 of 9
Dr. Stephen James	GP Member	7 of 9
Dr. Deborah Shepherd	Locality Chair	6 of 9
Dr. Tim Lyttle	GP Member/Locality Chair	5 of 6
Dr. Julian Povey	CCG Chair & GP Member	5 of 9
William Hutton	Lay Member	7 of 9
Observers		
Jayne Randall Smith Daphne Lewis Vanessa Barrett Lynn Cawley	Healthwatch	2 of 2 1 of 1 2 of 2 3 of 4

Key Achievements / Areas of Work

The Primary Care Commissioning Committee has continued to focus on the main strands of work from the GP Forward View in 2018/19. Our most significant challenges remain workforce and premises. Reports from the Care Quality Commission and patient surveys show that the quality of primary care in the county remains high and compares favourably with the rest of the country. Patients now have greater access to primary care with the launch of "extended hours" in October 2018. The Committee monitors the progress of the work themes to ensure delivery is proceeding according to the timetables and to assess the impact is as positive as expected. More broadly, PCCC monitors the risks facing primary care and considers the actions that management are taking to mitigate and eventually remove them.

The Committee has regularly discussed the business cases for three key premises developments: Whitchurch, Riverside and Shifnal. These are at different stages, but the Committee is keen to promote developments to provide premises that allow greater flexibility in the services available to patients and that meet the highest standards. The Whitchurch and Riverside developments involve co-operation with partners, including Shropshire Council, as we look for innovative ways to provide services for local communities.

Financial pressures are becoming an increasing concern for the Committee. We started 2018/19 with the potential for a small deficit. Close management by the Finance and Primary Care Teams has kept expenditure under control and in the short term the Committee is confident it can continue to match the needs of primary care with the resources that are available to us. However, the Committee reviewed a Medium Term Plan for the delegated primary care budget. This makes clear we face an increasingly difficult task to deliver the delegated budget, with a significant deficit forecast in years four and five of the plan. A particular concern is the revenue consequences of the development of premises. In the forthcoming year we have asked for further reports and an action plan to help us to address the forecast gap in our budget.

The Committee has already reviewed the impact of the NHS Long Term Plan on the delegated primary care budget. There is a series of deadlines we will have to deliver locally to meet the national expectations on issues, such as the creation of Primary Care Networks. We will also be completing the re-procurement of the APMS contract for the Whitehall practice in Shrewsbury. We completed an extensive exercise of engagement with patients and stakeholders in 2018/19 in anticipation of a new contract beginning in October 2019. The new year presents many challenges for the Committee, but also opportunities to continue our support for the primary care services Shropshire patients rely on.

Risk Management Arrangements & 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 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 2018/19 the CCG has continued to utilise an Issues Log to compliment 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 Committee changes agreed in 2016/17 have now been embedded and mean that we now have better oversight on areas of importance and concern, identifying and mitigating risks more quickly and effectively. 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 and 2018/19. 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 are 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 set out on the Governing Board Assurance Framework at 31 March 2019 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 2018/19.	Continued embedding of the PMO process. The development of joint work with T&W CCG with collective schemes under consideration. Ongoing work to develop QIPP schemes. Continue focus on improvements in the levels of CCG assurance through internal and external audit reports. Audit programme in place; results reported to Audit Committee through the year. Restructure of Finance Team completed. CHC action plan in place to address gaps in controls. Progress monitored by both Finance Committee and Audit Committee. Monthly QIPP Programme Board cycle ramped up to weekly from October 2018 to support pace of project delivery required.

Quality and Safety

Risk to Delivery	Mitigating Actions
There is a risk that we will fail to commission safe, quality services for our population.	Quality Strategy and Delivery Plan to take into account Long Term Plan. Oversight of CCG strategic objectives and operational plan by the Quality Committee. West Midlands Quality Review of clinical governance and quality arrangements complete and action plan in development. Self-assessment of governance arrangements of quality functions to be undertaken.

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. System wide demand and capacity plan in development. For cancer, the findings of the NHSI deep dive into cancer delivery at SaTH to be incorporated into formal remedial action plans and received by the CCG.

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.	NHS England has provided funding in the form of an Intervention and Support Agreement to ensure that the CCG has sufficient transformation resource to achieve its objectives. The CCG has entered into an Alliance Agreement with Shropshire Council and Shropshire Community Health NHS Trust to drive the changes in the Care Closer to Home programme. Sir Neil McKay has been appointed as the independent STP chair. As a result a review of the STP programme is underway in which the CCG is fully engaged.

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.	The CCG continues to undertake a significant amount of communications and engagement work. Work plans and priorities are kept under continuous review and adjustments made where necessary to maximise capacity and responsiveness. Communication and engagement arrangements for all major work streams are in place.

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.	Workforce statistics including sickness absence rates and mandatory training levels regularly reviewed by Executives and are reported to the Governing Body quarterly. Staff "Hero" identified for CCG award each month and showcased at the CCG's AGM. Monthly staff newsletter used to communicate key messages, good news stories and CCG developments to staff. Staff survey completed with results to inform the development of the CCG's OD strategy.

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 360 degree stakeholder survey for 17/18 was undertaken and results presented to the Governing Body. Results show a significant improvement on the previous year which is of further note due to the challenging climate the CCG continues to operate in. The 2018/19 survey has been undertaken. Communication and engagement arrangements for all major work streams are in place supported by the Lay Member for Patient and Public Involvement. GP leadership development programme has commenced. Two cohorts have been completed and further cohorts are planned.

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.	A full review of the Better Care Fund is underway which will test associated investments in support of keeping people out of hospital. Independent governance review of the BCF undertaken. A review of options to reduce Non Elective admissions is underway in relation to areas where the CCG is an outlier according to RightCare data using the BCF and Alliance Agreement with the Local Authority.

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.	Intensive Support Team visit to assess quality, safety and governance of the 0-25 Health and Wellbeing Service. A comprehensive action, communication and governance plan developed by the contract lead provider. A short life Task and Finish Group established to provide additional assurance to CQRM. Plan linked to the CYP LTP which has been agreed to be quarterly reviewed rather annually.

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.

Moreover, the Audit Committee plans to review the risk registers from each Directorate on a periodic basis and focus on the processes to identify risks, the controls that are in place, and the assurances on the effectiveness of those controls. In addition, each of the sub committees will review the Corporate Risk Register and Issues Log. As the Governing Body relies on committees to carry out specific areas of work, the Chair of each committee is invited to attend the Audit Committee as necessary to discuss the operation of the Committee and the governance processes in place. In addition, the CCG Chair is invited to attend at least once a year. This input is supplemented by attendance of members of the Audit Committee at some of the Committee meetings.

The Risk Management Framework is very much centred on identifying principal risks and managing them in a controlled way through the Assurance Framework.

Annual Audit of Conflicts of Interest Management

During 2018/19, we received £455m 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 2018/19 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.

We meet the requirements by having:

- A Conflicts of Interest Policy, and Declaration of Gifts, Hospitality and Sponsorship Policy and Procedure which sets out how we wish our GP Membership, Governing Body and Committee Members, staff and contractors to behave, and the measures we will take to manage conflicts of interest
- A Register of Interests for all our staff, GP member partners and other practice staff involved in CCG business, contractors and Governing Body and Committee Members, which clearly sets out everyone's interests so it is much easier to identify a conflict and manage it
- A Register of Gifts, Hospitality and Sponsorship showing where offers of gifts,hospitality and sponsorship have been made and declined or accepted
- A Register of Procurement Decisions to demonstrate how we have managed conflicts of interest pertaining to procurement/contractual decisions made by the CCG
- A Register of Conflicts of Interest Breaches to ensure that where there is a breach of the conflicts of interest policy, this is captured and lessons learned are shared more widely.

To continue with our robust management of conflicts of interest, the Chair of the Audit Committee has continued to perform the role of Conflicts of Interest Guardian during 2018/19. This role, in collaboration with the Director of Corporate Affairs, should:

- Act as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest
- Be a safe point of contact for employees, contractors, Governing Body and Committee Members to raise any concerns in relation to this policy
- Support the rigorous application of conflict of interest principles and policies
- Provide independent advice and judgement where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
- Provide advice on minimising the risks of conflicts of interest.

During 2018/19 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. This maintains the CCG's 17/18 position into 18/19; however, the following recommendations were made for further action:

- Ensure that up-to-date declarations (including nil returns) are maintained in line with guidance and escalate non-compliance of individuals where required with this requirement

- Joint procurement decisions should be recorded on the register of contracts awarded as appropriate

- Continue to maintain the profile of conflicts of interest management across the CCG and localities, reminding all relevant groups of the need to complete declarations fully in a timely manner.

