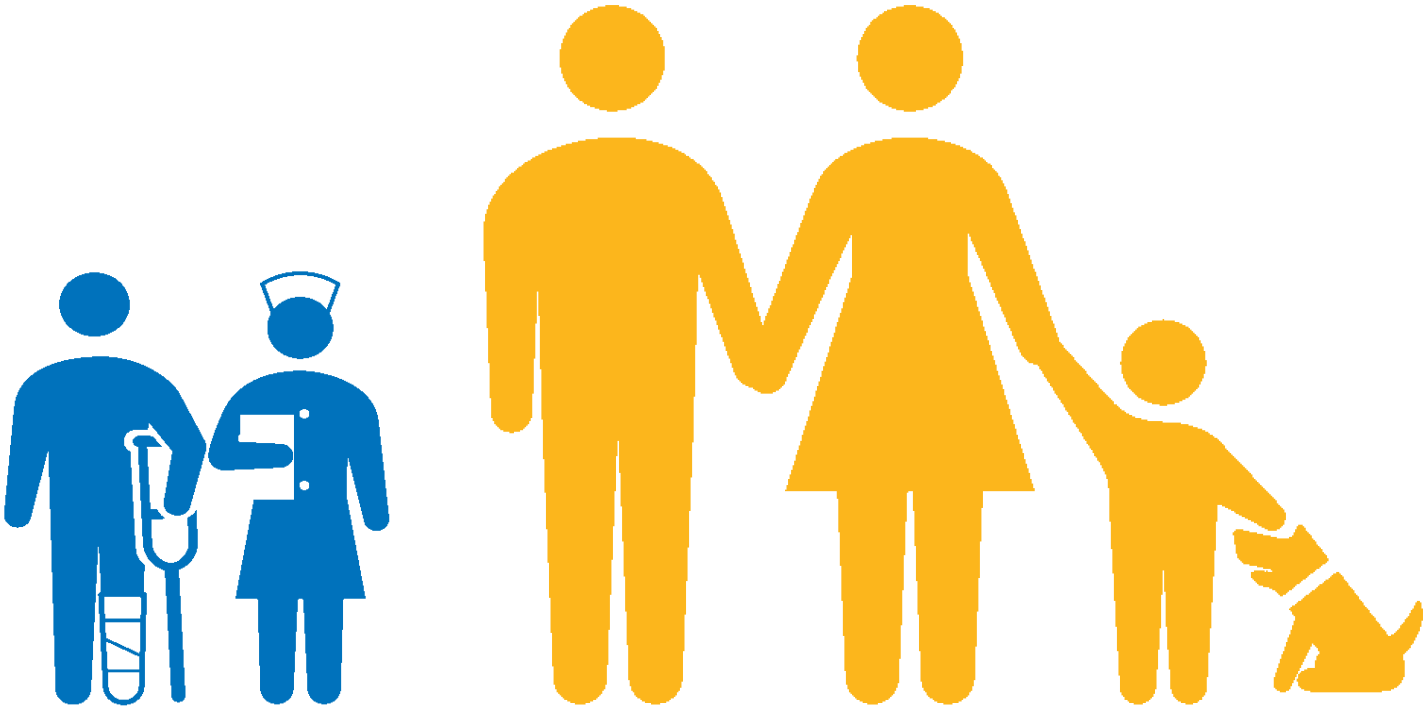
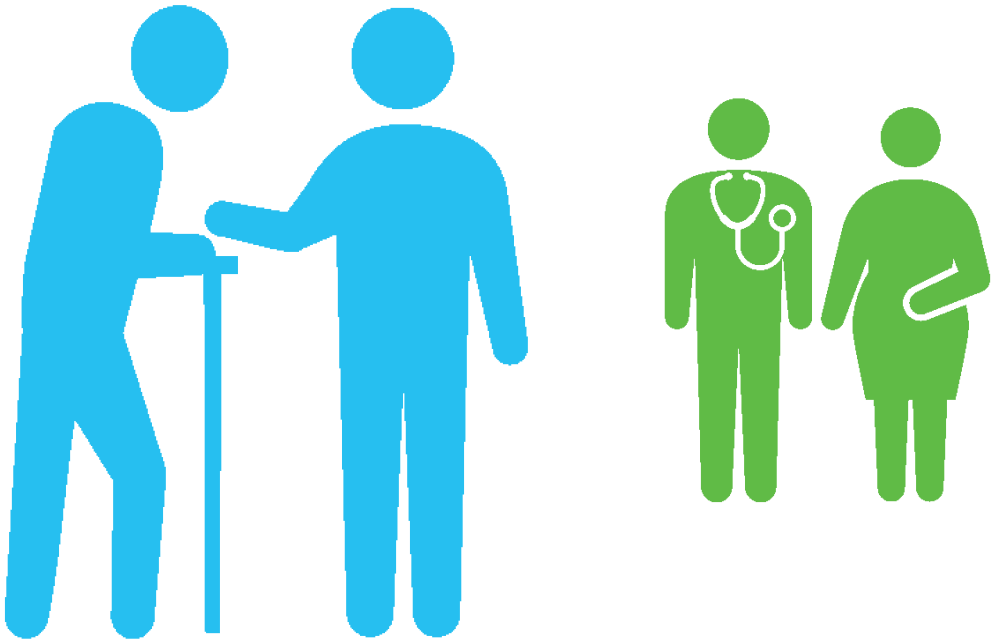
At the heart of Shropshire's health

NHS
Shropshire
Clinical Commissioning Group



Annual Report
2017/18



Contents

Introduction from Shropshire Clinical Commissioning Group Chair and Accountable Officer

We are delighted to introduce our Annual Report for the year 2017/18, a year that has brought significant challenges and seen significant positive strides forward for NHS Shropshire Clinical Commissioning Group (CCG).

As 2016/17 was a year of consolidation, understanding and gaining control of the CCG both organisationally and financially, 2017/18 has been a year of resolve to hold to our plans and push forward with the CCG's recovery. In 2016/17 we were able to reach to our financial control total target. We are disappointed that in 2017/18 we have not been able to achieve our control total but in 2018/19 we hope to return to financial balance. 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.

We have successfully recruited a new substantive Executive team who work closely not only with each other to implement the CCG's plans, but also with our partners across the health and social care economy to ensure the delivery of our plans results in improvements to the care patients receive. Alongside the Executive team we have successfully recruited two additional Lay Members to our Governing Body. These Lay Members will focus in particular on Transformation and Patient and Public Involvement and when taken alongside our existing Lay Members whose focus is on Audit, Governance and Performance this results in a strengthened position of scrutiny and independent oversight of the CCG's work. As a result of our successful recruitment endeavours in 2017/18 we will move into 2018/19 with the full complement of Governing Body positions filled.

The CCG has been able to commence implementation of its ambitious, but necessary, Financial Recovery Plan which seeks to return the CCG to a recurrent balance over a number of years. Despite the set-back of not reaching our financial control total for 2017/18 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 was been developed with our partners in health and social care.

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 undertaking 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 have already begun to move forwards with transformation plans, details of which are contained within this report and we are 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 to look towards the priorities for 2018/19, 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

Dr Simon Freeman
Accountable Officer

1.0 Performance report

1.1 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 £436m budget to ensure high-quality, sustainable healthcare for our population. We are a clinically-led organisation, comprising 43 GP practices, and we provide healthcare services for patients who are registered with a GP in Shropshire.

Our population

Our planned activities undertaken in 2017/18 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 312,407, 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. Based on demographic profiles, this is significantly higher than the figure of five per cent nationally. National research highlights that 3 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 7 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.

Our structure and 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

Elective musculoskeletal (MSK) activity has been identified by Shropshire CCG based on the NHS RightCare analysis as a significant outlier compared to other similar CCGs. Patients in Shropshire are significantly more likely to receive surgical interventions rather than non-surgical alternatives than the national average. Shropshire CCG have undertaken benchmarking of performance against comparator CCG's to better understand this issue and inform our service planning.

Frailty

An elderly population is more likely to have complex health and care needs associated with multiple co-morbidities 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 in conjunction with Right Care requirements have 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.

Workforce

The recruitment and retention of key groups of health professionals remains a challenge for the health community. Shropshire faces the issue of many local GPs nearing retirement age, and 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 development of our Out of Hospital models is expected to have a positive impact once operationalised. In addition during 2017/18 we have recruited a system Urgent Care Director who is leading and co-ordinating a programme of work to support A&E performance delivery on behalf of all stakeholders and partners.

Working in Partnership

We know that pressures on social care are of particular concern in Shropshire. Plans supported by the Better Care Fund programme enable joined-up working between health and social care and will lead to the long-term transformation of Shropshire's health and social care economy, enhancing people's independence, health and quality of life through seamless and efficient care. During the year, we have been working with social care partners locally to align our strategic objectives and ensure that, together, we 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 & Telford Hospital NHS Trust now consistently being met and significant progress being made to reduce the number in other key settings.

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 prevention 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.

1.2 Financial Performance

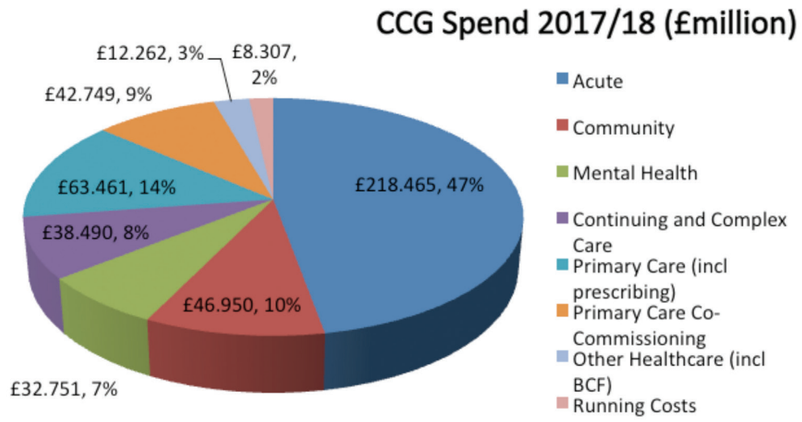
The CCG is required to meet national and local targets with respect to its expenditure and reported position. 2017/18 has proved to be a particularly challenging year and therefore, disappointingly, we have been unable to meet all of these targets. Performance is summarised below:

2017/18 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)	£438,559m	£465,602m
Capital resource use does not exceed the amount specified in Directions	Nil	Nil
Revenue resource use does not exceed the amount specified in Directions	£436,391m	£463,434m
Revenue administration resource use does not exceed the amount specified in Directions	£6,636m	£8,307m
Non-Statutory Duties		
Better Payment Practice Code: NHS	95%	97.9%
Better Payment Practice Code: Non NHS	95%	98.3%
Cash draw down target	Achieved	Achieved
QIPP (Quality, Innovation, Productivity and Prevention)	£17.7m	£16.1m

It should be noted that the CCG has accrued an accumulated deficit of £32.6m to date. Once the 2017/18 deficit of £27.1m is added to this figure, the deficit carried forward to 2018/19 becomes £59.7m.

The CCG is striving to meet its statutory duty to not spend more than it has been allocated and is developing a 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:



Information in relation going concern is included in the Annual Accounts

1.3 Assurance on how well we are performing

To help NHS England, patients and the public identify how well CCG's are performing in their role as commissioners of health services there is an Improvement an 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 and 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.

1.4 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 2017/18 against a number of these targets and plans to build on this solid foundation in 2018/19.

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 2017/18 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 2017/18, 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 was not achieved, although performance has improved from 2016/17. RTT waiting times were met by Shrewsbury & Telford Hospital and almost met by Robert Jones Agnes Hunt, our 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 2017/18:

Standard	Performance
Referral to Treatment (RTT) for non-urgent consultant led services: admitted, non-admitted and incomplete patients to start treatment within a maximum of 18 weeks from referral	From October 2016, we were monitored only on our performance in relation to the Incomplete Waits Standard. For internal purposes, we will continue to monitor the admitted and non-admitted waits standards via the Planned Care Working Group. At the end of March we achieved 89.8 per cent of patients waiting under 18 weeks for treatment. This was made up of 91.8 per cent at SaTH, 92.1 per cent at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH), 92.5 per cent at Shropshire Community Trust and 82.1per cent in aggregate at all other providers.
Number of 52 week RTT pathways (incompletes): zero tolerance of over 52 week waits	At the end of March, published figures showed five Shropshire patients had been waiting over 52 weeks for treatment. There was four at Wye Valley NHS Trust and one at Somerset and Taunton Hospitals NHS Trust.
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 consistently throughout the year and were 99.2 per cent at March.
A&E waits: patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	Acute providers were monitored against a trajectory agreed with NHS Improvement outlining the performance level to which they would achieve the national standard for 2017/18. 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 67.2 per cent of A&E attendances waiting less than 4 hours in March 2017. 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 easily. The local system is working with NHS Improvement and Health Education England to look at innovative ways of addressing the workforce challenges. Difficulties in achieving the A&E performance target continue throughout the NHS at present.

Cancer waiting times: First outpatient appointment for patients referred urgently with suspected cancer by a GP	Performance against the range of cancer targets has been generally good throughout the year. With some exceptions in relation to two-week wait targets for possible breast cancers and 62 day wait urgent referrals. SaTH have achieved most targets through the year. Some performance difficulties have been evident with Out of County providers

Description	Target %		Cumulative 17/18	Number of Months Achieved (out of 11)
Cancer urgent referral to first outpatient appointment (14 day referral)	93%	Achieved	93.06%	7
		Total Referrals	12517	
		Breaches	869	
Proportion of patients with breast symptoms referred to a specialist who are seen (14 day referral)	93%	Achieved	91.65%	1
		Total Referrals	1018	
		Breaches	85	
Cancer diagnosis to treatment waiting times (31 day first treatment)	96%	Achieved	99.05%	11
		Total Referrals	1786	
		Breaches	17	
31 days for subsequent cancer treatment (surgery)	94%	Achieved	97.3%	10
		Total Referrals	371	
		Breaches	10	
31 days for subsequent cancer treatment (drugs)	98%	Achieved	99.85%	11
		Total Referrals	647	
		Breaches	1	
31-Day Standard for Subsequent Cancer Treatments (Radiotherapy)	94%	Achieved	99.25%	11
		Total Referrals	531	
		Breaches	4	
Urgent referral to treatment waiting times (62 day referral to treatment) Not including Rare Cancers – Open Exeter	85%	Achieved	82.97%	4
		Total Referrals	917	
		Breaches	156	
Urgent referral to treatment waiting times (62 day referral to treatment) Including Rare Cancers – NHS England Published	85%	Achieved	82.97%	4
		Total Referrals	916	
		Breaches	156	
Extended 62-Day Cancer Treatment – Screening (part a)	90%	Achieved	88.04%	4
		Total Referrals	92	
		Breaches	11	
Extended 62-Day Cancer Treatment – Consultant upgrade (part b)	(tbc)	Achieved	87.93%	n/a
		Total Referrals	381	
		Breaches	46	

Category 1 ambulance calls: Category 1 calls to have an average emergency response within seven minutes and a reach 90% of calls within 15 minutes	We have not achieved the targets locally during 2017/18. Difficulty in achieving these targets is true for many of the more rural CCGs within the West Midlands. New definitions for the categorisation of emergency ambulance calls were adopted nationally during the year. This has made it more difficult to achieve the Category 1 call standards everywhere. The new measures indicate that performance in Call categories 3 and 4 , the less urgent cases, performance in Shropshire is better than many other parts of the West Midlands.