Implementation of recommendations will be monitored by the CCG's Audit Committee.

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.

During 2018/19, we provided IG training for staff and we have been able to meet our 95% compliance target for the year.

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.

During 2018/19, there was only one information governance incident reported, which following risk assessment was deemed to be a non-reportable breach. There have been no breaches that were reportable 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, determine 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 2017/18 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 a category 2 responder 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 participated in a local EPRR exercise and has run its own internal communication exercise.

During 2018/19 NHS England undertook an assurance exercise of CCGs in relation to EPRR. Shropshire CCG gained full assurance, the highest level of assurance, which is a further improvement on the 2017/18 rating. The CCG has further plans for testing its EPRR arrangements during 2019/20 with a view to maintaining this assurance level.

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.

As we will not achieve our revenue resource limit, the External Auditor for 2018/19 is expected to issue a qualified regularity opinion and this report will be published after we have the result. The CCG has not achieved its agreed control total of £13.3m deficit for 2018/19, with a year end deficit position of £17.1m.

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. The CCG has made significant strides forward with its Financial Recovery Plan. However, we have been unable to meet our control total for 2018/19.

To ensure we remain focused on the delivery of safe, sustainable local healthcare, and appropriate access for patients, we continue to implement our Financial Recovery Plan adopting the following key principles:

- We ensure that quality of care and patient safety is our first priority at all times
- 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.

Key Milestones in Respect of the Financial Position

Throughout the year, Executives have been in continuing dialogue with NHS England colleagues around the progress toward an agreed outturn position.

During 2018/19 the CCG has lead on the economy-wide Future Fit programme. This has taken benchmarked data and challenged the local organisational processes and commissioning decisions to streamline and modernise the way in which high quality services are secured for the people we serve. Having achieved the NHS England requirements to proceed to public consultation and being granted Treasury approval for capital funding to support the redevelopment programme, the programme completed a 14 week programme of public consultation which concluded in September 2018.

Our financial governance arrangements are scrutinised by our internal auditors and independent scrutiny of the accounts is provided by Grant Thornton, our external auditors, as part of their annual review of the accounts.

In addition, further independent scrutiny was provided during quarter four, 2017/18 by Price Waterhouse Coopers who undertook a detailed review of the CCG's financial systems and process.

On 30 April 2018, the CCG Audit Committee signed off an action plan that combined actions from the report with those outstanding from an earlier Finance Team effectiveness review, also supported by Price Waterhouse Coopers. Throughout the financial year, the Committee received updates and considered progress against the combined plan. An independent evaluation of completion of the actions was performed by Deloitte in late 2018 and after consideration of the report at its February meeting, the Committee agreed for any further work on financial governance, system and process, to be undertaken through 'business as usual' and therefore be subject to the CCG's usual internal audit process.

Delegation of Functions

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

During 2017/18 a Joint Committee was formed to include membership of both Shropshire CCG and Telford & Wrekin CCG along with independent clinical members and an independent chair. The purpose of this Joint Committee was to approve the recommendations from the NHS Future Fit Board on the outcome of the Option Appraisal. This Committee has again met in 2018/19 to accept the Future Fit Decision Making Business Case following the public consultation on the two Future Fit Options.

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. These included recruiting to a new Director of Primary Care position and investing in three Locality Managers. This remains the position in 2018/19 as we continue to discharge our delegated 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.

Head of Internal Audit Opinion

Following completion of the planned audit work for the 2018/19 financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control. The Head of Internal Audit concluded:

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

Within my opinion I have noted that:

- The CCG has an effective Assurance Framework but there should be more of a focus on planned actions to address risks within the Framework
- During the year Moderate Assurance has been provided for the following reviews: Financial Systems – Accounts Payable & Receivable; Budget Setting including QIPP; Continuing Healthcare; Financial Reporting; Contract Monitoring and Workforce controls
- The implementation of agreed actions is in the most part effective in the CCG and in particular we have seen improvements within the Finance Function. However some recommendations have not been fully addressed for a number of years in relation to Continuing Healthcare and the Better Care Fund where the CCG has struggled to fully address ongoing risks.

I have highlighted the following significant internal control issues that must be reported within your Annual Governance Statement:-Financial Delivery in year, CHC, oversight of SaTH contract and direction arrangements.

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 the CCG has in place and also by giving consideration to the wider reporting to the Governing Body that informs their assessment of the effectiveness of the organisation's the system of internal control. As part of the review of the Board Assurance Framework we noted that there should be a presentational refresh and actions should have a target date for completion.

It is my current view that notwithstanding the need for a presentational refresh, an Assurance Framework has been established which is designed and operating to meet the requirements of the 2018/19 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

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

Area of Audit	Level of Assurance Given
Conflicts of Interest Management	Significant assurance
QIPP**	Significant assurance
Financial Ledger	Significant assurance
Payroll	Significant assurance
Budget Setting	Moderate assurance
Financial Reporting and Delivery	Moderate assurance
Contract Monitoring	Moderate assurance
Continuing Healthcare	Moderate assurance
Accounts Receivable	Moderate assurance
Accounts Payable	Moderate assurance
Workforce Controls	Moderate assurance
Interim BAF	Level A assurance with recommendations to improve
Final GBAF	Level A assurance with recommendations to improve
GDPR	Non-assurance assignments
Data Protection & Security Toolkit	
CMHS Procurement	Advisory review
Betsi Cadwaladr University Health Board	

** The control objective in relation to realistic and achievable plans has Moderate Assurance

The following areas are highlighted as presenting moderate assurance:

Budget Setting including QIPP

The review established that although the CCG had made some improvements in its approach to budget setting from the previous year, there were still financial risks and issues to address. It was acknowledged that the majority of budget holders noted an improvement in the budget setting process and in particular the engagement between finance and the budget holders. This improved relationship was also reflected by the reduction in caveats associated with the sign off of budgets. Notwithstanding this, a budget holder raised concerns about being asked to sign off a budget where parts of the budget were not their responsibility and lack of accuracy around the information received.

Risks were also noted with the continued growth trend in outturn of Continuing Healthcare (CHC), including Complex Care and Funded Nursing Care budgets. The workings behind the Continuing Healthcare, including Complex Care and Funded Nursing Care budgets were very basic and the budget was starting to overspend. Whilst extensive work was on-going in relation to scrutinising cost drivers the review highlighted that this should have been completed sooner to feed into the budget setting process.

Financial Reporting

The review identified that the CCG was reporting its current year to date position accurately. Significant improvement had been made since last year when forecasting was RAG rated red (limited). It was established that forecasts were derived from extrapolations of the year to date position, adjusted as appropriate for known issues/challenges. However, the review noted some elements of forecasting, in particular acute (SaTH) and non-acute (CHC expenditure) were impacted by uncertainty. It was noted that whilst the financial risks were reported and the CCG was making endeavours to take these into account in forecasts, it was important that action was brought to a conclusion to resolve uncertainty.

Themes identified in Budget Setting continued with volatility in CHC spend; in particular Complex Care, over-performance in major acute contracts and under-delivery in the QIPP programme being noted. The review recognised that the challenge going forward was to embed and sustain action taken to address these issues. Whilst improvements had been noted within CHC, there remained a lack of confidence in the integrity of the data held within the BroadCare System and work continued to resolve these underlying issues. The CCG had consistently reported an increasing overspend and forecast outturn for Complex Care.

Identified risks of £3.5m reported in M7 were fully mitigated. However, at that time £2.4m of the mitigation related to QIPP and control of expenditure. The review noted that this would need significant management over the final months of the financial year if the CCG was to achieve its planned control total.

Continuing Healthcare (CHC) – Health check

The review noted progress made against a number of key areas for improvement within the CHC service, mainly resulting from a critical focus being placed on driving forward and implementing actions outlined within the CCG's internal consolidated CHC action plan. Multi Disciplinary Team delays had been reduced, Quality Premium (28 day referral) targets for new cases were now being met and performance continues to improve. A number of data cleansing exercises had resulted in increased confidence with system outputs and a Summary Performance Dashboard has been reintroduced to assist with performance monitoring within the service. Business critical procedures had been developed and work continued in the production of all supporting/ associated Standard Operating Procedures (SOPs) for the service.