Mixed sex accommodation breaches (minimise breaches)	During 2017/18, nine breaches have been reported up to the end of March
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 2017/18, up to the end of March where a patient 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	Published figures are at Q4, which show 96.5 per cent compliance on this measure for the year so far.

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 and in the middle quartile for a further 21.
- Only 2 of the indicators showed the CCG in the lowest quartile nationally – one of these (EIP 2wk referral) was subject to the variability produced by small numbers and will now be achieved for 2017/18.
- A&E performance remains the most significant challenge for the CCG and the local system.

Better Health

			Period	CCG		Peers	England	Trend
R	102a	% 10-11 classified overweight /obese	2013/14 to 2015/16	30.3%	▼	1/11	45/207	
	103a	Diabetes patients who achieved NICE targets	2016-17	40.2%	▲	8/11	96/207	
	103b	Attendance of structured education course	2016-17*	3.4%	▲	7/11	138/207	
R	104a	Injuries from falls in people 65yrs +	17-18 Q2	940	▼	1/11	7/207	
R	105b	Personal health budgets	17-18 Q3	10.76	▲	7/11	130/207	
R	106a	Inequality Chronic – ACS & UCSCs	17-18 Q2	842	▲	1/11	9/207	
R	107a	AMR: appropriate prescribing	2017 12	1.012	▼	3/11	86/207	
R	107b	AMR: Broad spectrum prescribing	2017 12	7.8%	▲	5/11	65/207	
R	108a	Quality of life of carers	2017	0.66	●	5/11	78/207	

Better Care

			Period	CCG		Peers	England	Trend
R	121a	High quality care – acute	17-18 Q3	60	▲	#N/A	99/207	
R	121b	High quality care – primary care	17-18 Q3	69	◀ ▶	4/11	20/207	
R	121c	High quality care – adult social care	17-18 Q3	64	◀ ▶	3/11	21/207	
R	122a	Cancers diagnosed at early stage	2016	50.6%	▼	9/11	137/207	
R	122b	Cancer 62 days of referral to treatment	17-18 Q3	86.0%	▲	2/11	56/207	
	122c	One-year survival from all cancers	2015	72.4%	▲	5/11	84/207	
	122d	Cancer patient experience	2016	8.7	▼	6/11	123/207	
R	123a	IAPT recovery rate	2017 12	54.3%	▲	2/11	45/207	
R	123b	IAPT Access	2017 12	3.4%	▼	9/11	157/207	
R	123c	EIP 2 week referral	2018 02	51.9%	▲	9/11	193/207	
	123d	MH – CYP mental health (not available)						
R	123f	MH – OAP	17-18 Q3	25	●			
	123e	MH – Crisis care and liaison (not available)						
R	124a	LD – reliance on specialist IP care	17-18 Q3	67	▲	7/11	161/207	
	124b	LD – annual health check	2016-17	65.0%	▲	1/11	13/207	
	124c	Completeness of the GP learning disability register	2016-17	0.52%	●	6/11	68/207	
R	125d	Maternal smoking at delivery	17-18 Q3	11.7%	▼	5/11	108/207	
	125a	Neonatal mortality and stillbirths	2015	4.6	●	6/11	101/207	
R	125b	Experience of maternity services	2017	88.0	●	3/11	12/207	
R	125c	Choices in maternity services	2017	66.2	●	1/11	24/207	
R	126a	Dementia diagnosis rate	2018 02	69.8%	▲	1/11	85/207	
	126b	Dementia post diagnostic support	2016-17	82.3%	▲	1/11	18/207	
R	127b	Emergency admissions for UCS conditions	17-18 Q2	1,735	▼	4/11	22/207	
R	127c	A&E admission, transfer, discharge within 4 hours	2018 03	75.0%	▲	9/11	184/207	
R	127e	Delayed transfers of care per 100,000 population	2018 02	7.1	▲	3/11	56/207	
R	127f	Hospital bed use following emerg admission	17-18 Q2	413.6	▼	4/11	28/207	
	105c	% of deaths with 3+ emergency admissions in last three months of life (not available)						
	128b	Patient experience of GP services	2017	89.1%	▼	2/11	27/207	
R	128c	Primary care access	2018 01	47.0%	◀ ▶	6/11	112/207	
R	128d	Primary care workforce	2017 09	1.14	▼	8/11	31/207	
R	129a	18 week RTT	2018 02	90.2%	▼	3/11	85/207	
	130a	7 DS – achievement of standards (not available)						
R	131a	% NHS CHC assesments taking place in acute hospital setting	17-18 Q3	4.5%	▼	4/11	47/207	
	132a	Sepsis awareness (not available)						

Key

- Worst quartile in England
- Best quartile in England
- Interquartile range

1.5 Other items of strategic importance

NHS Future Fit programme

Launched in January 2014, the programme aims 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 '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 focuses 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.

The programme acknowledges that there are some very good health services in our region, but the population's needs are changing. The number of people aged over 65 in Shropshire has increased by 25 per cent in just 10 years and we face new challenges, such as not enough of the right medical workforce to adequately staff our hospitals, tighter budgets and more stringent quality standards.

The proposed model involves one hospital becoming an emergency care centre which brings together specialist doctors to treat life-threatening injuries and illnesses and the other hospital becoming a planned care centre for all non-complex planned operations and procedures. Both sites would also have 24/7 Urgent Care centres for injuries and illnesses that are not life or limb-threatening but require urgent attention. In addition there would be access to midwife led services, outpatient services and tests at both hospitals.

During 2017/18 a significant amount of work has taken place to progress the programme. In March 2018 the Department of Health and Social Care announced that the CCG's will 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 our hospital services, the largest capital investment in the NHS in Shropshire in the last 70 years.

Further to this announcement and following a rigorous NHS England assurance programme, the decision to proceed to public consultation has now been granted.

As we move into 2018/19 the Future Fit team are undertaking the process of finalising plans to commence the consultation which will ask for people's views on the options for service configuration.

Sustainability and Transformation Plan

We are one of the local partners responsible for helping to develop the Sustainability and Transformation Partnership (STP) for Shropshire, Telford & Wrekin. This sets out how health and care services will need to change in order to meet the needs of local people. 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 is the culmination of a wide range of local organisations, patient representatives and care professionals coming together 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 this document.

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

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

STP priorities include:

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

The STP is an evolving programme, building on work carried out 2017/18 we anticipate in 2018/19, our STP will take an increasingly prominent role in planning and managing system-wide efforts to improve services. Including:

- Ensuring a system-wide approach to operating plans that aligns key assumptions between providers and commissioners;
- Work 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;
- Identify system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions;
- Undertake 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; and
- Take 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.

Shropshire 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 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 2017-18 budget for the Shropshire BCF is £29,277,201, the minimum contributions from the CCG and the Local Authority.

Shropshire CCGs contribution is a total of £19,646,698, which is made up of services commissioned and funded by Shropshire CCG (£11,802,592), the balance (£7,845,106) of the CCG minimum contribution is passed to Shropshire Council to commission services. (The latter would include previous s.256 services).

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

Out of Hospital Transformation (OOH)

Shropshire CCG has commenced a review of the current provision of community-based services with a view to making the necessary changes to the overall system that is required to better deliver services closer to home. This supports the delivery of the The Five Year Forward View that advocates collaborative whole system solutions and the Future Fit Programme.

Out of Hospital care will become a much larger part of what we do across the Shropshire health and care economy. The Community Services Review work will continue as follows:

- Option development for DAART and Community Beds will form part of the Out of Hospital programme at Phase 3 building on from the work of the CCG in 2017;
- Option development for Minor Injuries Services will move to the CCG's Urgent Care Portfolio for development alongside the system's urgent care agenda.

The vision for the out of hospital transformation programme for Shropshire 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".*

Key priorities

Phase 1 Frailty Front door (presently operational) – A dedicated Multi-Disciplinary Team (MDT) 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. This team will liaise and work 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 2 – Primary Care Development including Local Enhanced Services and Case Management (Collaborative design by March 2018 – Risk stratification to commence as soon as possible) built around general practices with a core Locality Team including district nurses, care co-ordinators, allied health professionals, social care and matrons. 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.

Phase 3 Hospital at Home/Crisis Intervention/Rapid Response/DAART and Step Up Community Beds (Collaborative design by June 2018) – Where care needs 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 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.

1.6 Our Achievements in 2017/18

Urgent care

Integrated Acute and Community Frailty ‘Front Door Team’

In November 2017, a previously separate group of health and social care professionals came together to work as a team at the front door of the Royal Shrewsbury Hospital with a special focus on early identification, assessment and treatment of frail older people. The team comprises a geriatrician, therapists, advanced nurse practitioners, community matron and social workers. They operate in A&E, CDU and AMU and early results are showing a reduction in admissions and length of stay for patients over 75 years of age. The aim of the team is to avoid an admission if at all possible and where admission is necessary to achieve discharge within 72 hours.

Evaluation of phase 2 of the service from October 2017 to March 2018 shows that the frailty team have delivered between a 4-10% reduction in admissions from A&E which equates to 92 fewer admissions per month compared to the same period the previous year. During the same period the average length of stay for all >75s at RSH reduced from 11.4 to 10.4 days compared to the same period the year before. The average length of stay for patients on the Frailty Team’s caseload was 1 day. This is important because for this type of patient staying in an acute hospital bed longer than their need for specialist acute care can lead to a significant loss of independence and mobility.

High intensity service users of emergency and urgent care services

Our project worker continues to work with a number of our most complex and vulnerable patients across the county who are high users of the Accident and Emergency Department. Direct contact with patients is provided through a highly personalised approach, empathic coaching and facilitating communication between services both statutory and voluntary. Patients are now increasingly making the effort to reconcile their own issues and change their behaviour, building upon their strengths resulting in a better quality of life for them and reduced demand on A&E.

In 2017-18, the use of A&E by this patient group reduced by up to 60% compared to the period before joining the high intensity service user caseload.

NHS 111

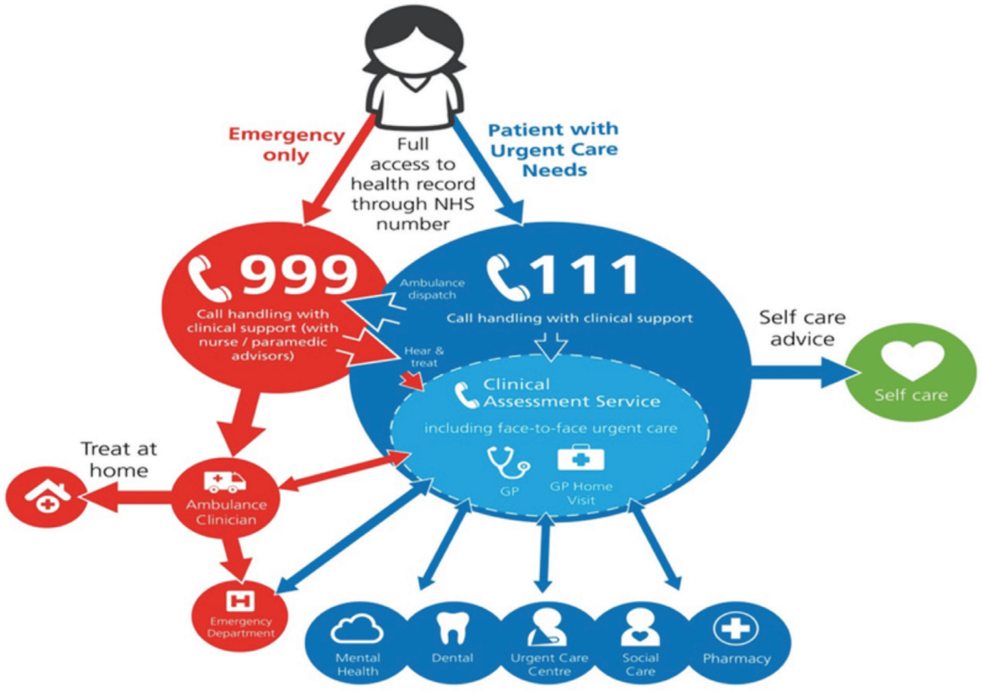
NHS 111 is a free, non-emergency service for the West Midlands, provided by Care UK. It is one of many national initiatives implemented to try to reduce pressure on hospital A&E departments. The service provides a free to call patient number and delivers free healthcare advice and signposting to the correct service for patients, on a 24/7 basis and is growing month-by-month as patients recognise its value.

NHS 111 assesses patients’ needs and directs them to the local service that can help them best, for example community pharmacy or the GP out-of-hours service. The 999 service is still there for life-threatening emergencies.

In 2017, NHS England and NHS Improvement published the Next Steps on the NHS Five Year Forward View which highlighted the importance of delivering a functionally integrated urgent care service to help address the fragmented nature of out-of-hospital services. The aim of this integration is to provide care closer to people’s homes, incorporate the ‘consult and complete’ model and help tackle the rising pressures on all urgent care services. In response to this NHS England published a new national service specification in August 2017 for the provision of an integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call-handling and former GP out-of-hours services.

The local GP Out of Hours Service is provided by Shropdoc (Shropshire Doctors Co-Operative). The service operates between the hours of 6.30pm and 8am Monday to Thursday and 6.30pm Friday and 8am the following Monday plus bank holidays. The service provides clinical assessment and advice to patients over the telephone and face to face consultations through appointments at various GP Out of Hours bases throughout the county and home visits. The service also provides telephone clinical advice to health care professionals such as ambulance crews.

A diagram of the national overview of integrated urgent care is given below:



Central to this is the development of the NHS111 Clinical Assessment Service (CAS) offering patients who require it access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and nurses in residential homes and the community, so that no decision needs to be taken in isolation.

Current service provision delivered by the NHS 111 and GP out-of-hours service does not meet the requirements of the new specification. In December 2017, we began a procurement process for a new contract which will deliver the national service specification from 1st October 2018.

One of the key local changes will be that in 2018 all patient access to GP Out of Hours services will be via NHS111, which is in line with the rest of the country and the national service specification.

Planned care

Orthopaedics

Shropshire CCG has continued to work towards the desired national and local goals in relation to Musculo-Skeletal (MSK) services. A number of service developments have been delivered in year including a detailed service specification for the Shropshire Orthopaedic Outreach Service. This has been rolled out to the North and the Shrewsbury area of the county in year and the first clinic was held in the South of the county in March 18. Further locations will come on board in the South during Q1 2018/19. A new specification has also been developed for physio and that will take effect during 2018/19. The CCG has also introduced a new Carpal Tunnel pathway providing better access to conservative management at an earlier stage via our GP practices. The CCG has become part of the Shared Decision Making Collaborative with NHS England to support our patients in their decisions regarding their choice of treatment for MSK conditions. Our Value Based Commissioning Policy has also been updated to reflect the latest evidence base for MSK treatments. Finally we have developed and agreed our MSK triage process which will take effect from 1st April 2018 in line with the national guidance.

This work has contributed savings of over £1million to the total CCG position whilst ensuring good quality MSK services and outcomes for our patients. The vision for MSK for the CCG remains:

'To commission a transformed MSK service that provides capacity to meet the needs of Shropshire patients in line with evidence based best practice.'

Referral Assessment Service (RAS)

Where possible, we want every Shropshire patient to be able to choose where they are treated. We also want our providers to receive appropriate referrals that are supported by a good package of 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 2017/18, RAS successfully implemented a prior approvals process, which ensures greater consistency in both referrals and treatment for those procedures which research has shown are of limited clinical value.

Beyond 2017/18, RAS will take a leading role within the local NHS as it moves to full usage of electronic referrals (including 'advice and guidance' requests and two week cancer waits) using 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 201/18 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.

Pain management

Shropshire CCG awarded a contract to Pain Management Solutions (PMS) to deliver community pain services in early 2017. PMS clinics are based in the community across Shropshire. Sometimes a patient may need a procedure to be carried out in a hospital: PMS are able to refer into our local hospitals for these services. The value of this service to the CCG continues to be monitored closely, in line with the MSK transformation programme.

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. We are pleased to report that the hospital trust was able to maintain its excellent performance on cancer waiting times during 2017/18.

End of life

End of life care helps people die with dignity. Ensuring that this care is provided in a setting chosen by patients and their families is of paramount importance. Working closely with Severn Hospice, we have expanded a successful pilot to support people nearing the end of their life to stay at home, wherever possible.

When a patient is referred to Severn Hospice their needs are assessed by the Enhanced Care Team, who then work with the multiple health services involved in a patient's care, including GPs and district nurses. The team can then have sensitive discussions with the patient, relative or carer to develop a package of care. This could include nursing visits at home, carer respite at night time or support over the phone. Patients can now be confident that there is 24/7 advice and support available when they most need it.

Carers

We have worked closely with Shropshire Council to complete a new carer strategy and action plan, building on the Care Act 2014 and new directions to the NHS.

Discharge to assess

Our 'discharge to assess' initiative continues to improve the management of complex patients, as they prepare to leave hospital. The model has recently been extended to all community and acute hospitals, with Sheldon Ward in Oswestry the latest site to launch during March 2017. The home first philosophy, central to the model, is supporting patients to return home safely supported by a range of health and social care services. There has been a positive increase in hospital discharges to pathway1. January 2016 – 17 saw a 72% increase in pathway 1 discharges from acute and community hospitals (185 discharges January 2017 compared to 254 discharges in 2018) and hence there has been a reduction in pathway 2 bed based rehabilitation (pathway 2).

There has also been an increase in the number of patients from the acute hospital into interim beds to enable their complex assessments to be undertaken (pathway 3). This is as a result of the local authority increasing council-funded community independent sector capacity during 2017/18.

The NHS England 2017/18 mandate between the Government and NHS England set the expectation that delayed transfers of care (NHS, adult social care and jointly attributable combined) should be reduced by September 2017 to 3.5% of occupied hospital beds. Reducing delayed transfers of care locally remains a key focus to ensure our patients are not delayed in their discharge from hospital. We are continuously striving to ensure discharge services are in place to facilitate discharges within the estimated discharge date. Our Delayed Transfers of Care performance has improved over the last 12 months across both acute and community hospitals with 919 less lost bed days in the 12 months to December 2017.

The Discharge to Assess work streams, newly developed and enhanced discharge services across adult social care health and intermediate care services have contributed to the significant DTOC reduction and achieving the DTOC trajectory. The Local Authority has set itself a target that all patients requiring their support are discharged within 48 hours of them receiving the referral.

Date	SaTH	SCHT	RJAH
Dec 2016	4.2%	27.5%	9.6%
Dec 2017	2.6%	5.8%	6.3%

Work is continuing, aligned with the Better Care Fund, to look at how processes could be further streamlined and integrated across health and social services. As set out earlier in this report in November 2017 we introduced an integrated acute and community frailty team to work in A&E and Acute Medical Assessment Unit in the Royal Shrewsbury Hospital. The aim of this service is to identify frail elderly patients at risk of an emergency admission early in their arrival at the acute hospital, ensure they have holistic frailty assessments and necessary treatment and discharge home within 72 hours wherever possible. Early indications from the service are that length of stay for frail patients is reducing as a result.

Integrated Community Services (ICS)

Integrated Community Services (ICS) continue to provide effective short-term support in a patient's home, either when they have been discharged from hospital or to avoid an unnecessary admission. ICS has been rolled-out and expanded to include admission avoidance across all localities. The service operates seven days a week, 8am-8pm, and provides rapid access to nursing, therapy and care services through an integrated health and social care team response, in order to best manage the patient's condition. Work continues with the team to scope the changes required to meet the needs of the Out of Hospital Transformation programme and the NICE guidance published in September 2017.

Women's and children's services

A Local Maternity System has been established to deliver improvements to maternity services in line with the requirements of a national review (Better Births). The Local Maternity System brings a range of partners together, including women and their families as well as professionals working in or with maternity services in order to design and deliver the required transformation. By 2021, the work of the Local Maternity System will see improvements in local maternity services that will improve safety, choice and personalisation.

Midwife Led Units Service Review

Shropshire currently has five Midwife led Units (MLU's) in Shrewsbury, Ludlow, Oswestry, Bridgnorth and Telford. These Units are supported by two Community Hubs at Market Drayton and Whitchurch and a Consultant led Unit at Princess Royal Hospital in Telford.

The MLU operating model has remained consistent over the past thirty years undertaking all antenatal bookings and both high and low risk antenatal care for Consultant Unit, community care, postnatal inpatient care for high and low risk cases as well as low risk births. Over the past three years deliveries within the MLU's have declined.

Shrewsbury and Telford Hospital NHS Trust have raised concerns regarding the sustainability of the current MLU model and Shropshire CCG have responded to this by initiating a comprehensive service review which is being undertaken jointly with Telford & Wrekin CCG as well as in partnership with women and their families and those who work in or with maternity services. A proposed new service model has been developed which will deliver improved outcomes for women and their families. Subject to NHS England Assurance, consultation on the proposed service model is expected to be undertaken during 2018/19.

Emotional Health and Wellbeing

A new service, which has been designed in part by local young people, parents and carers, has been developed and commissioned. The service promotes emotional resilience, help to prevent mental health crises and respond quickly to the mental health needs of children and young people. It provides a much wider choice of service options for how children, young people and families engage with local services.

This service is not a mirror image of the previous CAMHs provision but a very different and progressive portfolio of services which has very much been modelled together with the young people it serves. Fundamentally it is a different model of care, with an underlying core principle that emotional health and wellbeing services are provided as partnership across many different organisations.

South Staffordshire and Shropshire Foundation Trust (SSSFT), in partnership with Kooth (an online service that offers emotional and mental health support for children and young people) Healios (specialists in online counselling) and The Children's Society deliver this contract across Shropshire, Telford & Wrekin.

Mental health

Improving Access to Psychological Therapies (IAPT)

Improving Access to Psychological Therapies (IAPT) has been a priority for the CCG during 2017/18. Following recognition of varying levels of support being available for the people of Shropshire across the county, we have undertaken a review of psychological therapies that has included GP counselling services.

This review involved 9 workshops where we involved the public and listened to what they had to say, a paper-based and an internet based public survey, feedback from GP practices and from the people delivering the services.

The learning that resulted from this work has meant that we are now looking forward to delivering improvements for our population in coming years. These will enable our population to enjoy more responsive services whilst enabling us to achieve national targets.

Enable

'Enable' delivers the Individual Placement Support (IPS) programme to help people experiencing mental illness back into work. The service is successful and continues to deliver excellent outcomes for people. The Five Year Forward View for mental health 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 workers within the service to support people back to work.

Crisis care

The CCG continues to develop Crisis Care with the following developments planned for 18/19:

- Development of a recovery-focused daytime drop-in centre as part of a 'Health & Wellbeing' Centre alliance.
- Increased mental health advocacy.
- Secondary prevention enabling participation in design and fabrication offering practical and leadership skills.

In light of being an outlier for section 136 assessments, Shropshire Sanctuary was commissioned to provide police with an alternative place to take people who they would have otherwise detained under the Mental Health Act. The number of 136 detentions has declined and usage of the Sanctuary was increased with opening times extended.

Further information about key crisis care schemes are set out below:

Shropshire Sanctuary

When police officers encounter people in mental distress in a public place and they have concerns about the citizen causing harm to themselves or others, they have to act. Police officers who had such concerns would often detain these people under section 136 of the Mental Health Act.

When a person is detained under section 136, they have to, by law, be assessed under the Mental Health Act. Shropshire Sanctuary offers people experiencing crisis in their mental health the opportunity to receive non-clinical, humanistic support out-of-hours. It is a new option for the local police force and has resulted in the number of section 136 assessments reducing by over 50%.

Shropshire Sanctuary has recently started to be used by the ambulance service in preference to taking distressed people to A&E and discussions are being held in relation to the 111 service being another avenue for targeting service provision. Based upon its success, the Sanctuary's hours of operation were extended during the winter months and plans for 2018/19 are to make these extended hours a permanent feature of the provision.

In March 2018 Shropshire Sanctuary was able to support 48 people in crisis and resulted in only 10 detentions under section 136. This service has demonstrated an extremely positive impact on patients and is a result of strong partnership work across a number of agencies. As a result of the impact it is making the scheme has been nominated for a Mayor's award.

Shropshire Well-Being 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 which the CCG will formalise on 1st April 2018.

Although not commissioned by the CCG, the Samaritans have also agreed to contribute to the well-being hub alliance. Although this is an informal arrangement, we believe this offer of support reflects the level of value that this arrangement represents. It is expected that the well-being hub will be able to deliver non-clinical humanistic support in a wide range of locations, even those who live in remote, hard to reach areas.

Although delivered across a number of locations in the county, the central building from which the well-being hub will be based is Observer House in Shrewsbury, the same premises from which the Sanctuary is delivered. We believe that this development reflects a true, 24 hour, 7 days a week, 365 days a year support option for people experiencing mental distress.

ADHD

Following a growing need to establish local adult ADHD services, we have commissioned a service to assess adults suspected of and treat adults who have ADHD. We are confident that this will have a positive impact on those people affected by the condition as it will mean that people no longer have to travel out of Shropshire to be assessed and treated. Feedback to date has been positive in relation to this development and we hope to see continued positive performance throughout 2018/19.

Dementia

"We believe that people living with dementia in Shropshire should feel supported in their homes, safe in their communities and secure in the knowledge that when their needs change, they will be met with high quality, person-centred care."

Following on from the publication of the Shropshire Dementia Strategy, we have worked with our partner organisations to commence delivery of the goals set out. In Oswestry and Ludlow we have launched our locally conceived Dementia Companion service in pilot form. 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 are designed to 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 who have concerns that they may have dementia can be assessed 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. This will mean that we will be able to reduce the distress associated with hospital admissions caused to people living with dementia, by better meeting their needs at home with a more comprehensive and intensive provision of community treatment than is presently available.

During 2017/18 the Governing Body heard first-hand how the proactive approach adopted by a member of Community Hospital staff had led to improvements for patients living with dementia. The dedication and passion displayed by the staff member to provide person centred care was recognised by Governing Body members, who welcomed the opportunity to reflect on the benefits seen when staff are encouraged to progress their own ideas and initiatives. There was little doubt that the patients mentioned had received an excellent standard of care following the staff member's welcome approach. The Board were also particularly pleased to learn about the work being undertaken to promote the wider use of 'This is Me' patient literature. It was acknowledged that this would help to ensure the valuable sharing of information between Health and Social Care professionals about the needs, interests, preferences, likes and dislikes of patients.

Medicines management

Medicines Optimisation

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 optimisation team have been working on a number of projects to improve the quality of care for patients and make the best use of medicines.

Prescription Ordering Direct (POD)

In June 2017 the CCG launched the Prescription Ordering Direct (POD) service; for patients to order their repeat medication. 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 – it is estimated that unused prescription medicines cost the NHS over £1million every year in Shropshire alone.

Shropshire CCG currently provides the POD service to 5 practices; namely Severn Fields Medical Practice(Shrewsbury), Cambrian Medical Practice (Oswestry), Bridgnorth Medical Practice, Riverside Medical Practice (Shrewsbury) and The Caxton Surgery (Oswestry), with others waiting to join.

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

"It's nice to speak to someone who knows what they're doing."

"Is that it? I thought the new system would be much more complicated!"

"I was dubious about the service when it started, but have to admit that it is spot on – thank you."

"This is my first time using this service and I can't believe how easy it is! It has made my day!"

"I'm so thankful for this new service; it's so nice to actually speak to a real person rather than a machine. My husband has dementia and it's nice to have a proper conversation, this has genuinely made my day – thank you."

"This system is really efficient."

"Very impressive service, thank you very much for your swiftness!"

Nutrition Project

Work this year has been largely focused on the appropriate treatment of malnutrition in adults. The 'Think Food' approach centres on using everyday food and drink to treat malnutrition and treatment pathways have been developed for use in Care Homes and Primary Care settings as well as patient resources and useful recipes.

Educational work has been a major focus of this project and training sessions have been rolled out across GP localities as well as Care Home training for around 50 homes via both one-to-one sessions and a module at the Rolling Training Programme via Shropshire Partners in Care. Development of the Think Food approach has also allowed for increased dietetic input for care homes resulting in positive outcomes for patients health needs and improved use of resources in primary care.

Care Home Team

The Medicines Optimisation Care Home Team expanded this year to include: a Technician Lead, Clinical Pharmacist, GP with a Special Interest in Frailty, Pharmacy Technician and Specialist Dietitian. The Team continue 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 work of the team includes: polypharmacy reviews for care home residents focusing on good quality de-prescribing and the development of the Think Food in Care Homes Pathway promoting a food based approach to treat malnutrition. 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. Overall, around 500 delegates from 150 organisations have attended training via the team this year. The Annual Educational event was attended by 42 managers from 23 care homes; this year the focus of the event was around team work and support and included a cookery demonstration from a guest chef.

Stoma Project

We are currently undertaking a pilot with an independent stoma nurse to address the need of community patients to be able to access high quality independent advice and clinical review in their GP practice. It is hoped that by ensuring that all products are clinically appropriate, skin and stoma problems are addressed quickly and the patient having access to high quality training in stoma care that the current high spend on stoma care will be reduced.