However, performance continued to be impacted by resourcing issues, with reliance being placed on the use of agency and interim staff. It was understood that a new proposed staffing structure had not been put in place and therefore there was a lack of stability within the team. In addition, there were still a number of ongoing challenges to be resolved.

Ongoing data cleansing exercises as well as updates to the BroadCare System in November 2017 has had positive effects on the accuracy of the system. Financial reconciliation and forecasting processes have been refined, with regular updates being provided from the CHC Team to Finance regarding emerging cases not yet on BroadCare. However, the accuracy of forecasting continued to be an issue, with a significant increase in forecast outturn between M8 & M9 of £1.6m. Whilst this was in part a result of increased service demand, internal communication issues within the CHC Team had also been identified as contributing factor.

A price costing framework was not yet in place and the CCG was continuing to explore collaborative commissioning options. Agreement of joint funded children CHC cases in particular required action to ensure cases are completed on a needs basis and to provide additional stability to financial forecasts. The need to focus efforts on implementation of these areas was highlighted within our previous CHC Health Check Report issued in October 2017.

Contract Monitoring

As lead commissioner for Shrewsbury and Telford Hospitals NHS Trust (SaTH), Shropshire CCG had implemented a governance structure to monitor delivery of the contract. A Joint Strategic Commissioning (JSC) Board was introduced in 2017 at an Executive level which includes membership from Shropshire CCG, Telford & Wrekin CCG and the Trust. The JSC Board initially met on a bi-monthly basis but revised this to meet monthly following an extension of its remit to include monitoring of QIPP performance. By exception, it has been receiving reports from an operational contract governance structure which, until July 2018, included five groups covering activity, finance and quality issues.

The review noted that contract monitoring arrangements and their governance structure had been under considerable pressure. The well-publicised challenges that SaTH was facing in delivery of some of its services had impacted on the structure, notably through the introduction of a specific group which monitors the quality of the Maternity Service and more generally through items considered by the Clinical Quality Review Meeting (CQRM), the Service Performance Forum (SPF) and the Planned Care Working Group (PCWG).

Indicative of the challenge facing the CCG in monitoring delivery of the contract in the context of current concerns was the number of actions generated across the governance structure. In May 2018 a total of 48 actions were raised at the five meetings held in that month, bringing the total number of actions which were ongoing across all five Groups to 73. The review noted that in these circumstances it was important to ensure that the contract monitoring structure is properly resourced and that it is was as streamlined as possible to avoid duplication of effort and 'firefighting' without compromising the level of monitoring being applied.

There was some evidence that aspects of the structure were not operating as was originally intended when it was established at the beginning of the contract in April 2017. Details are outlined below:

- The current contract monitoring structure was larger than that which is referred to within the contract, with two additional Group meetings each month (the Maternity CQRM and the PCWG). Terms of Reference for the original Groups in the structure have not been updated to reflect how these Groups interact with the two additional Groups highlighted and the impact this has had on how monitoring duties are delivered;

- Attendance at meetings by the nominated Chair of the Activity & Finance (A&F) and the Service & Performance (S&P) Groups was irregular. In this officer's absence the meetings were being chaired by the Head of Contracts who has been regularly attending all five monitoring groups.

- The CQRM needed to demonstrate more clearly through its agenda and reporting that it is monitoring the Trust's performance against all quality requirements set out in schedule 4 of the contract and;

- The CCG needed to demonstrate more clearly that the contract monitoring structure was sufficiently assured with regards to implementing Remedial Action Plans for instances whereby these are being taken forward and reviewed outside of the structure.

A number of the challenges that SaTH faced in relation to A&E, Referral to Treatment, staffing and quality concerns had been ongoing for an extended period of time. The CCG, with specialist support, was in the process of reviewing its contract reporting and producing a more detailed information report. The contract was also being reviewed in detail to ensure all required contract variation notices had been made over the life of the contract to date. In addition to this, partnership working continued to help ensure that system wide measures are taken to strategically address some of the complex issues at root cause.

Financial Systems – Accounts Receivable, Accounts Payable
A number of significant improvements have been made following our 2017/18 review when limited assurance was provided. These included the introduction of a new policy framework; significant reduction in the number of supplier invoices being withheld for payment, introducing a clear scheme of IFSE delegated limits and introducing a clear audit trail in support of independent review and sign off control accounts.

Notwithstanding this progress, our review noted a number of issues within accounts receivable and payable linked to CHC and Shropshire Council. In addition, we noted a salary overpayment of £5.4k resulting from delayed completion and submission of termination paperwork into the CSU.

Workforce Controls
The workforce review identified improvements that could be made in relation to controls over higher cost interim staff. It also noted improvements in controls put in place in relation to permanent staff and new procedures for interim staff.

QIPP (realistic and achievable plans control objective)
The review found that the CCG has established new processes for identifying, developing, approving, managing and governing QIPP. Changes included the introduction of new procedures to develop and approve schemes, standard templates and the comprehensive reporting and introduction of a clear governance structure including regular Executive and Programme Management Office (PMO) meetings.

The 2017/18 QIPP delivery was £16.121m against a target of £17.71m. Within this there was significant non delivery within acute schemes. The 2018/19 QIPP target set at the start of the year was even more challenging at £20.5m. At the time of the revised annual plan submission to the Governing Body (9 May 2018), £2.97m of the QIPP target (14.5% of the total plan) was yet to be identified. The CCG had then been focusing on this and it was reported to the Programme Board (17 July 2018) that £1.6m remained outstanding. The CCG was endeavoring to put mitigation arrangements in place for high risk schemes. There was evidence of challenge on performance, process and reporting. Work was also continuing to encourage engagement and ownership with leads.

Performance to 30 June 2018 as reported to the Programme Board (17 July 2018) showed there has been slippage of £123k against year to date forecast of £3.7m which has been caused by a variety of issues impacting on timing of delivery of schemes and the failure of others. These were widely reported within the CCG's QIPP governance structure. There was evidence that movements in current year to date were reflected in the forecast outturn and that the CCG was regularly reviewing forecasts. There was evidence of over optimism with one scheme (namely MSK Redesign) and across the programme scheme delivery was not forecast to be straight-line but was back ended presenting a risk to the position.

Non GMS Payments
The review focused on payments made by the CCG to GP practices for the provision of Locally Commissioned Services (LCS). A number of different teams undertake a range of checks prior to LCS payments being made. There was, however, a lack of an audit trail to support checks made for our entire sample. The review also noted the need to develop clearly defined procedures in support of all stages of the LCS payment validation and approval process.

There was no formal reporting on performance in line with KPI's outlined within LSC contracts/ service specifications along with a lack of detailed expenditure reporting for some services within LCS contracts.

No evidence was provided that the annual quality audits, which are specified and agreed within LCS contracts, took place.

Betsi Cadwaladr University Health Board - Advisory
The advisory review looked into a number of control weaknesses in relation to payments and reporting for this out of area contract and identified a number of lessons to be taken forward by the CCG and in particular, the Contract Team.

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

Our Assurance Framework provides me with the evidence that the effectiveness of controls that manage the risks of the organisation achieving its strategic principal objectives have been reviewed. The Assurance Framework is reviewed regularly by the Governing Body, Audit Committee and Executives and I am satisfied that it reflects the key challenges faced by the CCG.

My review is also informed via assurances provided 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 2018/19. 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 improved 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 we will strive to enhance and build on these tools.