Community and Care Co-ordinator project (C&CC)

The Community and Care Co-ordinators (C&CCs) are based in 42 out of the 43 practice teams across Shropshire. They are non-clinical individuals working as part of the practice team. They assist patients with unmet social care needs such as financial difficulties, poor housing, low self – esteem, social isolation and relationship difficulties. They also work with patients who are living longer and struggling to cope and adapt to living with Long Term Conditions which can't be addressed by a clinical consultation. It has been estimated that 20% of patients consult their GP for what is primarily a social problem.

The aims of the project are to identify the most vulnerable patients with unmet social care needs, to help address those unmet needs and in doing so improve their health and well-being. Evidence to date demonstrates that doing the above reduces avoidable demand in the health and social care economy. The key findings of an evaluation carried out in 2016/17, by a Public Health Registrar showed that patients working with the project with the most complex needs had:

- 23% fewer GP appointments
- 34% fewer A&E attendances
- 21% fewer unplanned admissions
- 21% fewer calls to Shropdoc

This evaluation was carried out on 170 patients who were identified via the project over a 12 month period.

The number of referrals has continued to increase year on year since the start of the project in 2012. The number of referrals last year saw a 17% increase to a high of 7850. The data collected so far this year suggests that the number of referrals will rise still further.

The C&CCs increase the practice team's awareness of the services and skills provided by both the voluntary sector and volunteers in the community. They have been instrumental in many practices developing their own Compassionate Communities using volunteers from the local community to support vulnerable patients from the practice. As well as facilitating the use of non-clinical support for patients, the C&CC's have also led to practices developing wider relationships with their communities and the third sector.

The priority for the coming year will be to continue to work closely with other forms of social prescribing being implemented across the county and to be aware of developing elements of community resilience making sure the Community and Care Co-ordination project is relevant and supportive.

Primary Care

During 2017/18, the CCG has invested in the development of a new Primary Care Directorate. This has resulted in the CCG making clear progress in developing Primary Care Commissioning. 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.

The CCG has 43 practices across 3 localities and the Primary Care Team has 3 locality commissioning managers who support the development of these localities and act as a first point of contact with the CCG.

The CCG has developed a Primary Care Strategy and in the first half of the financial year the Primary Care Team were also able to finalise a Primary Care Needs Assessment to determine the delivery priorities for 2017/18. Further work undertaken focused on the implementation of the GP Forward View, which is the national sustainability and development strategy for Primary Care.

During the year the CCG has supported the development of practices by ensuring that it accesses all available funding and support from regional and national development schemes as well as drawing on local resources. Practices have received investments and support around the following key areas:

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

The work of the Primary Care Team is mainly overseen by the Primary Care Commissioning Committee who receive 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.

In July 2017 the national GP Patient Survey reported that practices in Shropshire had higher than average patient satisfaction rates with an overall rating of 89%, however the CCG is continuing to develop plans to improve this through further extended opening.

The Primary Care Team has also 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 2018/19.

Under the “at Scale” working the team has supported work towards the merger of 3 Practices around the Whitchurch area, to take place on 1 April 2018 and continues to support these and another Practice in Whitchurch with a new Premises Development.

In the latter half of 2017/18, the focus has been on ensuring a balanced budget and delivery of the GP Forward View with an emphasis on improving access, sustainability and the development of a Primary Care Workforce Plan. This will continue to be a priority for 2018/19.

2.0 Sustainable development

We take our responsibilities to the environment seriously. We undertake a range of measures that promote environmental sustainability, including:

- Introduction of Paperless Governing Body, Committee and Executive meetings to reduce the CCG’s use of paper and printing supplies
- Introduction of a health and wellbeing programme for CCG staff focusing on support with exercise, healthy eating, sleep and stress to promote the health and wellbeing of our staff and to support productivity
- Participation in the development of and signing a local Social Value Charter with other local public sector partners to demonstrate our commitment to local sustainability
- Environmental focus on a range of issues such as reducing staff travel and use of technology to reduce our carbon footprint.

3.0 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. MyNHS provides an important source of data that is taken into account when reports are prepared. The Quality Committee will make recommendations on the findings of these reviews and oversight of corrective actions. This work is then 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.

The following table has been extracted from the current data available on MyNHS and provides an overview of local providers. Overall, providers are performing well. Quality performance concerns and the CQC action plans are reviewed and monitored at the relevant provider Clinical Quality Review Meetings (CQRMs).

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	Requires Improvement	72.13% Patients seen within 4 hours	OK Number of deaths within the expected range	OK Within expected range with a value of 59%	✔ 92% of patients waiting less than 18 weeks from referral	97% Patients recommend this hospital. 625 responses
The Princess Royal Hospital	Requires Improvement	72.13% Patients seen within 4 hours	OK Number of deaths within the expected range	OK Within expected range with a value of 59%	✔ 92% of patients waiting less than 18 weeks from referral	98% Patients recommend this hospital. 753 responses
The Robert Jones and Agnes Hunt Orthopaedic Hospital	Requires Improvement	Patients seen within 4 hours	N/A Not available for independent or specialist hospitals	✔ Among the best with a value of 93%	! 89% of patients waiting less than 18 weeks from referral	99% Patients recommend this hospital. 538 responses
Shropshire Community Hospitals Bridgnorth Hospital Bishops Castle Ludlow Hospital	No rating Visit CQC profile	99.97% Patients seen within 4 hours	Not available for independent or specialist hospitals	OK Within expected range with a value of 74%	✔ 93% of patients waiting less than 18 weeks from referral	No relevant data available
SSSFT 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%	N/A No relevant data available	N/A No relevant data available
Nuffield Health, Shrewsbury Hospital	✔ Good Visit CQC profile	N/A No A&E at this hospital	N/A Not available for independent or specialist hospitals	N/A No relevant data available	! 83% of patients waiting less than 18 weeks from referral	99% Patients recommend this hospital. 67 responses

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.

The Quality Committee monitors and reviews the safety and quality of commissioned services

- 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 ensure that risks relating to quality of services commissioned or patient safety are adequately identified, evaluated and managed and, where necessary, to escalate risks or areas of concern.
- To encourage and foster an environment of continuous quality improvement, audit and research and the development of evidence-based practice in all areas of clinical service delivery.
- To ratify CCG policies and procedures in relation to the processes supporting healthcare governance relating to quality, safety and patient experience.

During 2017 a strategic review of the CCG's quality systems and procedures took place leading to the development of our Quality Strategy and Delivery Plan 2018-2019, a restructuring of the Quality Directorate and a review of the terms of reference of the Quality Committee to ensure the right level of quality assurance.

The Quality Strategy, developed with staff and external stakeholders, sets the following Mission, Vision and Values:

Our Mission

To commission healthcare that is safe, clinically effective and which delivers a positive experience for everyone in Shropshire.

Our vision

People in Shropshire have absolute faith in their healthcare.

Our values

We shall always:

- Strive for continuous improvement to the quality of Shropshire health services;
- Act swiftly and with courage when the quality of healthcare is substandard;
- Be credible, creative and ambitious on behalf of our local population;
- Work collaboratively with our partners;
- Respect everyone with whom we work;
- Be focussed, committed and hardworking;
- Stay alert to the needs of all our population, particularly those who are most vulnerable;
- Operate with integrity and be trustworthy at all times;
- Encourage and support each other

Key achievements/areas of work

During 2017/18, the Quality Committee has worked to provide oversight on quality issues for the CCG and the services that it commissions, thereby providing assurance to the CCG Governing Body on all areas of responsibility. Some examples of this year's achievements include:

The annual health check pilot for people with learning disabilities.

A new tool including the Health Equalities Framework (HEF) has been developed in order to help increase the uptake of the annual health check; 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 in order to ensure timely investigations are requested if required.

Quality visits in care homes.

Working in partnership with the Infection Prevention Control and medicine management team offering both support and challenge to care homes to reduce variations in care and improve standards across Shropshire.

Roll out of the short form version of the NHS contract for care homes and domiciliary care providers across Shropshire progressed well in 2017. This is in line with the national trend of tailoring the contract to suit smaller organisations. In addition, the quality team continue to work closely with Shropshire Partners in Care (SPIC), a not-for-profit organisation representing over 240 independent nursing, residential, supported living and domiciliary care companies in the area) to ensure that local quality monitoring requirements are relevant and achievable.

Promoting quality and safety

During 2017/2018 we have refreshed our Quality Impact Assessment (QIA) documentation and processes. The Quality Team has forged closer working relationships with the commissioning team in the CCG to ensure we commission safe and effective services for our population.

Serious Incidents

During 2017/2018 the CCG undertook a retrospective review of serious incidents which had occurred within commissioned services. This retrospective review considered local themes in respect to surgical incidents and confirmed that whilst our providers had low levels of such incidents, there were some recurrent themes. The retrospective review therefore concluded that further work should be undertaken to ensure learning is cascaded more widely across the healthcare system.

Safeguarding Children and Young People and Adults at Risk of Harm

Working with partner organisations and health providers to protect vulnerable children, young people and adults at risk is a key priority for Shropshire Clinical Commissioning Group. Some patients and members of the public may be unable to uphold their rights and protect themselves from harm or abuse. They may have greatest dependency on our services and yet be unable to hold services to account for the quality of care they receive. In such cases, we have particular responsibilities to ensure that those patients receive high quality care and that their rights are upheld, including their right to be safe.

We are working with our partners including local police, social care, education, care homes and other local statutory and voluntary organisations and with our GP practices and other health care organisations to strengthen arrangements for safeguarding adults and children in Shropshire. Within the CCG, Children's and Adults' safeguarding issues are considered in detail at the Serious Incident Committee which reports to the Quality Committee and, in turn, to the CCG Board.

One of the key roles of the CCG within Adult Safeguarding is to work with our commissioned services to ensure that they have the right processes in place to safeguard their patients and to prevent abuse and neglect. This year the CCG has worked with NHS commissioned services to produce a Themes and Trends analysis. This has enabled the provider and the CCG to review all the safeguarding issues that have arisen, identify any patterns and to learn and make changes.

Perpetrators of domestic abuse: Following a multi-agency Audit it was recognised that there was a lack of support for perpetrators of domestic abuse. The CCG Designated Nurse for safeguarding children took a lead role in the development of a domestic perpetrator programme which has now been rolled out.

Prevent: is one of the four elements of 'Contest', the government's anti-terrorist strategy. The Adult Safeguarding Lead has been working with Providers to ensure they all recruit named Prevent leads. Prevent is included in the National NHS Contract for 2017-2019 and is monitored at CQRMs with providers.

Working with our patient experience lead to revisit and review the existing process around NHS2NHS reporting, which was initially introduced in 2013 to capture feedback from primary care colleagues, regarding local providers. The process continues to evolve as part of an open and effective reporting culture. We are now considering the purpose of the NHS2NHS reporting process and how it fulfils expectations across all relevant stakeholders.

Quality Assurance Framework for care homes and domiciliary care providers is due to be completed during 2017/18.

Healthcare associated infections

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

In March 2018, the nutrition and hydration drive was launched as part of the Local Health Economy E.coli blood stream infection improvement plan and a range of resources focusing on hydration have been produced. Work is continuing, in partnership with the independent care sector, with the development of a Urinary Tract Infection (UTI) toolkit for care homes and a UTI assessment form, which is currently being piloted in a number of care homes. The aim of the form is to assist in the diagnosis and correct management of residents with UTIs and aid care home staff in the early recognition of UTIs through knowledge of symptoms.

As we work towards implementing our three-year Infection Prevention and Control Strategy (2015-18), our overall vision remains that no person in Shropshire is harmed by a preventable infection.

The local health economy Infection Prevention and Control Group provides the opportunity to work collaboratively with providers and partner organisations to address the future development of infection prevention and drive improvement across the whole health economy. This has enabled a shared understanding of pertinent issues and a focus for our efforts, not only on the measurement of healthcare associated infections targets and objectives, but also on the identification of learning and the implementation of action to ensure improved outcomes for patients.

We have maintained low levels of MRSA blood stream infection and Clostridium Difficile infection and the Clostridium Difficile Infection Action Plan has been regularly reviewed by the local health economy Infection Prevention and Control Group to ensure it continues to provide a sharp focus and remains responsive to change. As a health community, robust root cause analysis has been applied to all cases of MRSA blood stream infection and Clostridium Difficile infection.

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 2019. Co-production and engagement with families, carers, adults and young people with LD underpins the work being developed.

Key developments during 2017 include:

- The creation of a robust and dynamic risk register and the implementation of effective Care and Treatment Review (CTR) and CETR processes which are keeping Children and 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.
- A successful capital application to NHS England has enabled the planning for accommodation, to ensure high specification housing is built to meet the needs of highly complex individuals returning from hospital into the community.
- As part of the Learning Disability Mortality Review (LeDeR programme), LeDeR reviews are informing developments linked to TCP. Including the use of the hospital passport, advanced decision making and the annual health check tool.

There are Personal Health Budget's in place for 11 Shropshire patients with Learning Disabilities.

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.

Our providers generally receive very positive feedback from patients about the care received. 96% of patients would recommend the ward they were treated on to friends and family, if they needed similar care and treatment.

Consideration is given to a wide range of information and in addition to the FFT, we triangulate information from other intelligence available including staff surveys, Healthwatch reports, complaints, compliments and focus groups. Each provider contract has a Clinical Quality and Risk Management (CQRM) that meets on a regular basis and reviews a range of quality indicators including the FFT. Review of the information in this way allows for early identification of challenged services and specialties in order to support improvement.

Healthwatch

We have strong links with Healthwatch in Shrophire, 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 other Healthwatch representatives are involved in project groups to support the review, development and implementation of CCG programs and projects. Healthwatch provide 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.

4.0 Patient and public involvement

Your views are vitally important to us, as they help shape current and future services.

We recognise that healthcare and wellbeing are not the sole responsibilities of one organisation. We must actively seek opportunities to work collaboratively with patients, carers, GPs, NHS staff, the public, our partners and other people with an interest in local health and social care developments.

Involvement and engagement is a two-way communication process using a wide range of methods and activities to enable people to co-produce and plan service improvements and to participate in decision making.

This year saw the creation of the Patient Involvement Forum set up to provide a means by which Shropshire patients and the public can be fully involved in service planning, the development of new services and decisions on service changes.

The forum has to date been focused on the Out of Hospital Transformation Programme but over time will be the main vehicle by which commissioners can seek the views of Shropshire people in their ongoing work.

Patient Participation Groups (PPG's) also play an important role in helping us to shape and improve services and the network of PPG's in Shropshire continues to grow and develop.

Patients and the public engage with us on a daily basis through various routes, including the Patient Advice and Liaison Service, complaints, and comments on social media. This provides valuable insight to inform our work. However, commissioners engage with patients in more formal settings. Examples of this are the range of patient and public engagement events that have taken place in reviewing services areas such as the Midwifery Led Units.

Patient experience

During 2017/18, we received:

- Complaints – **49**
- MP letters – **49**
- Patient Advice and Liaison Service (PALS) – **155**
- A total of **397** Insight issues have been recorded.

Use of Insight

We use Insight as an integral part of an ongoing commitment to improve the quality and safety of our services.

The Insight service collates, aggregates, analyses and reports quality data, supplying 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:

- Delays with payments for Continuing Health Care and Complex Care funding led to a number of complaints. To help reduce delays with receipt of payments, additional staff were allocated to tackle a backlog of cases based on a defined and transparent system of prioritisation.

- New guidance from the National Institute for Health and Care Excellence (NICE) led to changes in the range of treatment available for the management of pain. A new community-based Pain Management Pathway bringing care closer to patients' homes and offering treatments not previous available or considered by some patients.
- Two separate complaints were raised about a particular consultant's attitude towards patients. The consultant was previously unaware of the impact their manner was having but they have now been given support to develop a more empathetic and person-centered approach.
- A concern about the service provision for Adult Attention Deficit Hyperactivity Disorder (ADHD) was raised. This led to a meeting with the commissioner for Mental Health services to gain a full understanding of where improvements were required, particularly for those transitioning from Child and Adolescent Mental Health Services to those for Adults.

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 2017/18. One was rejected and the others are still being considered. A further case referred in 2016/17 is still under investigation. A case referred in 2014/15 was discontinued by the PHSO during 2017/18 as it is still under investigation by the CCG. No cases referred to the PHSO have been upheld during 2017/18.

Increased focus on Patient Experience

We are continually looking at ways to improve how we manage complaints and associated patient experience feedback. During 2017/18, we have welcomed Meredith Vivian OBE as our new Lay Member to the Governing Body with responsibilities for Patient and Public Involvement.

With experience working nationally in Public Health as the policy lead for Patient and Public Involvement, Meredith was involved in the creation of the Patient Advice and Liaison Service (PALS). He says: "I have always been keen to be involved at a local level, to make use of my experiences to help foster a closer and more collaborative relationship between the NHS and the people who pay for and use it."

In January 2018, we created the position of Patient Insight Officer, a role dedicated to dealing with complaints, PALS enquiries and letters from MPs.

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 individualised basis.

During 2017/18, a total of 318 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 77 requests were approved, 119 were not approved, 81 requests were referred to appropriate services and 42 are currently pending (awaiting further information and review).

Patient stories at Governing Body – the difference a CCG can make

Patient stories are a regular agenda item at our public Governing Body meetings. They 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.

A courageous family member shared her experience of end of life care for her late father. This was a very powerful insight into some of the obstacles faced by patients and family to ensure supportive and seamless care at home during the final stages of life. This was a very moving account which helped the Governing Body to understand what worked well and what could have been done better. It was also useful to hear how plain, straightforward communication can help everyone during such difficult and upsetting times. To hear about the experience was felt to be really informative and the Governing Body and wider CCG were reminded that good healthcare is not just about clinical care. Some very tangible learning outcomes were identified and acted upon to support and promote the benefits of end of life patients spending their final days at home in familiar surroundings and a calm environment.

A patient story assisted in directly improving the Non-Emergency Patient Transport (NEPT) service. The patient, who was visually-impaired, explained to the Governing Body how important it was to be accompanied by his partner when travelling to medical appointments. Due to the partner having mobility issues, they had not been permitted to use NEPT.

A joint approach was taken by the commissioning lead and the provider of the NEPT service to look at the feasibility for a patient to be accompanied by their partner in certain situations. Although there remained a need to minimize risks by avoiding ferrying additional potentially frail passengers on board, it was recognized that when these passengers are performing roles such as trained guide for partially-sighted people, they should be allowed to travel.

As a direct result of this patient story, there was a greater understanding of how those attending medical appointments often need support from companions and that these additional passengers should be allowed to board the transport when appropriate and in the best interests of the patient.

In addition, during 2017/18, the Governing Body received patient stories relating to:

- Experience of Care Week – CCG involvement in NHS England initiative showcasing how teams were working to improve patient/family/carer and staff experiences.
- Learning disabilities – The experience of patient and their carer (mother). This included health issues of people with disabilities and an overview of the challenges carer's can face.
- Patients living with dementia – A staff experience account of the changes they had made in their working environment at a Community Hospital to make a positive impact for patients living with Dementia.

We recognise the need to embed effective and vigorous processes to ensure that patient experience feedback, across the whole commissioning portfolio including acute, specialist, community, mental health, ambulance services, and independent providers, is gathered and used to ensure that the services meet the expected standards.

There is a range of contractual mechanisms through which we capture and review the way in which local providers seek and use patient experience feedback to inform service improvement. An integral part of this, is the monitoring of the nationally recognised Friends and Family Test, which offers patients, across a wide range of services, the opportunity to respond to the question:

> *"How likely are you to recommend our services to friends and family if they needed similar care or treatment?"*

During the year, we continued to focus on ensuring that, not only are our patients being given the opportunity to provide feedback, but also that this is being consistently and proactively used to influence associated improvements. We recognise that it is important for patients to know that their feedback will be considered to inform service improvements.

The wealth of valuable information that this simple test generates, together with patient experience feedback from other sources, is used to ensure that any emergent themes can be identified to influence improvements in patient experience across the range of commissioned services.

We continue to promote the test and its value, given that the more feedback we receive, the better informed we are to ensure that the needs of the patients are being effectively met. It is therefore encouraging that the response rates reported across the health economy are increasing, with a good level of satisfaction being reported.

5.0 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.

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.

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. Our 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. As a result, we have worked closely with Public Health on the development of a Healthy Lives programme, which includes workstreams on:

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

Focus on Social Prescribing

A Social Prescribing model is being tested in the Oswestry area with referrals from four GP practices, Adult Social Care, the voluntary sector, the local pharmacy, Family Matters, and the mental health team. The model builds on the existing Community and Care Co-ordinator programme that has been in place for a number of years in GP practices.

Evaluation data is being collated and will be evaluated by the University of Westminster but early indications and patient feedback suggest the service has being well utilised and is having a positive impact on patients' lives.

Focus on Fire Service Safe and Well

Shropshire Fire and Rescue Service is working 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 scheme expands the home fire safety checks 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. Planning is underway to begin increasing 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. Both invites and take-up of the service continue to rise year-on-year, with currently over 8,500 patients having attended a Health Check appointment. The close working between organisations has also enabled essential follow-up lifestyle interventions based within General Practice and the community settings to be made available, addressing lifestyle risks such as Weight Management, Smoking and Physical inactivity.

Current trends indicate a continued year on year increase in activity, with all Shropshire General Practice's now participating. The Public Health Help2change provider team are also supporting practices who may have limited capacity to offer appointments, often utilising the Help2change community mobile NHS Health Check Clinic.

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 workstream 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.

6.0 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 & 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 and its action plan has been developed in line with national guidance and local needs. This has been undertaken in partnership with Shropshire Council, Healthwatch and the Voluntary and Community Sector Assembly.

The Strategy is aimed at improving health and wellbeing outcomes for the people of Shropshire, focusing on: starting well, living well and ageing well. Progress against the action plan is regularly reviewed by the Board, with delivery of the strategy also supported by Health and Wellbeing Board subcommittees, of which the CCG is a member.

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.

7.0 Accountability report

7.1 Corporate governance report

Members' Report

Member profiles

Our CCG consists of 43 GP member practices that are working together to ensure the local population has high quality and sustainable healthcare services.

Member practices

1.	Albrighton Medical Practice	23.	Marysville Medical Practice
2.	Alveley Medical Practice	24.	Much Wenlock & Cressage Medical Practice
3.	Belvidere Medical Practice	25.	Mytton Oak Medical Practice
4.	Bishops Castle Medical Practice	26.	Plas Ffynnon Medical Centre
5.	Bridgewater Family Medical Practice	27.	Pontesbury Medical Practice
6.	Bridgnorth Medical Practice	28.	Portcullis Surgery
7.	Broseley Medical Practice	29.	Prescott Surgery
8.	Brown Clee Medical Practice	30.	Radbrook Green Surgery
9.	Cambrian Medical Centre	31.	Riverside Medical Practice
10.	Church Stretton Medical Practice	32.	Severn Fields Medical Practice
11.	Claremont Bank Surgery	33.	Shawbury Medical Practice
12.	Claypit Street Medical Practice	34.	Shifnal & Priorslee Medical Practice
13.	Cleobury Mortimer Medical Centre	35.	South Hermitage Surgery
14.	Clive Medical Practice	36.	Station Drive Surgery
15.	Craven Arms Medical Practice	37.	The Beeches Medical Practice
16.	Dodington Surgery	38.	The Caxton Surgery
17.	Drayton Medical Practice	39.	The Meadows Medical Practice
18.	Ellesmere Medical Practice	40.	Wem & Prees Medical Practice
19.	Highley Medical Centre	41.	Westbury Medical Centre
20.	Hodnet Medical Centre	42.	Whitehall Medical Practice
21.	Knockin Medical Centre	43.	Worthen Medical Practice
22.	Marden 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 31/03/2018, the make-up of our Governing Body is as follows:

Dr Julian Povey	Clinical Chair
Mr William Hutton	Lay Member for Governance & Audit, Vice Chair
Dr Simon Freeman	Accountable Officer
Mrs Claire Skidmore	Chief Finance Officer (from 1 June 2017)
Dr Stephen James	GP Member, Clinical Director of Information and Enhanced Technologies
Dr Jessica Sokolov	GP Member, Clinical Director, Women's and Children's, Deputy Clinical Chair
Dr Finola Lynch	GP Member
Dr Geoff Davies	GP Member (until 5 July 2017, position subsequently vacant)
Dr Deborah Shephard	Locality Chair (Shrewsbury and Atcham)
Dr Shailendra Allen	Locality Chair (South)
Mr Tim Lyttle	Locality Chair (North)
Mr Kevin Morris	Practice Representative
Dr Ed Rysdale	Clinical Member, Secondary Care
Dr Julie Davies	Director of Performance and Delivery
Mrs Nicky Wilde	Director of Primary Care (from 22 May 2017)
Ms Dawn Clarke	Director of Nursing, Quality & Patient Experience (from 1 July 2017)
Mrs Gail Fortes Mayer	Director of Planning and Contracting (from 1 July 2017)
Mrs Sam Tilley	Director of Corporate Affairs (from 10 April 2017)
Mr Keith Timmis	Lay Member for Performance
Ms Sarah Porter	Lay Member for Transformation (from 31 May 2017)
Mr Meredith Vivian	Lay Member for Public & Patient Involvement (from 31 May 2017)
Professor Rod Thomson FRCN FFPH	Director of Public Health

The remuneration report contains details on all Governing Body Members in post during the 2017/18 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 has 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 Governing Body's register of interests can be downloaded from the CCG's website.

Personal data related incidents

The Clinical Commissioning Group has recorded three Information Governance incidents relating to data security breaches by the CCG during 2017/18, one of which remains under investigation. However, none of these have been categorised as Serious Untoward Incidents (further information is set out on page 69). Data security breaches by other organisations that the Clinical Commissioning Group has become aware of have been reported to the relevant organisations to manage within their own relevant reporting structures.

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 have 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."

7.2 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 Dr Simon Freeman to be the Accountable Officer of NHS Shropshire CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- 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).
- That the CCG has adequate arrangements for VFM.

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

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 2017/2018, the CCG has not met its statutory financial duty as it has recorded an over spend against allocation. Further, failures in control within financial reporting have occurred and hence an adverse Value for Money opinion has been received as the CCG cannot demonstrate that it has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources in year.

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.

Dr Simon Freeman
Accountable Officer

8.0 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 1 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 2017/18. 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
- 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.

During 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 forward made in 2016/17 and to reach our aspiration to achieve financial balance whilst maintaining high quality services for patients and subsequently to 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 now has a substantive Executive Team in place and has embedded its new Committee structure.
- The Governing Body make up has been reviewed and all positions recruited to. This has enabled the CCG to achieve an effective balance between clinical and non-clinical members. The CCG has also increased its Lay Members from two to four to ensure robust independent scrutiny of all its areas of business.
- The CCG's finance function has been reviewed and plans exist to ensure there is sufficient capacity and capability to deliver a robust and strategic finance service. In particular this year we have been supported by PriceWaterhouseCoopers to plan improvements to the effectiveness of the function and, most recently, they have provided 'due diligence' to inform the production of our annual accounts. Work to support the finance function continues.
- The CCG continues to implement its operational plan for 2017-2019 and is moving forward with a series of service reviews to make sure key local NHS services are both clinically and financially sustainable in the coming years.

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.

Dr Simon Freeman
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.

Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, these 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.

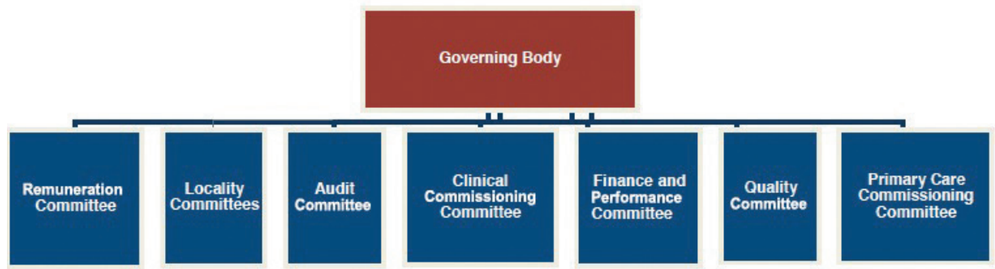
The CCG's Scheme of Reservation and Delegation sets out how the decision – making responsibilities of the CCG are shared between the Membership and the Governing Body and its various committees.