David Stout
Interim Accountable Officer

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
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 2018/19 (audited information)

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)
Allen	Shailendra	Locality Chair - South	01/04/18 to 01/08/18	15-20				0-2.5	15-20
Bird	Matthew	Locality Chair - South	01/01/19 to 31/03/19	0-5				0-2.5	0-5
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
George	Priya	GP Member	01/02/19 to 31/03/19	0-5					0-5
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				125-127.5	170-75
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 - Women & Children	01/04/18 to 02/12/18	45-50				2.5-5	50-55
Sokolov	Jessica	Medical Director	03/12/18 to 31/03/19	20-25				0-2.5	20-25
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 2 Pension Benefits 2018/19

Surname	Forename	Title	Appointment Details	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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019 £'000	Cash Equivalent Transfer Value at 1 April 2018 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Allen	Shailendra	Locality Chair - South	01/04/18 to 01/08/18	0-2.5	0-2.5	5-10	15-20	130	110	16	0
Bird	Michael	Locality Chair - South	01/01/19 to 31/03/19	0-2.5	0-2.5	0-5	5-10	47	44	2	0
Clarke	Dawn	Executive Nurse Director	01/04/18 to 31/03/19	0-2.5	2.5-5	25-30	80-85	649	550	82	0
Davies	Julie	Director of Strategy and Service Redesign	01/04/18 to 31/03/19	0-2.5	0-2.5	15-20	35-40	353	289	55	0
Fortes-Mayer	Gail	Basic Salary - Director	01/04/18 to 31/03/19	5-7.5	10-12.5	40-45	65-70	618	432	172	0
Freeman	Simon	Accountable Officer	01/04/18 to 26/03/19	0-2.5	2.5-5	25-30	80-85	626	533	78	0
George	Priya	GP Member	01/02/19 to 31/03/19	Figures unavailable at the time of publication							
Lynch	Finola	GP Member/Clinical Director - Communication & Engagement	01/04/18 to 31/03/19	0-2.5	0-2.5	10-15	30-35	236	191	39	0
Lyttle	Timothy	Executive Medical Director	03/04/18 to 04/10/18	0-2.5	0-2.5	5-10	15-20	124	95	26	0
Morris	Kevin	Locality Chair - North	01/04/18 to 31/03/19	0-2.5	0-2.5	15-20	40-45	337	296	32	0
Pepper	John	Clinical Director -Medical	01/04/18 to 31/03/19	5-7.5	12.5-15	5-10	20-25	173	51	120	0
Shepherd	Deborah	Executive Medical Director	01/04/18 to 31/03/19	0-2.5	0-2.5	10-15	25-30	219	183	30	0
Skidmore	Claire	Basic Salary - Director	01/04/18 to 31/03/19	0-2.5	0-2.5	35-40	80-85	529	424	93	0
Sokolov	Jessica	GP Member/Clinical Director - Women & Children	01/04/18 to 02/12/18	0-2.5	0-2.5	5-10	20-25	147	126	17	0
Sokolov	Jessica	Medical Director	03/12/18 to 31/03/19	0-2.5	0-2.5	0-5	10-15	71	61	8	0
Tilley	Samantha	Basic Salary - Director	01/04/18 to 31/03/19	2.5-5	2.5-5	20-25	55-60	405	300	95	0
Wilde	Nicola	Basic Salary - Director	01/04/18 to 31/03/19	2.5-5	5-7.5	25-30	60-65	523	399	112	0

Table 3 Salaries and allowances 2017/18 (audited information)

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)
Allen	Shailendra	Chair - South Locality	01/04/17 to 31/03/18	45-50	-	-	-	82.5-85.0	130-135
Beal	Barbara	Interim Director of Nursing and Quality (to 7 July 2017)	01/04/17 to 07/07/17	25-30	-	-	-	-	25-30
Clarke	Dawn	Director of Nursing Quality & Experience (from 1 July 2017)	01/07/17 to 31/03/18	70-75	-	-	-	82.5-85.0	155-160
Clowes	Peter	GP Lead (to 31 May 2017)	01/04/17 to 31/05/17	0-5	-	-	-	-	0-5
Collins-Izquierdo	Linda	Director of Nursing, Quality and Patient Experience (on secondment in 2017)	01/04/17 to 31/03/18	75-80	-	-	-	15.0-17.5	95-100
Davies	Geoffrey	GP Member/Clinical Director - Urgent Care & Finance (to 7 July 2017)	01/04/17 to 05/07/17	5-10	-	-	-	-	5-10
Davies	Julie	Director of Strategy and Service Redesign/ Director of Performance and Delivery	01/04/17 to 31/03/18	95-100	-	-	-	77.5-80.0	175-180
Dray	Anne	Interim Director of Corporate Affairs (to 17 May 2017)	01/04/17 to 17/05/17	5-10	-	-	-	-	5-10
Fortes-Mayer	Gail	Director of Contracting and Planning (from 1 July 2017)	01/07/17 to 31/03/18	70-75	-	-	-	140.0-142.5	215-220
Freeman	Simon	Accountable Officer	01/04/17 to 31/03/18	140-145	-	-	-	72.5-75.0	215-220
Hutton	William	Lay Member - Audit Chair	01/04/17 to 31/03/18	15-20	-	-	-	-	15-20
James	Stephen	GP Member/Clinical Director - Primary Care	01/04/17 to 31/03/18	85-90	-	-	-	-	85-90
Lynch	Finola	GP Member/Clinical Director - Communication & Engagement	01/04/17 to 31/03/18	50-55	-	-	-	40.0-42.5	95-100
Lyttle	Timothy	Chair - North Locality (from 3 July 2017)	03/07/17 to 31/03/18	25-30	-	-	-	-	25-30
Morris	Kevin	Practice Representative	01/04/17 to 31/03/18	45-50	-	-	-	230.0-232.5	280-285
Porter	Sarah	Non-Executive Member (from 31 May 2017)	31/05/17 to 01/03/18	5-10	-	-	-	-	5-10
Povey	Julian	Clinical Chair	01/04/17 to 31/03/18	105-110	-	-	-	-	105-110
Rysdale	Edward	Secondary Care Clinical Member	01/04/17 to 31/03/18	5-10	-	-	-	-	5-10
Shepherd	Deborah	Chair – Shrewsbury & Atcham Locality	01/04/17 to 31/03/18	50-55	-	-	-	52.5-55.0	100-105
Skidmore	Claire	Chief Finance Officer (from 1 June 2017)	01/06/17 to 31/03/18	95-100	-	-	-	102.5-105.0	200-205
Sokolov	Jessica	GP Member/Clinical Director - Womens & Children	01/04/17 to 31/03/18	55-60	-	-	-	202.5-205.0	260-265
Tilley	Samantha	Director of Corporate Affairs (from 10 April 2017)	10/04/17 to 31/03/18	75-80	-	-	-	112.5-115.0	190-195
Timmis	Keith	Lay Member for Governance and Performance	01/04/17 to 31/03/18	-	15,200	-	-	-	15-20
Tulley	Paul	Chief Operating Officer (to 31 May 2017)	01/04/17 to 31/05/17	15-20	-	-	-	5.0-7.5	20-25
Vivian	Meredith	Non-Executive Members (from 31 May 2017)	31/05/17 to 01/03/18	5-10	-	-	-	-	5-10
Wilde	Nicola	Director of Primary Care (from 23 May 2017)	23/05/17 to 01/03/18	75-80	-	-	-	82.5-85.0	155-160
Whitworth	Michael	Interim Director of Contracting and Planning (to 30 April 2017)	01/04/17 to 30/06/17	-	72,400	-	-	-	70-75
Hayman	Deborah	Interim Chief Finance Officer (to 31 May 2017)	01/04/17 to 31/05/17	-	42,000	-	-	-	40-45

Table 4 Pension Benefits as at 31 March 2018 (audited information)

Surname	Forename	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019 £'000	Cash Equivalent Transfer Value at 1 April 2018 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Allen	Shailendra	Chair - South Locality	2.5-5.0	15.0-17.5	5-10	15-20	110	12	98	0
Clarke	Dawn	Director of Nursing Quality & Experience (from 1 July 2017)	2.5-5.0	10.0-12.5	20-25	70-75	550	444	77	0
Clowes	Peter	GP Lead (to 31 May 2017)	0	0	0-5	10-15	0	0	0	0
Collins-Izquierdo	Linda	Director of Nursing, Quality and Patient Experience (on secondment in 2017)	0.0-2.5	0.0-2.5	30-35	90-95	630	577	47	0
Davies	Julie	Director of Strategy and Service Redesign/ Director of Performance and Delivery	2.5-5.0	5.0-7.5	15-20	35-40	289	221	66	0
Freeman	Simon	Accountable Officer	2.5-5.0	7.5-10.0	25-30	75-80	533	450	78	0
James	Stephen	GP Member/Clinical Director - Primary Care	2.5-5.0	167.5-170.0	15-20	210-215	0	317	0	0
Lynch	Finola	GP Member/Clinical Director - Communication & Engagement	0.0-2.5	2.5-5.0	10-15	30-35	191	159	30	0
Morris	Kevin	Practice Representative	10.0-12.5	27.5-30.0	15-20	40-45	296	99	196	0
Shepherd	Deborah	Chair – Shrewsbury & Atcham Locality	0.0-2.5	2.5-5.0	10-15	25-30	183	143	39	0
Skidmore	Claire	Chief Finance Officer (from 1 June 2017)	2.5-5.0	7.5-10.0	30-35	80-85	424	342	65	0
Sokolov	Jessica	GP Member/Clinical Director - Womens & Children	7.5-10.0	22.5-25.0	10-15	30-35	187	44	143	0
Tilley	Samantha	Director of Corporate Affairs (from 10 April 2017)	5.0-7.5	10.0-12.5	20-25	45-50	300	221	75	0
Tulley	Paul	Chief Operating Officer (to 31 May 2017)	0.0-2.5	0	35-40	95-100	643	598	39	0
Fortes-Mayer	Gail	Director of Contracting and Planning (from 1 July 2017)	5.0-7.5	7.5-10.0	30-35	50-55	432	340	175	0
Wilde	Nicola	Director of Primary Care (from 23 May 2017)	2.5-5.0	5.0-7.5	20-25	50-55	399	326	60	0

Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on Early Retirement or for Loss of Office

The CCG made no contractual payments in lieu of notice or for loss of office in 2018/19 (No payments were made in 2017/18).