Discharge of statutory functions

In light of the 1983 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 and 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 which has now been fully embedded. This 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 2017/18 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 2017/18 is set out below:

Name	Title	Attendance
Dr Julian Povey	Clinical Chair	13 of 13
Dr Simon Freeman	Accountable Officer	10 of 13
Dr Steve James	GP Member/Clinical Director	11 of 13
Dr Jessica Sokolov	GP Member/Clinical Director	12 of 13
Dr Geoff Davies	GP Member/Clinical Director (ceased in post 7 July 2017)	2 of 4
Dr Finola Lynch	GP Member/Clinical Director	12 of 13
Mr Kevin Morris	Practice Representative (commenced in post 19 April 2017)	8 of 12
Dr Tim Lyttle	Chair – North Locality (commenced in post 3 July 2017)	9 of 10
Dr Shailendra Allen	Chair – South Locality	13 of 13
Dr Deborah Shepherd	Chair – Shrewsbury & Atcham Locality	10 of 13
Mrs Deborah Hayman	Interim Chief Finance Officer (ceased in post 31 May 2017)	2 of 2
Mrs Claire Skidmore	Chief Finance Officer (commenced in post 1 June 2017)	10 of 11
Mrs Barbara Beal	Interim Director of Nursing and Quality (ceased in post on 7 July 2017)	2 of 3
Ms Dawn Clarke	Director of Nursing Quality & Experience (commenced in post 1 July 2017)	10 of 10
Mrs Anne Dray	Interim Director of Corporate Affairs (ceased in post 17 May 2017)	2 of 2
Mrs Sam Tilley	Director of Corporate Affairs (commenced in post 10 April 2017)	12 of 13
Dr Julie Davies	Director of Strategy and Service Redesign/Director of Performance and Delivery	13 of 13
Mrs Nicky Wilde	Director of Primary Care (commenced in post 23 May)	9 of 11
Mr Michael Whitworth	Interim Director of Contracting and Planning (ceased in post 30 June 2017)	3 of 3
Mrs Gail Fortes Mayer	Director of Contracting and Planning (commenced in post 1 July 2017)	3 of 10
Professor Rod Thomson	Director of Public Health	7 of 13
Mr William Hutton	Lay Member – Governance and Audit	13 of 13
Mr Keith Timmis	Lay Member – Performance	13 of 13
Ms Sarah Porter	Lay Member for Transformation (commenced in post 31 May 2017)	11 of 11
Mr Meredith Vivian	Lay Member for Public and Patient Involvement (commenced in post 31 May 2017)	10 of 11
Dr Ed Rysdale	Secondary Care Clinical Member	11 of 13
Observers		
Mr Graham Shepherd	Observer – Shropshire Patient Group	13 of 13
Mrs Jane Randall-Smith	Observer – Healthwatch Shropshire	10 of 13
Mrs Wendy Saviour	NHS England Representatives	8 of 13
Mrs Vikki Taylor		
Mrs Jane Chapman		
Mr Jonathan Bletcher		
Others		
Paul Tulley	Chief Operating Officer (on secondment then ceased in post 31 May 2017)	0 of 0
Mrs Linda Izquierdo	Director of Nursing, Quality, Safety and Patient Experience (on secondment from the CCG during 2017)	0 of 0

The Governing Body held monthly meetings in public throughout 2017/18. Public attendance at the meetings has been encouraging, indicating a high level of local interest in the work of the CCG.

As set out in the introduction, during 2017/18 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, entering a period of 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)
- Re-focused 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.

Following a period of development and transformation for the Governing Body in 2016/17 a new substantive Executive team has been established in 2017/18, two additional Lay Members have been recruited and the CCG will enter 2018/19 with a full complement of Governing Body members.

Locality committees

The CCG is a membership organisation, comprising the 43 GP practices located within the geographical area of Shropshire (excluding the Borough of Telford and Wrekin, which has its own CCG). There are three Locality Committees, which meet regularly to conduct business that informs and supports the work of the CCG.

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

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

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 as follows:

			Attendance	
Name	**Title**	**Medical Practice**	**Formal mtgs**	**Workshop**
North Locality Committee				
Dr A Booth	General Practitioner	Baschurch	7 of 9	1 of 1
Mr Nic Storey	Practice Manager		8 of 9	1 of 1
Dr G Davies	General Practitioner	Clive	4 of 9	1 of 1
Mrs Zoe Bishop	Practice Manager		0 of 9	0 of 1
Dr N Von Hirschberg	General Practitioner	Ellesmere	8 of 9	1 of 1
Ms Jenny Davies	Practice Manager		8 of 9	1 of 1
Dr N Raichura	General Practitioner	Hodnet	9 of 9	1 of 1
Mrs Christine Charlesworth	Practice Manager		9 of 9	0 of 1
Dr J Davies	General Practitioner	Knockin	7 of 9	0 of 1
Mrs Mary Herbert	Practice Manager		7 of 9	1 of 1
Dr M Matthee	General Practitioner	Market Drayton	9 of 9	1 of 1
Mrs Michele Matthee	Practice Manager		9 of 9	1 of 1
Dr S Eslava	General Practitioner	Oswestry Cambrian	9 of 9	1 of 1
Mr K Morris	Practice Manager		6 of 9	1 of 1
Dr S Lachowicz	General Practitioner	Oswestry Caxton	7 of 9	1 of 1
Mr James Bradbury	Practice Manager		9 of 9	1 of 1
Dr Y Vibhishanan / Dr C Bell	General Practitioner	Oswestry Plas Ffynnon	8 of 9	1 of 1
Mrs Sue Evans	Practice Manager		6 of 9	1 of 1
Dr A C W Clark	General Practitioner	Shawbury	8 of 9	0 of 1
Ms Jane Coles	Practice Manager		0 of 9	0 of 1
Dr C Rogers / Dr E Smart	General Practitioner	Wem / Prees	3 of 9	1 of 1
Mr Richard Birkenhead	Practice Manager		4 of 9	1 of 1
Dr K Lewis	General Practitioner	Westbury	5 of 9	1 of 1
Mrs Helen Bowkett	Practice Manager		3 of 9	0 of 1
Dr T W Lyttle / (Chair) Dr S Tuft	General Practitioner	Whitchurch Bridgewater	9 of 9	1 of 1
Mrs Suzanne Lyttle	Clinical Manager		6 of 9	0 of 1
Dr R Muirhead	General Practitioner	Whitchurch Claypit Street	1 of 5	N/A
Ms Debbie Tildsley	Practice Manager		0 of 5	N/A
Dr R Clayton	General Practitioner	Whitchurch Dodington	5 of 9	1 of 1
Mrs Elaine Ashley	Practice Manager		5 of 9	1 of 1
Mrs Janet Gittins	Locality Manager		8 of 9	1 of 1
Mrs Sandra Stackhouse	Minute Recorder		9 of 9	N/A
Shrewsbury and Atcham Locality Committee				
Dr D Shepherd (Chair)	General Practitioner	Locum GP	8 of 8	1 of 1
Dr J Pepper / Dr K Leach	General Practitioner	Belvidere	7 of 8	1 of 1
Ms Caroline Davis	Practice Manager		4 of 8	0 of 1
Dr M Fallon	General Practitioner	Claremont Bank	4 of 8	1 of 1
Ms Jane Read	Practice Manager		6 of 8	0 of 1
Dr E Baines	General Practitioner	Marden	7 of 8	0 of 1
Mrs Joy Baker / Mrs Zoe George	Practice Manager		4 of 8	1 of 1
Dr A Cameron / Dr J Visick	General Practitioner	Marysville	6 of 8	0 of 1
Mrs Izzy Culliss	Practice Manager		1 of 8	0 of 1
Dr S Watton	General Practitioner	Mytton Oak	4 of 8	0 of 1
Mr Adrian Kirsop	Practice Manager		4 of 8	1 of 1
Dr R Bland / Dr D Puiu	General Practitioner	Pontesbury	6 of 8	1 of 1
Ms Heather Brown	Practice Manager		7 of 8	0 of 1

Dr N Russell / Dr H Callahan / Dr B Roberts	General Practitioner	Radbrook Green	4 of 8	0 of 1
Ms Angela Treherne	Practice Manager		6 of 8	0 of 1
Dr D Clesham	General Practitioner	Riverside	3 of 8	0 of 1
Ms Tracy Willocks (Vice Chair)	Practice Manager		5 of 8	1 of 1
Dr D Martin	General Practitioner	Severn Fields	4 of 8	0 of 1
Mr Steve Ellis	Practice Manager		4 of 4	N/A
Dr L Davis	General Practitioner	South Hermitage	6 of 8	1 of 1
Mrs Caroline Brown	Practice Manager		6 of 8	1 of 1
Dr E Jutsum	General Practitioner	The Beeches Bayston Hill	8 of 8	1 of 1
Ms Kim Richards	Practice Manager		6 of 8	1 of 1
Mr Tim Bellett	Business Manager	Whitehall Malling Health	1 of 1	N/A
Ms Joanne Beason	Practice Manager		5 of 8	1 of 1
Dr K McCormack	General Practitioner	Worthen	2 of 8	0 of 1
Ms Cheryl Brierley	Practice Manager		4 of 8	0 of 1
Mrs Jenny Stevenson	Locality Manager		7 of 8	1 of 1
Mrs Sandra Stackhouse	Minute Recorder		8 of 8	N/A
South Locality Committee				
Dr M Bird	General Practitioner	Albrighton	6 of 6	1 of 1
Ms Val Eastup	Practice Manager		5 of 6	1 of 1
Dr D Abbotts	General Practitioner	Alveley	4 of 6	0 of 1
Mrs Lindsey Clark	Practice Manager		5 of 6	0 of 1
Dr A Penney	General Practitioner	Bishop's Castle	6 of 6	1 of 1
Ms Sarah Bevan	Practice Manager		0 of 6	0 of 1
Dr S Wright	General Practitioner	Bridgnorth	5 of 6	1 of 1
Mrs Sandra Sutton	Practice Manager		5 of 6	1 of 1
Dr M Babu	General Practitioner	Broseley	5 of 6	0 of 1
Ms Nina Wakenell	Practice Manager		4 of 6	1 of 1
Dr W Bassett	General Practitioner	Brown Clee	4 of 6	1 of 1
Ms Vicki Brassington	Practice Manager		0 of 6	0 of 1
Dr A Chamberlain	General Practitioner	Church Stretton	4 of 6	1 of 1
Ms Emma Kay	Practice Manager		6 of 6	1 of 1
Dr P Thompson	General Practitioner	Cleobury Mortimer	5 of 6	1 of 1
Mr Mark Dodds / Dr J Bennett	Practice Manager		5 of 6	1 of 1
Dr W J Walton	General Practitioner	Clun	5 of 6	1 of 1
Mr Peter Allen	Practice Manager		2 of 6	1 of 1
Dr D Appleby	General Practitioner	Craven Arms	4 of 6	0 of 1
Mrs Susan Mellor-Palmer	Practice Manager		6 of 6	1 of 1
Dr S Allen (Chair)	General Practitioner	Highley	5 of 6	1 of 1
Ms Theresa Dolman	Practice Manager		4 of 6	0 of 1
Dr C Beanland	General Practitioner	Ludlow Portcullis	2 of 6	1 of 1
Mrs Julia Thompson	Practice Manager		6 of 6	1 of 1
Dr G Cook	General Practitioner	Ludlow Station Drive	3 of 6	0 of 1
Dr J Bailey	General Practitioner	Much Wenlock & Cressage	4 of 6	1 of 1
Mrs Sarah Hope	Practice Manager		4 of 6	1 of 1
Dr P Leigh / Dr M Brinkley / Dr R Shore	General Practitioner	Shifnal & Priorslee	1 of 6	1 of 1
Ms Sheila MacLucas	Practice Manager		2 of 6	0 of 1
Mr Tom Brettell	Locality Manager		3 of 6	1 of 1
Mrs Sandra Stackhouse	Minute Recorder		6 of 6	1 of 1

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:

- Prescribing services
- NHS Future Fit Programme
- The Sustainability and Transformation Plan (STP)
- General Practice Forward View
- Primary Care Strategy
- NHS 111 service
- New models of care / Out of Hospital programme
- ScriptSwitch
- Prescription Ordering Direct
- Ophthalmology services
- Osteoarthritis services
- Diabetes services
- Mental health services
- Musculoskeletal pathway
- DMARDs
- Frailty services
- Familial Hypercholesterolemia service
- Referral routes and communications with other providers

A key development during 2017/18 has been the appointment of new Locality Chairs, with an expansion of this role, and the appointment of Locality Commissioning Group Managers. Visits to all practices to understand the issues they face are helping to improve engagement. Locality plans are at varying stages of development and are helping to identify the different practice and population needs across the CCG.

Meetings have had high levels of attendance and there continues to be enthusiasm to improve services which we commission. Practices are starting to work more collaboratively, with clusters of practices emerging, supported by the GP Forward View.

Locality practices are taking an active part in giving views on service transformation and the impact on rural and urban patients. Engagement in developing the new Out Of Hospital model is key, with practices currently working in task and finish groups alongside commissioners and other providers to progress this work.

A Locality Assurance Framework (LAF) is in place and has been used by each locality committee to log and track issues/concerns and to raise these where appropriate.

Quality Committee

The role of the Quality Committee is to ensure that the work of commissioned services, including jointly-commissioned services, are 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.

The Quality Committee's priorities have been:

- To monitor and review the safety and quality of commissioned services
- 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 ensure that risks relating to quality of services commissioned or patient safety are adequately identified, evaluated and managed and, where necessary, to escalate risks or areas of concern

- To encourage and foster an environment of continuous quality improvement, audit and research and the development of evidence-based practice in all areas of clinical service delivery
- To ratify CCG policies and procedures in relation to the processes supporting healthcare governance relating to quality, safety and patient experience.

During 2017 a strategic review of the CCG's quality systems and procedures took place leading to the development of a quality strategy and delivery plan, a restructuring of the Quality Directorate and a review of the terms of reference of the Quality Committee to ensure the right level of quality assurance.

The Quality Strategy, developed with staff and external stakeholders, sets the following Mission, Vision and Values:

Our Mission

To commission healthcare that is safe, clinically effective and which delivers a positive experience for everyone in Shropshire.

Our vision

People in Shropshire have absolute faith in their healthcare.

Our values

We shall always:

- Strive for continuous improvement to the quality of Shropshire health services;
- Act swiftly and with courage when the quality of healthcare is substandard;
- Be credible, creative and ambitious on behalf of our local population;
- Work collaboratively with our partners;
- Respect everyone with whom we work;
- Be focussed, committed and hardworking;
- Stay alert to the needs of all our population, particularly those who are most vulnerable;
- Operate with integrity and be trustworthy at all times;
- Encourage and support each other.

The Quality Committee membership and attendance is set out below:

Name	Title	Attendance
Mrs Barbara Beal	Interim Director of Nursing (ceased in post 7 July 2017)	3 of 3
Mrs Dawn Clarke	Director of Nursing, Quality & Patient Experience (commenced in post 1 July 2017)	8 of 9
Mrs Sara Bailey	Lead Nurse for Quality	12 of 12
Dr Julie Davies	Lead Nurse for Quality	7 of 12
Dr Jessica Sokolov	GP Member	7 of 12
Dr Ed Rysdale	Secondary Care Clinician	9 of 12
Dr Finola Lynch	GP Member	10 of 12
Mr William Hutton	Lay Member for Governance and Audit (ceased to be a member from September 2017)	5 of 6
Mr Meredith Vivian	Lay Member for Public & Patient Involvement (commenced in post 31 May 2017)	7 of 10
Mr Keith Timmis	Lay Member for Performance	7 of 12
Mrs Sarah Porter	Lay Member for Transformation (commenced in post 341 May 2017)	7 of 10
Observer		
Mrs Jane Randall-Smith	Shropshire Healthwatch	6 of 12

Key achievements/areas of work

During 2017/18, the Quality Committee has worked to provide oversight on quality issues for the CCG and the services that it commissions, thereby providing assurance to the CCG Governing Body on all areas of responsibility. Some examples of this year's achievements include:

The annual health check pilot for people with learning disabilities

A new tool including the Health Equalities Framework (HEF) has been developed in order to help increase the uptake of the annual health check; 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 in order to ensure timely investigations are requested if required.