Pay Multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid member of the Governing Body in the CCG in the financial year 2018-19 was £142,500 (2017-18, £143,879). This was 3.89 times (2017-18, 4.24) the median remuneration of the workforce, which was £36,644 (2017-18, £33,895).

In 2018/19, 2 employees (2017-18, 1) received remuneration in excess of the highest paid member of the CCG Governing Body. Remuneration ranged from £15,461 to £166,858 (2017/18, £16,104 to £166,858).

Staff Report

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

Number of Senior Managers (subject to audit)

Pay Band	Headcount
Band 2	5
Band 3	35
Band 4	14
Band 5	25
Band 6	21
Band 7	20
Band 8 - Range A	18
Band 8 - Range B	10
Band 8 - Range C	4
Band 8 - Range D	2
Band 9	2
Medical	13
VSM	14
Gov Body (off payroll)	1
Grand Total	**184**

Staff Numbers and Costs (subject to audit)			
	Total	Permanent Employees	Other
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	6,663	4,877	1,786
Social security costs	525	525	-
Employer contributions to the 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	7,857	6,071	1,786
Less: Recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Net employee benefits expenditure including capitalised costs	7,857	6,071	1,786
Less: Employee costs capitalised	-	-	-
Net employee benefits expenditure excluding capitalised costs	7,857	6,071	1,786

Employee Benefits 2017/18	Total	Permanent Employees	Other
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	6,920	4,712	2,208
Social security costs	487	487	-
Employer contributions to the NHS Pension Scheme	542	542	-
Other pension costs	-	-	-
Apprenticeship Levy	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross Employee Benefits Expenditure	7,950	5,741	2,208
Less: Recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Net employee benefits expenditure including capitalised costs	7,950	5,741	2,208
Less: Employee costs capitalised	-	-	-
Net employee benefits expenditure excluding capitalised costs	7,950	5,741	2,208

Staff Composition including Composition by Gender (subject to audit)

	Headcount by gender				% by Gender		
Staff Grouping	Female	Male	Unknown*	Totals	Female	Male	Unknown*
Governing Body	11	11	1	**23**	47.8%	47.8%	4.3%
Other Senior Management (Band 8c+)	11	2	0	**13**	84.6%	15.4%	0.0%
All Other Employees	119	29	0	**148**	80.4%	19.6%	0.0%
Grand Total	**141**	**42**	**1**	**184**	**76.63%**	**22.83%**	**0.54%**

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

Named Individuals categorised as Unknown are:-

Rod Thomson Director of Public Health (Shropshire Council)

Sickness Absence Data (subject to audit)

Staff sickness absence and ill-health retirements	2018-19 Number
Total Days Lost	1221.29
Total Staff Years	129.94
Average Working Days Lost	9.40

Sickness absence rate is defined as the amount of time lost through absences, as a percentage of staff time available. This does not cover maternity leave, carers leave or any periods of absence agreed under our CCG family-friendly or flexible working policies.

The CCG has an agreed Sickness Absence policy. In addition, CCG employees have access to Occupational Health and Staff Counselling services. The CCG also obtains support from its CSU Human Resources team in managing individual sickness cases.

Staff policies

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 or employment on grounds of age, disability, gender/gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex, or sexual orientation.

During 2018/19 all HR polices have been reviewed and updated. A staff survey has been carried out, the results of which will inform an action plan regarding any Organisational Development requirements.

Expenditure on consultancy

Expenditure on consultancy is disclosed in note 5 of the Annual Accounts.

Off-payroll engagements

There is a Treasury requirement for public sector bodies to report arrangements whereby individuals are paid through their own companies and so are responsible for their own tax and NI arrangements. Such 'off-payroll' engagements also include payments to GP practices for the services of GPs and GP practice staff.

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

	Number
Number of existing engagements as of 31 March 2019	5
Of which, number that have existed:	
for less than one year at the time of reporting	4
for between one and two years at the time of reporting	1
for between two and three years at the time of reporting	
for between three and four years at the time of reporting	
for four or more years at the time of reporting	

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.

New off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	19
Of which:	
Number assessed as caught by IR35	5
Number assessed as not caught by IR35	14

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

Off-payroll Engagements / Senior Official Engagements

For any off-payroll engagements of Board Members and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

Number of off-payroll engagements of Board Members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "Board Members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	26

Exit packages, including special (non-contractual) payments

The CCG did not incur contractual payments in lieu of notice during 2018/19

Remuneration of Very Senior Managers (VSMs)

In 2018/19 there were no individuals employed or engaged by the CCG earning more than the Prime Minister's salary of £150,000 per annum.

External Auditor's Remuneration

The CCG's external auditor is Grant Thornton UK LLP. Work performed for the CCG in 2018/19 related solely to the statutory audit and amounted to £52,800, (£63,360 inc VAT).
This is shown within Audit Fees in Note 5 of the annual accounts.

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.

Annual Accounts
2018-19

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Notes to the Accounts

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

Employee Benefits 2017/18			
	Note	**2018-19 £'000**	**2017-18 £'000**
Income from sale of goods and services	2	0	(1,085)
Other operating income	2	(1,374)	(1,082)
Total operating income		**(1,374)**	**(2,168)**
Staff costs	4	7,857	7,950
Purchase of goods and services	5	464,874	456,654
Depreciation and impairment charges	5	-	84
Provision expense	5	-	104
Other operating expenditure	5	750	810
Total operating expenditure		**473,481**	**465,602**
Net operating expenditure		**472,107**	**463,434**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**472,107**	**463,434**
Net (Gain) Loss on Transfer by Absorption		-	-
Total net expenditure for the financial year		**472,107**	**463,434**
Comprehensive expenditure for the financial year ended 31 March 2019		**472,107**	**463,434**

The CCG's planned in-year deficit was £13.30m, adjusted to £11.97m after the application of Commissioner Sustainability Funding of £1.33m, and has concluded the year with an in-year deficit of £17.06m.

The cumulative deficit is £76.73 million, following the application of the cumulative deficit brought forward from previous years of £59.67 million. The Clinical Commissioning Group has a residual cash balance of £88k on 31 March 2019 that is within the tolerance required by NHS England. This balance can be seen in the Statement of Cash flows.

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 notes on pages 122 to 144.

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Current assets:			
Trade and other receivables	9	3,687	4,074
Cash and cash equivalents	10	88	197
Total current assets		3,775	4,271
Total assets		**3,775**	**4,271**
Current liabilities			
Trade and other payables	11	(31,315)	(30,850)
Provisions	12		(104)
Total current Liabilities		**(31,315)**	**(30,954)**
Non-Current Assets plus/less Net Current Assets/Liabilities		(27,540)	(26,683)
Assets less Liabilities		(27,540)	(26,683)
Financed by Taxpayers' Equity			
General fund		(27,540)	(26,683)
Revaluation reserve			
Other reserves			
Charitable Reserves			
Total taxpayers' equity:		**(27,540)**	**(26,683)**

The financial statements and notes on pages 103 to 144 were approved by the Audit Committee on 21 May and signed on its behalf by

David Stout
Accountable Officer

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

	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Total Reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 1 April 2018	(26,683)	0	0	**(26,683)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Impact of applying IFRS 9 to Opening Balances	0			**00**
Impact of applying IFRS 15 to Opening Balances	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				
Net operating expenditure 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 other investments and Financial Assets (excluding 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				
Net actuarial gain (loss) on pensions	0	0	0	**0**
Movements in other 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 Changes In Taxpayers Equity for the year ended 31 March 2018

	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Total Reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 1 April 2017	(18,063)	0	0	**(18,063)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	(18,063)	0	0	**(18,063)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(463,434)			**(463,434)**
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				
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	(463,434)			**(463,434)**
Net funding	454,814	0	0	**454,814**
Balance at 31 March 2018	(26,683)	**0**	**0**	**(26,683)**

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(472,107)	(463,434)
Depreciation and amortisation	5	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	9	387	1,087
(Increase)/decrease) in trade & other receivables		0	0
(Increase)/decrease) in other current assets	11	465	7,419
(Increase/(decrease) in trade & other payables		0	0
(Increase/(decrease) in other current liabilities	12	(104)	0
Provisions utilised		0	0
(Increase/(decrease) in provisions	12	0	104
Net Cash Inflow/(Outflow) from Operating Activities		**(471,359)**	**(454,740)**
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		**(471,359)**	**(454,740)**

	Note	2018-19 £'000	2017-18 £'000
Cash Flows from Financing Activities			
Grant in Aid Funding Received		471,250	454,814
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		**471,250**	**454,814**
Net increase/(Decrease) in Cash & Cash Equivalents	**10**	**(109)**	**75**
Cash & Cash Equivalents at the Beginning of the Financial Year		**197**	**122**
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		**88**	**197**

Notes to the financial statements

1. Accounting Policies

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

1.1 Going Concern

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

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 2018/19, 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 2018/19:

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 2018/19 and 2019/20;
- 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 drawdown on the allocated funds based on its cash requirements and in accordance with the arrangements put in place by NHS England.

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

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions [which have been accounted for under merger accounting] have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

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.

There were no movements of assets in the financial year.

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 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.

1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.6.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements 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:

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 Key Sources of Estimation Uncertainty

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

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

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- As per paragraph 121 of the Standard the Clinical Commissioning Group will not disclose information regarding 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.

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,
  - 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 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation. Land and buildings used for the Clinical Commissioning Group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use. Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

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

1.11.3 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 2018/19.

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 their estimated useful lives.

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

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
NHS Shropshire 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. Cash, bank and overdraft balances are recorded at current values.

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 positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

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

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

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

1.18 Clinical Negligence Costs
NHS Resolution operates a risk pooling scheme under which the Clinical Commissioning Group pays an annual contribution and 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 2018-19 NHS Resolution held a provision of £0k for clinical negligence cases that are still to be settled.

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 Continuing Healthcare Risk Pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical Commissioning Groups contributed annually to a pooled fund, which is being used to settle the claims. There has been no contribution to this pooled fund in 2018/19.

1.21 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.

1.22 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.

1.22.1 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.

1.22.2 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 2018/19.

1.22.3 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 2018/19.

1.22.4 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, the 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.

1.23 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.

1.23.1 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.

NHS Shropshire CCG did not take financial guarantee contracts during 2018/19.

1.23.2 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.

NHS Shropshire CCG did not hold any financial liabilities at fair value through profit and loss during 2018/19.

1.23.3 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.

1.24 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.

1.25 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 2018/19.

1.26 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.

1.27 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).

1.28 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.

1.29 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.

1.29.1 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 £33.8m in 2018/19. 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 £20m.

1.29.2 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.

1.30 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Department of Health and Social Security Government Accounting Manual does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

The application of the Standards as revised would not have a material impact on the financial statements of the CCG for 2018/19, were they to be applied where relevant.

2. Other Operating Revenue

	2018-19 Total £'000	2018-19 Admin £'000	2018-19 Programme £'000	2018-19 Total £'000
Income from sale of goods and services (contracts) *				
Education, training and research	-	-	-	-
Non-patient care services to other bodies	-	-	-	1,085
Patient transport services	-	-	-	-
Prescription fees and charges	-	-	-	-
Dental fees and charges	-	-	-	-
Income generation	-	-	-	-
Other contract income	(0)	0	(0)	-
Recoveries in respect of employee benefits	-	-	-	
Total Income from sale of goods and services	**(0)**	**0**	**(0)**	**1,085**
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	1,374	147	1,227	1,082
Total Other operating income	**1,374**	**147**	**1,227**	**1,082**
Total Operating Income	**1,374**	**147**	**1,227**	**2,168**

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.

* Income has been re-assessed in 2018/19 following the implementation of International Financial Reporting Standard (IFRS)15. All CCG income received in both 2018/19 and 2017/18 has been classified as non-contract (other) income. HM Treasury have mandated that there should be no re-statement of prior year figures.

The effect of the application of IFRS15 on current year closing balances is not material and separate disclosure has therefore not been made.

3. Contact Revenue

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

The CCG did not receive any income in 2018/19 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 2018/19 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 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 4.1.2)	-	-	**-**
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**

4.1.1 Employee benefits 2017-18

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,712	2,208	**6,920**
Social security costs	487	-	**487**
Employer contributions to NHS Pension scheme	542		**542**
Other pension costs	-	-	**-**
Apprenticeship Levy	-	-	**-**
Other post-employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	-	-	**-**
Gross employee benefits expenditure	5,741	2,208	**7,950**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**5,741**	**2,208**	**7,950**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**5,741**	**2,208**	**7,950**

4.1.2 Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in 2018/19 (nil in 2017/18).

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number	Total Number
Total	**133.66**	**29.89**	**163.55**	118.20	26.33	144.53
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-	-

4.3 Exit packages agreed in the financial year

The CCG has made no payments in respect of exit packages in 2018/19, (nil in 2017/18). The CCG has made no special payments in respect of employee departures in 2108/19, (nil in 2017/18).

4.4 Pension costs

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

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

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

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

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

For 2018-19, employers' contributions of £689,734 were payable to the NHS Pensions Scheme (2017-18: £610,415), at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1, (net of recharges to other organisations).

5. Operating Expenses

	2018-19 £'000	2017-18 £'000
Purchase of goods and services		
Services from other CCGs and NHS England	2,428	2,499
Services from foundation trusts	85,807	84,087
Services from other NHS trusts	205,916	199,984
Services from Other WGA bodies	3	0
Purchase of healthcare from non-NHS bodies	64,429	60,166
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	49,793	52,465
Pharmaceutical services	-	-
General Ophthalmic services	363	345
GPMS/APMS and PCTMS	45,117	45,087
Supplies and services – clinical	1,081	1,060
Supplies and services – general	6,456	7,181
Consultancy services	1,031	986
Establishment	1,019	1,412
Premises	391	764
Audit fees	63	50
Other non statutory audit expenditure:		
Other services	10	-
Other professional fees	751	54
Legal fees	85	336
Education, training and conferences	39	30
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Total Purchase of goods and services	**464,874**	**456,654**

	2018-19 £'000	2017-18 £'000
Depreciation and impairment charges		
Depreciation	-	84
Total Depreciation and impairment charges		**84**
Provision expense		
Change in discount rate	-	-
Provisions	-	104
Total Provision expense		**104**
Other Operating Expenditure		
Chair and Non Executive Members	253	244
Grants to Other bodies	202	247
Clinical negligence	-	-
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	294	72
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Non cash apprenticeship training grants	-	-
Other expenditure	-	247
Total Other Operating Expenditure	750	810
Total Operating Expenditure	**465,624**	**457,652**

The above includes expenditure dealt with under the pooled budget arrangement for the Better Care Fund as set out in Note 16.

Health care expenditure includes £457k in respect of an increase 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 £53k in 2018/19, (included within other professional services).

External Audit Fees are inclusive of VAT. The auditor's liability for external audit work carried out for the financial year 2018/19 is limited to £2 million.

6. Prompt Payment Targets

6.1 Better Payment Practice Code

	2018-19 Number	2018-19 £'000	2017-18 Number	2017-18 £'000
Measure of compliance				
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	26,802	133,687	19,634	123,783
Total Non-NHS Trade invoices paid within target	26,347	131,397	19,293	119,564
Percentage of Non-NHS Trade invoices paid within target	**98.30%**	**98.29%**	**98.26%**	**96.59%**
NHS Payables				
Total Non-NHS Trade invoices paid in the Year	3,149	296,161	3,230	288,583
Total Non-NHS Trade invoices paid within target	3,066	293,778	3,161	287,042
Percentage of Non-NHS Trade invoices paid within target	**97.36%**	**99.20%**	**97.86%**	**99.47%**

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

The above includes expenditure dealt with under the pooled budget arrangement for the Better Care Fund as set out in Note 16.

Health care expenditure includes £457k in respect of an increase 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 £53k in 2018/19, (included within other professional services).