Quality visits in care homes

Working in partnership with the Infection Prevention Control and medicine management team offering both support and challenge to care homes to reduce variations in care and improve standards across Shropshire.

Promoting quality and safety

During 2017/2018 we have refreshed our Quality Impact Assessment (QIA) documentation and processes. The Quality Team has forged closer working relationships with the commissioning team in the CCG to ensure we commission safe and effective services for our population.

Serious Incidents

During 2017/2018 the CCG undertook a retrospective review of serious incidents which had occurred within commissioned services. This retrospective review considered local themes in respect to surgical incidents and confirmed that whilst our providers had low levels of such incidents, there were some recurrent themes. The retrospective review therefore concluded that further work should be undertaken to ensure learning is cascaded more widely across the healthcare system.

Safeguarding

One of the key roles of the CCG within Adult Safeguarding is to work with our commissioned services to make sure that they have the right processes in place to safeguard their patients and to prevent abuse and neglect. This year the CCG has worked with NHS commissioned services to produce a Themes and Trends analysis. This has enabled the provider and the CCG to review all the safeguarding issues that have arisen, identify any patterns and to learn and make changes.

Perpetrators of domestic abuse

Following a multi – agency Audit it was recognised that there was a lack of support for perpetrators of domestic abuse. The CCG Designated Nurse for safeguarding children took a lead role in the development of a domestic perpetrator Programme which has now been rolled out.

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) 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 national and local 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 as follows:

Name	Title	Attendance
Mr Keith Timmis	Lay Member – Performance	10 of 11
Mr William Hutton	Lay Member – Audit	10 of 11
Mrs Claire Skidmore	Chief Finance Officer (commenced in post 1 June 2017)	9 of 10
Dr Julie Davies	Director of Performance and Delivery	9 of 11
Mrs Gail Fortes-Mayer	Director of Contracting and Planning (commenced in post 1 July 2017)	1 of 8
Mr Kevin Morris	GP Board Representative	7 of 11
Dr Jessica Sokolov	Deputy Clinical Chair	8 of 11
Mr Meredith Vivian	Lay Member – Patient and Public Engagement (commenced in post 31 May 2017)	5 of 8
Mrs Sarah Porter	Lay Member – Transformation (commenced in post 31 May 2017)	7 of 8
Mr Michael Whitworth	Interim Director of Contracting (ceased in post 30 June 2017)	3 of 3
Mrs Deborah Hayman	Interim Chief Finance Officer (ceased in post 31 May 2017)	2 of 2
Dr Geoff Davies	GP Board Member (ceased on post 7 July 2017) (April – June)	1 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 and identify the 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, ensuring that they are appropriately recorded within the Risk Register or Board Assurance Framework.

Key achievements/areas of work

The Finance and Performance Committee's main focus during the year has been to provide a supportive challenge to the financial forecasts for the year. It questioned the assumptions in the monthly and forecast year-end positions and reviewed the underlying contractual and performance data. The Committee also received reports on savings schemes. While the level of savings achieved has increased the Committee expressed concerns that some schemes have failed to proceed as planned and reported to the Governing Body on the need to continue to improve the CCG's approach to identifying and delivering savings.

After the turnover in the number of Chief Finance Officers in 2016/17, 2017/18 has been more stable and it has been easier to continue to make progress on the CCG's financial position. The financial position has been stabilised, although significant pressures have again emerged during the year. The most significant of these have been: the cost of acute care, the out of hours provider, the cost of drugs and the CCG's running cost budget. The Finance team has continued to resolve a number of 'legacy' issues on some long-standing debtors and creditors. These are now at a level the Committee considers as less material to the financial position. Serious challenges remain, particularly on the level of financial savings that are needed to return the CCG to financial balance and resolve the level of outstanding debt.

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 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 (commenced in post 31 May 2017)	8 of 8
Dr Julie Davies	Director of Performance & Delivery	10 of 12
Mrs Gail Fortes-Mayer	Director of Planning & Contracting (commenced in post 1 July 2017)	1 of 8
Dr Simon Freeman	Accountable Officer	3 of 12
Dr Steve James	GP Board Member	9 of 12
Dr Julian Povey	CCG Chair	7 of 12
Dr Ed Rysdale	Secondary Care Clinician	7 of 12
Prof. Rod Thomson	Director of Public Health	0 of 12
Mr William Hutton	Lay Member – Governance & Audit	11 of 12
Dr Shailendra Allen	South Locality Chair	8 of 9
Dr Tim Lyttle	North Locality Chair	9 of 9
Mrs Claire Skidmore	Chief Finance Officer (commenced in post 1 June 2017)	9 of 12
Ms Dawn Clarke	Director of Nursing (commenced in post 1 July 2017)	5 of 9
Mr Kevin Morris	Practice Representative (commenced in post 19 April 2017)	8 of 9
Dr Finola Lynch	GP Board Member	3 of 9
Dr Deborah Shepherd	Shrewsbury & Atcham Locality Chair	9 of 12
Mr Meredith Vivian	Lay member for Patient and Public Involvement	6 of 8
Dr Jessica Sokolov	GP Board Member	9 of 12
Mr Meredith Vivian	Lay Member Patient and Public Involvement (commenced in post 31 May 2017)	6 of 8
Mrs Nicky Wilde	Director of Primary Care (commenced in post 23 May 2017)	5 of 10
Ms Barbara Beale	Interim Director of Nursing (ceased in post 7 July 2017)	3 of 3
Ms Deborah Hayman	Interim Chief Finance Officer (ceased in post 31 May 2017)	1 of 2
Dr Geoff Davies,	GP Board Member (ceased in post 7 July 2017)	1 of 2
Mr Michael Whitworth	Interim Director of Contracting & Planning (ceased in post 30 June 2017)	2 of 4
Ms Emma Sandbach,	Public Health (rep. R Thomson)	4 of 12

Key achievements/areas of work

During 2017/18, 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 e.g. the review of Gluten Free Prescribing
- A new Adult ADHD service has been approved and commissioned
- The High Intensity Service User Project was evaluated and will be commissioned recurrently from 18/19
- The new MSK model of care including the service specification for SOOS Shropshire Orthopaedic Outreach Service
- Frailty Programme, including a proof of concept Frailty Front Door at RSH
- Agreeing the methodology and work programme for the Out of Hospital Programme of Work.
- The Local Maternity Services plan
- Updated Value Based Commissioning Policy
- Acute Kidney Injury in Primary Care pathway
- New Shared Care Agreement for DMARDS
- A Familial Hypercholesterolaemia pathway
- Fracture Liaison 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 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 programme 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 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 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	5 of 6
Mrs Sarah Porter	Lay Member – Transformation (commenced in post 31 may 2017)	2 of 3
Dr Ed Rysdale	Secondary Care Clinical Member (stepped down from Audit Committee August 2017)	1 of 4

Key achievements/areas of work

The Audit Committee was strengthened during 2017/18 as a result of the recruitment of two additional Lay Members for the CCG with one being a full member of the Committee.

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. Following recommendations made by our Internal Auditors at a Governing Body workshop on risk management, it was decided to create separate Registers of Issues in addition to the Risk Registers. In addition the separate Directorate registers (both Risks and Issues) were consolidated into single Corporate Risk Register and Issues Log. The Risk Management Policy for the CCG was updated to reflect these changes and the new arrangements were reviewed and approved by the Audit Committee in January 2018. 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 but did identify one area for further improvement in relation to risk action planning. This will be addressed early in 2018/19.

Following on from the extended Internal Audit work plan in 2016/17, the Audit Committee agreed to the same level of work in 2017/18 to provide additional assurance where control weaknesses had been identified during the previous years. The agreed work plan provided flexibility to address any additional control issues that were identified during the year.

As a result of actions taken by the Governing Body during 2016/17, there was a much stronger rigour in completing agreed actions resulting from Internal Audit review during 2017/18. Where any actions were overdue, the Audit Committee followed up where necessary to ensure completion of them in a timely manner.

The Audit Committee continued to report to Governing Body meetings the key matters discussed at each Audit Committee including clear recommendations where it was felt that action was 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.

In line with the updated guidance from NHS England on managing conflicts of interest issued in February 2017, an updated policy for the CCG was reviewed by the Audit Committee before approval by the Governing Body. Quarterly returns were provided to NHS England to confirm adherence to the guidance.

The Hospitality and Sponsorship Register was reviewed during the year in line with the strengthened disclosures agreed in the previous year. An updated policy was approved by the Audit Committee in line with the updated guidance on Conflicts of Interest.

The effectiveness of the governance arrangements in each committee of the Governing Body were reviewed during the year through feedback from committee chairs.

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

Internal audit

CW Audit Services are our appointed internal auditors. An extended internal audit work plan of 195 days was agreed by the Audit Committee for 2017/18, 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
Moderate Assurance	• Budget Setting • Continuing Healthcare-Health check • Financial Reporting • Primary Care Commissioning
Limited Assurance	• Payroll • Financial Ledger • Accounts Payable • Accounts Receivable • Provider Serious Incident • Better Care Fund

The Head of Internal Audit's overall opinion is that 'limited assurance' can be given. 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 in section 9.0.

Counter fraud

We adhere to the standards set by the NHS Counter Fraud Authority, which replaced NHS Protect during the year, 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. We employ the services of assurance provider CW Audit Services to provide our local counter fraud specialists and an accredited counter Fraud Specialist is contracted to undertake counter fraud work proportionate to the identified risks.

We do not tolerate economic crime. We have an Anti-Fraud, Bribery and Corruption Response Policy in place, which is designed to make all staff aware of their responsibilities, should they suspect offences are being committed. When economic crime is suspected, we will fully investigate it in line with legislation, and will take appropriate action, which can result in criminal, disciplinary and civil sanctions being applied. This work is monitored by the Audit Committee as a standing agenda item as per the committee's business cycle of work.

The Audit Committee agreed a work plan by CW Audit Services for counter-fraud at the start of 2017/18, 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 2017/18 work plan for external audit at the start of the year and, during the year, approved additional work at Year End as a result of challenges identified during 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. As a result there was streamlining on the reporting of some activities including the operation of Directorate risk registers and the effectiveness of other committees.

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 2016/17 was produced and presented to the Governing Body

Remuneration Committee

The Remuneration Committee was established in accordance with our constitution.

During the year, following the recruitment of two additional Lay Members for the CCG, the membership of the Committee was updated to comprise all of the Lay Members. Where matters regarding Lay Members were being discussed, a changed membership in line with the updated 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 5 times in 2017/18 and the membership, attendees and subsequent attendance is set out below:

Name	Title	Attendance
Mr William Hutton	Lay Member for Governance and Audit	4 of 4
Mr Keith Timmis	Lay Member for Performance	3 of 4
Mrs Sarah Porter	Lay Member for Transformation (Commenced in post 31 May 2017)	3 of 3
Mr Meredith Vivian	Lay Member for Patient and Public Engagement (commenced in post July 2017)	2 of 3
Dr Julian Povey	Clinical Chair	2 of 2
Dr Simon Freeman	Accountable Officer	5 of 5
Dr Ed Rysdale	Secondary Care Clinician	2 of 2
Mrs Sam Tilley	Director of Corporate Affairs (commenced in post 10 April 2017)	3 of 3
Mrs Lisa Kelly	HR Adviser	5 of 5

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 of '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 2017/18 is set out below:

Name	Title	Attendance
Mr Keith Timmis	Lay Member for Performance	9 of 12
Ms Sarah Porter	Lay Member for Transformation (commenced in post 31 May 2017)	8 of 12
Mr William Hutton	Lay Member for Governance and Audit	7 of 12
Mr Meredith Vivian	Lay Member for Patient and Public Involvement (commenced in post 31 May 2017)	5 of 10
Dr Simon Freeman	Accountable Officer	1 of 12
Mrs Claire Skidmore	Chief Finance Officer (commenced in post 1 June 2017)	7 of 10
Ms Ilse Newsome	Deputy Chief Finance Officer	1 of 12
Mr Roger Eades	Finance Representative	1 of 12
Dr Ed Rysdale	Secondary Care Consultant	6 of 12
Ms June Telford	Interim Head of Primary Care (ceased in post 28 July 2017)	2 of 4
Mrs Nicky Wilde	Director of Primary Care (commenced in post 32 May 2017)	9 of 10
Mr Steve Ellis	Head of Primary Care (commenced in post 30 October 2017)	5 of 5
Mrs Dawn Clarke (3.7.17 onwards)	Director of Nursing (commenced in post 1 July 2017)	3 of 9
Mrs Sam Tilley	Director of Corporate Affairs (commenced in post 10 April 2017)	9 of 11
Dr Colin Stanford	Independent GP Member (commenced in post 6 September 2017)	6 of 6
Mrs Rebecca Woods	NHS England	7 of 12
Mrs Amanda Alamanos	NHS England	7 of 12
Dr Shailendra Allen	GP Member	6 of 12
Dr Finola Lynch	GP Member	6 of 12
Mr Kevin Morris	Practice Representative	6 of 12
Dr Stephen James	GP Member	7 of 12
Dr Deborah Shepherd	Locality Chair	7 of 12
Dr Tim Lyttle	GP Member/Locality Chair (commenced in post 3 July 2017)	5 of 9
Dr Julian Povey	CCG Chair & GP Member	5 of 12
Dr Geoff Davies	GP Member (ceased in post 7 July 2017)	2 of 4

Key achievements/areas of work

The Primary Care Commissioning Committee has dealt with a significant increase in the number of issues affecting primary care in Shropshire in 2017/18. Workforce and premises issues have continued to be a challenge, although reports from the Care Quality Commission show that the quality of primary care in the county is high. The CCG has also benefitted from the appointment of a new Director and supporting team. The pace of change has increased during the year as we deal with the challenges and opportunities facing us.

The Committee again had to approve a short-term solution to primary care issues in Whitchurch, where Shropdoc found itself unable to continue to provide general practice from the new Claypit Street practice at the Whitchurch Community Hospital site. We are working for a longer-term solution that will ensure Whitchurch patients continue to receive the services they need. This includes options for new premises as well as a longer-term service for patients. Changes to the plans for the shopping centres in Shrewsbury have forced the Riverside practice to adapt their plans for a new surgery. The primary care team and NHS England colleagues are working closely with the practices in Whitchurch and Shrewsbury to deal with the needs in each area.

The Committee receives regular reports on the arrangements to implement the GP Five Year Forward View. Overall, progress is encouraging, but the challenges of improving access, maintaining a viable workforce and improving the quality of practice premises remain the main issues the Committee is focused on.