External Audit Fees are inclusive of VAT. The auditor's liability for external audit work carried out for the financial year 2018/19 is limited to £2 million.

	2018-19 £'000	2017-18 £'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

	2018-19				2017-18			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	-	223	5	228	-	703	8	711
Contingent rents	-	-	-	-	-	-	-	-
Sub-lease payments	-	-	-	-	-	-	-	-
Total	**-**	**223**	**5**	**228**	**-**	**703**	**8**	**711**

Buildings lease payments relate to expenditure with NHS Property Services Ltd for the rental of office accommodation (£78k), and void & subsidy costs (£145k). Note that the comparative figure for 2017/18 also includes service charges which have been excluded from this note in 2018/19 since they should not be recognised as lease costs.

Other lease payments relate to the rental of photocopiers.

7.1.2 Future minimum lease payments

	2018-19				2017-18			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable								
No later than one year	-	-	4	4	-	-	3	3
Between one and five years	-	-	3	3	-	-	-	-
After five years	-	-	-	-	-	-	-	-
Total	**-**	**-**	**7**	**7**	**-**	**-**	**3**	**3**

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. Disclosure relates to minor printer/photocopier leases.

7.2 As lessor

The Clinical Commissioning Group does not have any leasing arrangements as a lessor.

8. Property, Plant and Equipment

	Information technology £'000	Total £'000
2018-19		
Cost or valuation at 01 April 2018	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	-	-
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 2019	**114**	**114**
Depreciation 01 April 2018	**114**	**114**
Reclassifications	-	-
Reclassified as held for sale and reversals	-	-
Disposals other than by sale	-	-
Upward revaluation gains	-	-
Impairments charged	-	-
Reversal of impairments	-	-
Charged during the year	-	-
Transfer (to)/from other public sector body	-	-
Cumulative depreciation adjustment following revaluation		
Depreciation at 31 March 2019	**114**	**114**
Net Book Value at 31 March 2019	-	-
Purchased	-	-
Donated	-	-
Government Granted	-	-
Total at 31 March 2019	-	-

8.1 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. Trade and Other Receivables

	Current 2018-19 £'000	Current 2018-19 £'000
NHS receivables: Revenue	1,154	1,503
NHS receivables: Capital	-	-
NHS prepayments	50	-
NHS accrued income	1,708	53
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	990	970
Non-NHS and Other WGA receivables: Capital	-	-
Non-NHS and Other WGA prepayments	10	1,492
Non-NHS and Other WGA accrued income	67	102
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	(458)	(222)
VAT	165	171
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	1	5
Total Trade & other receivables	**3,687**	4,074
Included above: Prepaid pensions contributions		

9.1 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	1,189	203	1,441	297
By three to six months	-	280	11	77
By more than six months	-	14	-	599
Total	**1,189**	**497**	**1,452**	**973**

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

	Trade and other receivables - NHSE bodies £'000	Trade and other DHSC group bodies £'000	Trade and other receivables - external £'000	Other financial assets £'000	Total £'000
Classification under IAS 39 as at 31st March 2018					
Financial Assets held at FVTPL	-	-	-	-	-
Financial Assets held at Amortised cost	197	1,449	108	1,071	2,825
Financial assets held at FVOCI	-	-	-	-	-
Total at 31st March 2018	**197**	**1,449**	**108**	**1,071**	**2,825**
Classification under IFRS 9 as at 1st April 2018					
Financial Assets designated to FVTPL	-	-	-	-	-
Financial Assets mandated to FVTPL	-	-	-	-	-
Financial Assets measured at amortised cost	197	1,449	108	1,071	2,825
Financial assets measured at FVOCI	-	-	-	-	-
Total at 31st April 2018	**197**	**1,449**	**108**	**1,071**	**2,825**
Changes due to change in measurement attribute	-	-	-	-	-
Other changes	-	-	-	-	-
Change in carrying amount	-	-	-	-	-

9.3 Movement in loss allowances due to application of IFRS 9

	Trade and other receivables - NHSE bodies £'000	Trade and other DHSC group bodies £'000	Trade and other receivables - external £'000	Other financial assets £'000	Total £'000
Impairment and provisions allowances under IAS 39 as at 31st March 2018					
Financial Assets held at Amortised cost (i.e. the 1718 Closing Provision)	-	-	(222)	-	(222)
Financial assets held at FVOCI	-	-	-	-	-
Total at 31st March 2018	**-**	**-**	**(222)**	**-**	**(222)**
Loss allowance under IFRS 9 as at 1st April 2018					
Financial Assets measured at Amortised cost	-	-	(222)	-	(222)
Financial assets measured at FVOCI	-	-	-	-	-
Total at 1st April 2018	**-**	**-**	**(222)**	**-**	**(222)**
Change in loss allowance arising from application of IFRS 9	-	-	-	-	-

The clinical commissioning has assessed its opening loss allowance under IFRS9 and has concluded that no adjustments are arising from applying this new standard.

10. Cash and Cash Equivalents

	2018-19 £'000	2017-18 £'000
Balance at 1st April 2018	**197**	122
Net change in year	(109)	75
Balance at 31st March 2019	**88**	197
Made up of:		
Cash with the Government Banking Service	88	197
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**88**	**197**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31st March 2019	**88**	**197**

11. Trade and Other Payables

	Current 2018-19 £'000	Current 2017-18 £'000
Interest payable	-	-
NHS payables: Revenue	2,544	2,950
NHS payables: Capital	-	-
NHS accruals	2,898	2,340
NHS deferred income	-	-
NHS Contract Liabilities	-	-
Non-NHS and Other WGA payables: Revenue	7,249	7,019
Non-NHS and Other WGA payables: Capital	-	-
Non-NHS and Other WGA accruals	14,257	17,202
Non-NHS and Other WGA deferred income	1,395	-
Non-NHS Contract Liabilities	-	-
Social security costs	86	81
VAT	-	-
Tax	80	72
Payments received on account	-	-
Other payables and accruals	2,807	1,185
Total Trade & Other Payables	**31,315**	**30,850**

NHS payables include £1,824k in respect of partially completed spells (£1,328k in 2017/18).
Other payables include £508k outstanding pension contributions at 31 March 2019 (£318k in 2017/18).

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

	Trade and other payables - NHSE bodies £'000	Trade and other payables - other DHSC group bodies £'000	Trade and other payables - external £'000	Other borrowings (including finance lease obligations £'000	Other financial liabilities £'000	Total £'000
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at FVTPL	-	-	-	-		-
Financial Assets held at Amortised cost	**677**	**4,614**	**25,406**	-		**30,697**
Total at 31st March 2018	**677**	**4,614**	**25,406**	-		**30,697**
Classification under IFRS 9 as at 1st April 2018						
Financial Liabilities designated to FVTPL	-	-	-	-		-
Financial Liabilities mandated to FVTPL	-	-	-	-		-
Financial Liabilities measured at amortised cost	**677**	**4,614**	**25,406**	-		**30,697**
Financial Liabilities measured at FVOCI	-	-	-	-		-
Total at 1st April 2018	**677**	**4,614**	**25,406**	-		**30,697**
Changes due to change in measurement attribute	-	-	-	-		-
Other changes	-	-	-	-		-
Change in carrying amount	-	-	-	-		-

The clinical commissioning has assessed its opening financial liabilities under IFRS9 and has concluded that no adjustments are arising from applying this new standard.

12. Provisions

	Current 2018-19 £'000	Non-Current 2018-19 £'000	Current 2017-18 £'000	Non-Current 2017-18 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	-	-	104	
Other	-	-	-	-
Total	-	-	**104**	**-**
Total current and non-current			**104**	

	Continuing care £'000	Other £'000	Total £'000
Balance at 01 April 2018	**104**	**-**	**104**
Arising during the year	-	-	-
Utilised during the year	104	-	104
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 2019	-	-	-
Expected timing of cash flows:			
Within one year	-	-	-
Between one and five years	-	-	-
After five years	-	-	-
Balance at 31 March 2019	-	-	-

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 2018/19.

13. Contingencies

The Clinical Commissioning Group has no quantifiable contingent assets or liabilities as at 31 March 2019, (nil in 2017/18).

The Clinical Commissioning Group recognises a level of risk associated with elements of the 2018-19 contract held with a provider of healthcare services. Negotiations are ongoing to resolve this issue but these are hindered by the lack of a formal dispute process between English and Welsh health bodies. This risk is not quantifiable at the time of producing these accounts.

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 NHS Clinical Commissioning Group Prime Financial Policies agreed by the Governing Body. Treasury activity is subject to review by the NHS 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 NHS 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, the Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

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 NHS 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.

14.2 Financial assets

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'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	2,782	-	2,782
Trade and other receivables with other DHSC group bodies	183	-	183
Trade and other receivables with external bodies	954	-	954
Other financial assets	1		1
Cash and cash equivalents	88		88
Total at 31 March 2019	**4,008**	**-**	**4,008**

Trade and other receivables exclude the expected credit loss allowance of £458k as shown in Note 9

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Loans with group bodies	-	-	-
Loans with external bodies	-	-	-
Trade and other payables with NHSE bodies	561	-	561
Trade and other payables with other DHSC group bodies	13,343	-	13,343
Trade and other payables with external bodies	13,044	-	13,044
Other financial liabilities	2,807	-	2,807
Private Finance Initiative and finance lease obligations	-	-	-
Total at 31 March 2019	**29,754**	**-**	**29,754**

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

16.1 Interests in joint operations (amounts recognised in entity books only)

Description of arrangement	2018-19				2017-18			
	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'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 cares services	0	0	0	20,021	0	0	0	19,648

The total value of this pool for 2018/19 is £33.8m, £20m of this being the CCG's contribution (£19.6m for 2017/18).

A summary of the schemes relating to this expenditure is given below:

	2018-19 £'000	2017-18 £'000
Assistive Technologies	1,645	1,639
Care navigation/Co-ordination	1,739	1,363
Carers Services	2	1
Enablers for Integration	3,619	3,233
Healthcare Services to Care Homes	266	222
Integrated Care Planning	1,921	1,793
Intermediate Care Services	2,783	3,170
Personalised Healthcare at Home	267	332
Wellbeing Centres	0	50
L A Schemes	7,779	7,845
Total	20,021	19,648

17. Related Party Transactions

During 2018/19 the following Governing Body members and key members of management declared interest 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
Edward Rysdale Non Executive Director of the CCG, wife is GP Partner at Beeches Medical Practice	961	0	0	0
Kevin Morris Practice Representative on the Governing Body of the CCG is Managing Partner at Cambrian Surgery	1,741	0	3	0
Kevin Morris Practice Representative on the Governing Body of the CCG - Wife is Executive Director of NHS Telford & Wrekin CCG	4,526	0	315	0
Priya George GP Governing Body Member of the CCG - Husband is a Consultant (Radiologist) at University Hospital North Midlands NHS Trust	2,223	0	0	0
Mike Matthee Joint Locality Chair - North Locality of the CCG - GP Partner at Market Drayton Medical Practice	79	(1,472)	212	(13)
Dr J Povey Chair of the CCG is GP Partner at Pontesbury Medical Practice	2,145	0	0	0
Dr Julian Povey Chair of CCG - Wife is Medical Director at Shropshire Community Health NHS Trust	40,438	0	382	0
Dr Jessica Sokolov is Medical Director of the CCG - Father elected to Shropshire Council	11,389	(291)	1,759	(44)
Dr Jessica Sokolov is Medical Director of the CCG - Father is Governor of West Midlands Ambulance Service	3,274	0	51	(13)
Dr Stephen James is GP Governing Body Member of the CCG - Member of Shropshire Doctors Cooperative Ltd	13,650	0	144	0
Dr John Pepper GP Governing Body Member of the CCG - Partner at Belvidere Medical Practice	1,457	0	1	0
Matthew Bird - Locality Chair of the South Locality of the CCG - GP Partner at Albrighton Medical Practice	1,488	0	14	0
Katy Lewis - Joint Locality Chair of the North Locality of the CCG - GP Principle at Westbury Medical Centre	1,038	0	2	0
Dr Finola Lynch GP Governing Body Member of the CCG - Salaried GP at Bishop Castle Surgery	1,715	0	0	0
Samantha Tilley Executive Director of the CCG - Brother-in-law is Operations Manager at Shrewsbury and Telford Hospital NHS Trust	144,994	(371)	355	(81)

The Department of Health and Social Care is regarded as a related party. During the year the Clinical Commissioning Group has had material transactions with entities for which the Department is regarded as the parent Department. These are:

NHS England
Health Education 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 2018/19 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

The Clinical Commissioning Group does not have any events after the end of the reporting period to disclose.

19. Third Party Assets

The Clinical Commissioning Group did not hold any third party assets in 2018/19, (nil in 2017/18).

20. Financial Performance Targets

The Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). Performance against those duties was as follows:

	2018-19 Target £'000	2018-19 Performance £'000	2017-18 Target £'000	2017-18 Performance £'000
Expenditure not to exceed income	456,422	473,481	438,559	465,602
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	455,048	472,107	436,391	463,434
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	6,774	7,082	6,636	8,306

21. Analysis of Charitable Reserves

	2018-19 £'000	2017-18 £'000
Unrestricted funds	-	-
Restricted funds	1	2
Endowment funds	-	-
Total	1	2

The Clinical Commissioning Group holds a charitable donation of £1k for use towards staff welfare.

22. Losses and Special Payments

22.1 Losses

The total number of NHS Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2018-19 Number	Total Value of Cases 2018-19 £'000	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Administrative write-offs	0	0	5	319
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	0	0	**5**	**319**

22.2 Special Payments

The Clinical Commissioning Group has made no special payments in 2018/19, (nil in 2017/18).

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

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Conclusions relating to going concern

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

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

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information; we are required to report that fact. We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls. We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the Health and Social Care Act 2012; and

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

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 £17.06 million against its total in year revenue resource limit in its financial statements for the year ended 31 March 2019, 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 223I 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. In addition, the CCG exceeded its revenue administration resource limit by £0.308m in the year ended 31 March 2019, 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 2 May 2019 we referred a matter to the Secretary of State under section 30 (a) and (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. We further set out in this letter that the CCG has set a deficit budget of £12.3m for year ended 2019/20 and is therefore expected to breach the breakeven duty.

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 51 to 52], 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 November 2017, 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 2019.

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 £13.3m for the year ended 31 March 2019. Due to volatility in CHC and Complex Care, over-performance in major acute contracts and under-delivery of the QIPP programme, the CCG reported a deficit of £17.06 million in its financial statements for the year ended 31 March 2019.

- The CCG has an accumulated a cumulative deficit of £76m over a 6 year period, having identified limited opportunities to return to financial balance. The CCG has not yet succeeded in addressing the underlying deficit in its budget.

- The 2019/20 budget does not meet the CCGs control total set by NHS England of a £12.3m deficit, it instead shows a planned £22.9m deficit. In order to achieve the control total set by NHS England, a further £10.6 million of QIPP savings would need to be identified and delivered. The CCG would then have total QIPP savings for 2019/20 of £30.4m (6.5% of its resource limit).

- Of the £19.3m of QIPP savings identified so far for 2019/20, approximately £5m are deemed at risk of non-delivery.

- As the CCG cannot currently submit a plan that meets the NHS England control total and the size of the current gap, there has been no formal sign off of the 2019/20 budget by the Governing Body. 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 November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of NHS Shropshire Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

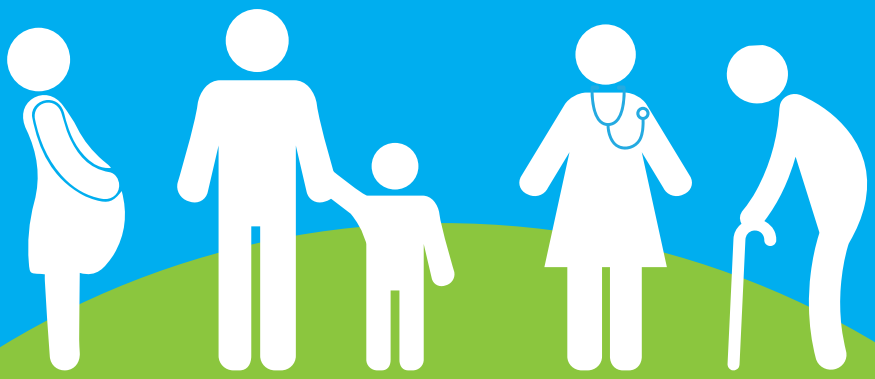
Use of our report

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.

Mark C Stocks
Partner for and on behalf of Grant Thornton UK LLP
Birmingham
24 May 2019

Annual Report

2018/2019



NHS
Shropshire
Clinical Commissioning Group

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