Risk management arrangements and effectiveness

We are committed to ensuring that we have in place structures that will effectively manage risks to a level that is in line with our key aims as set out in our Constitution. Some of these risks are internal and will be controlled by the internal control system and internal controls. 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 GBAF.

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 Risk Register on a quarterly basis. Risks are also regularly reviewed and highlighted at weekly Executive Team meetings.

Our Risk Management Policy, which has been reviewed and updated during 2017/18, 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.

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, the CCG continues to operate in a challenging financial environment and we were unable to achieve our control total for the 2017/18 year.

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 2018 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 2017/18	A refresh of financial policies and procedures and budget manager training has been undertaken
	The CCG will continue to use a Programme Management Office process
	The CGG will undertake recruitment to fill vacancies and replace interims with permanent staff
	The CCG will access support from PriceWaterHouseCooper

Quality and Safety

Risk to Delivery	Mitigating Actions
There is a risk that we will fail to commission safe, quality services for its population	The CCG has undertaken a review of the level of detail provided to the Quality Committee and the point of escalation of concerns to the Governing Body
	The CCG has completed the development of a Quality Strategy
	The CCG will undertake a comprehensive root and branch review of the quality and patient safety and experience team, systems, processes responsibilities and accountabilities

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	The weekly A&E Delivery group has been revised to include clinical input, focus on actions to improve discharge and to reduce numbers of stranded patients
	The CCG has supported the appointment of a system Urgent Care Director
	GP streaming is in place
	A complex discharge action plan has been developed

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	Revisions to STP governance structure will be undertaken.
	The STP is a standard item on Governing Body agendas
	The CCG is participating in the Kings Fund leadership programme
	A leadership development programme for local GP's is in place

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	A new communications and engagement team recruited
	Directorate work plans have been developed to map demand and allocate capacity
	Communications and engagement plans are in place for all major workstreams

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	The CCG's Organisational Development (OD) Group has been reinstated with focus on the development of an OD strategy, introduction of a health and wellbeing programme for staff, and re-designed staff briefings and newsletter. A staff survey will be carried out
	A new mandatory training system has been implemented

Provider workforce

Risk to Delivery	Mitigating Actions
There is a risk that providers' ability to deliver services and remain financially viable is not sustainable	A Primary Care Strategy has been developed with a link to the quality agenda
	Work is ongoing with providers and Health Education England to support providers

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'	A 2017/18 stakeholder survey undertaken
	A full communication and engagement team is now in place
	Communication and engagement plans are in place for all major workstreams
	The Lay Member for Patient and Public Involvement is providing support in place
	GP leadership development programme in place

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	Considerable work has been undertaken on the CCG's financial recovery plan liked to mitigating actions set out for Finance risk (1b) above

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.	National mitigation is in place via the iBCF fund
	The BCF two year plan has been developed.
	Joint working on the out of hospital workstream is in place

Impact of sustainability of local Out of Hours provider

Risk to Delivery	Mitigating Actions
The CCG will not be able to commission a sustainable and cost effective out of Hours provider in the future	The CCG is supporting the provider with the development of a clear recovery plan

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 and Issues Log has been introduced to allow 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, plan to reviews the risk registers from each Directorate on a rotating 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 Again, 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 on a rotating basis 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 2017/18, we received £436m 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 has revised its Conflict of Interest Policy accordingly and this was approved by the Audit Committee and Governing Body. It remains a requirement that CCGs 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 do this by having:

- A Conflicts of Interest Policy, and Declaration of Gifts, Hospitality and Sponsorship Policy and Procedure, which set 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 further support our internal controls process the Hospitality and Sponsorship Register was reviewed during the year in line with the strengthened disclosures agreed in the previous year. An updated policy was approved by the Audit Committee in line with the updated guidance on Conflicts of Interest.

To continue with our robust management of conflicts of interest, the Chair of the Audit Committee has remained the Conflicts of Interest Guardian during 2017/18. 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 2017/18 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 is an improvement on our 2016/17 position, however, the following recommendations were made for further action:

- To update the value limits in the Gifts, Hospitality and Sponsorship policy to ensure it reflects statutory guidance;
- To ensure all staff are aware of their responsibilities regarding Conflict of Interest declarations, in particular the requirements for CCG to publish these declarations;
- To update the Procurement Register and make it available on line;
- Deliver further training to staff once the NHS mandatory training pack had been made available.

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

Data quality

Our Prime Financial Policies clarify that the format and content of reporting to the membership and Governing Body are continually challenged, and reviewed in relation to fitness for purpose and the level of assurance given.

During this year, improvements to reporting arrangements and the quality of information have been made to continue to support staff and the Governing Body to implement the CCG's financial recovery plans.

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 an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

During 2017/18, 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 systems and processes in place to help protect patient and corporate information. We have an established information governance management framework and are developing information governance processes and procedures in line with our information governance toolkit. We are currently planning for the new General Data Protection Regulations (GDPR) that come into effect during 2018 with support from our internal auditors and our Commissioning Support Unit.

During 2017/18, there were three information governance incidents logged at the CCG. On investigation, one was determined to be a level 0 breach, one a level 1 breach and a further potential breach is currently under investigation. There have been no breaches that needed to be reported to the Information Commissioner's Office.

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, include the identification and treatment of associated risks, determine capacity, capability and control and ensures 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 has updated its Business Continuity Plan during 2017/18 which was approved by the Audit Committee and subsequently the Governing Body. 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 are category 2 responders and work closely with other agencies and NHS England in relation to the EPRR agenda. All Directors underwent refresher emergency planning training during 2017/18 and the CCG participated in a regional EPRR exercise.

During 2017/18 NHS England under took an assurance exercise or CCGs in relation to EPRR. Shropshire CCG gained a substantial rating, an improvement on 2016/17. Some areas for improvement were identified and an action plan has been developed to ensure the areas of only partial assurance are addressed in the coming months.

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 2017/18, 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 £19.4m deficit for 2017/18, with a year-end deficit position of £27.1m.

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 2017/18 resulting in an adverse Value for Money opinion.

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 all programmes which improve patient outcomes, efficiency of provision, reduced duplication and the aim of 'getting it right first time' for patients
- Areas of restricted access (such as Procedures of Limited Clinical Value) 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.

We are currently in the process of leading 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. As at 31 March 2018 the CCG had achieved the NHS England requirements to proceed to public consultation but awaited the decision from the Treasury regarding capital funding to support the redevelopment programme.

Our financial governance arrangements are scrutinised by our internal audit 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 has been provided during quarter 4 by Price Waterhouse Coopers who have undertaken a detailed review of the CCG's financial systems and process as we approached year end.

This report and the executive response to the report was received and agreed by an extra-ordinary Audit Committee on 30 April. The recommendation to accept the report with agreed actions by the Audit Committee was subsequently accepted by the Governing Body in May. The plan and the CCG's responsiveness to implementing the associated actions will form part of our ongoing assurance meetings with NHS England.

The action plan combines the responses to the current Price Waterhouse Cooper report, an internal Price Waterhouse Cooper report commissioned in late 2017 and internal audit observations that remain with less than full assurance in relation to actions identified in the current report.

Implementation of the plan will be reviewed by subsequent Audit Committee and Governing Body meetings. In additions preparations are underway to support the action plan with a series of Governing Body development sessions themed to support the actions identified.

In agreement with NHS England implementation of the action plan and its robustness will be subject to external review in September 2018.

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.

Delivering the service or through the contract review meetings, together with other partners we have worked to try to resolve the issues at a local level. During 2017/18 work has commenced, in partnership with the Local Authority, to review the Better Care Fund worksteams and budget to ensure the best value is gained from the fund, both in service outcome and financial terms.

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 has stood us in good stead in 2017/18 as we continue to discharge our delegated responsibilities.

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.

9.0 Head of Internal Audit opinion

Following completion of the planned audit work for the 2017/18 financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

My overall opinion is that Limited assurance can be given, as weaknesses in the design, and/or inconsistent application of controls, put the achievement of the organisation's objectives at risk in a number 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 Significant Assurance was only provided for one review. Moderate and Limited Assurance have been provided for the following reviews: Provider Serious Incidents, Financial Systems; Budget Setting including QIPP; Continuing Healthcare; Financial Reporting; Primary Care Commissioning and Better Care Fund.
- The implementation of agreed actions is in the most part effective in the CCG, although some recommendations in relation to Continuing Healthcare are outstanding and we understand other actions/controls in this area have lapsed in year.

I have highlighted the following Significant Internal Control Issues that must be reported within your Annual Governance Statement:-Financial Delivery in year and direction arrangements.

The design and operation of the Assurance Framework and associated processes

I have reviewed the overall arrangements the Board has in place to conduct its review of the system of internal control. This has entailed reviewing the way in which the Board has identified the principal risks to achieving its objectives, the identification of controls in operation to mitigate against these risks and the degree to which the organisation has received assurances that these risks are being effectively managed. I have approached this by examining the Assurance Framework documents that you have in place and also by giving consideration to the wider reporting to the Board that informs the Board's assessment of the effectiveness of the organisation's the system of internal control. As part of the review of the Framework we noted that there should be a greater focus on future actions to address risks and gaps identified in the framework.

It is my current view that notwithstanding the need for a greater focus on actions, an Assurance Framework has been established which is designed and operating to meet the requirements of the 2017/18 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
Budget setting	Moderate assurance
Financial reporting	Moderate assurance
Primary care commissioning	Moderate assurance
Continuing healthcare – Healthcheck	Moderate assurance
Payroll	Limited assurance
Financial Ledger	Limited assurance
Accounts receivable	Limited assurance
Accounts Payable	Limited assurance
Provider serious incidents	Limited assurance
BCF	Limited assurance
Information Governance Toolkit Compliance	Non-assurance assignment Level 2 compliance level achieved
Interim BAF	Non-assurance assignment Level A assurance
Final GBAF	Non-assurance assignment Level A assurance

The following areas are highlighted as presenting limited assurance:

Financial Systems – Payroll, Financial Ledger, Accounts Receivable, Accounts Payable

The review identified a number of issues in relation to the activities linked to financial systems that remain the responsibility of the CCG.

The CCG had no signed formal agreement in place for the provision of services from Midlands & Lancashire CSU. Procedure notes were not in place. We noted some inconsistencies between user access permissions set in ISFE and their delegated authority levels. In addition, a number of aged debts had yet to be resolved at the time of review. Recharges and invoices were not being raised in a timely manner. There was no evidence that key control accounts were being reviewed.

The review also noted that a significant number of invoices were being placed on hold each month and that these could impact on supplier/provider relations and the accuracy of BPPC reporting.

Provider Serious Incidents

The review noted a number of concerns in relation to how providers were being held to account over the Serious Incident process and a number of improvements that could be made with the CCG's processes. The CCG Interim Director of Nursing informed us that the CCG had commissioned an internal formative review by WMQRS of their Quality, Patient Safety and Assurance Functions to ensure they were fit for purpose. In addition the CCG was starting a bespoke SI training programme with their providers.

Better Care Fund

There were no contracts in place for 20 BCF schemes with a total value of £6.3m. A quarter of these schemes (5/20) did not have contracts in place or any specific budget allocation, with total costs incurred in 2017/18 totalling £540,895. Consequently expenditure and resulting service outputs have not yet been formally aligned with BCF schemes.

Whilst grant funded BCF schemes had a greater degree of regularity, the majority of CCG schemes funded by BCF were not supported by formal contracts/ agreements. Where formal block contracts with providers were in place, the BCF service lines within these contracts were not known. Actual expenditure was not aligned to budgets and consequently was unable to be linked to specific outputs.

There was no regular, robust KPI reporting of BCF schemes and potential delivery issues arising from them. The CCG did not have sufficient assurance from the local authority to be able to ensure that BCF funding transferred to the local authority was resulting in the effective delivery of intended outputs.

The CCG was aware of these issues and was taking steps to address them. There was clear leadership in place to challenge and take forward developments. The CCG needed to develop its existing action summary into a formal action plan to formalise the various initiatives underway including clear milestones and priorities.

The following areas are highlighted as presenting moderate assurance:

Budget Setting including QIPP

The review noted a number of significant improvements from the prior year, however there was still work to be done to drive the delivery of the financial plan, move away from directions and adopt good practice.

The CCG had improved budget holder sign off, however a significant number of budget holders only signed after detailing caveats/concerns. These concerns were also reflected in some of our discussions with a sample of the CCG's key budget holders. The Financial Plan was signed off by the Governing Body and version 6 was accepted by NHS England. The CCG's staffing structure was not authorised at the time of review and before the start of the financial year.

Significant gaps in the Business Cases reviewed as part of the QIPP development testing were noted with quality, patient experience and equality assessments not completed. All QIPP schemes were not fully authorised before the start of the financial year and at time of review. This is reflected in the performance against the Monitor Best Practice checklist. The CCG did recognise the significant challenges it faced with the overall QIPP programme and in relation to the largest QIPP scheme in terms of value. Both the historical performance against QIPP and the expediential increase in plan made the QIPP programme particularly challenging, organisation focus and stakeholder engagement were identified as key to success.

Continuing Healthcare – Health check

The CCG had taken clear action to address weaknesses in its complex care arrangements. We noted a number of key improvements including: ongoing critical review of the integrity of BroadCare data resulting in effective data cleansing processes; clearance of previous year backlogs of referrals and appeals and use of a joint funding tool for assessments agreed with the Local Authority. At the time of review, financial performance against budget had significantly improved compared to a similar period last year.

However, challenges still remained. A formal Pricing framework supported by contracts with providers was not yet in place. There was an ongoing shortfall in establishment capacity within the CHC team due to staff turnover, as well as a lack of clarity over succession planning for interim posts eg Business Manager and Accountant. In addition, as a demand led service, a small number of additional complex cases could impact significantly on financial outturn.

Primary Care Commissioning

Before 2017/18 the impact of a number of changes to leadership at the CCG and a lack of focus specifically on primary care commissioning due to financial and other priorities had resulted in little improvement against the findings from the previous Internal Audit Review dated May 2016, when limited assurance was provided over the controls in place.

During 2017/18, the CCG had invested in developing its primary care team, with The Director of Primary Care starting in June 2017 followed by a primary care team. This had resulted in the CCG starting to make clear progress in developing its arrangements for primary care commissioning. The CCG's Primary Care Needs Assessment and GP Forward View (GPFV) were in place and provide the platform for the CCG to continue to take forward its vision for Primary Care. A Shropshire STP Workforce Plan was initially submitted in October 2017 to NHSE and the CCG was in the process of implementing this as part of the GPFV.

Those interviewed expressed an increased confidence in the CCG's leadership and focus on primary care including on financial control. Whilst there have been additional cost pressures in year, these have been managed and at the time of our review the CCG was forecasting that spend would be contained within the delegated primary care allocation. There had also been an improved understanding of delegated budgets at the CCG in 2017/18.

There was a clear recognition within the CCG of the further development and work required for sustainable improvement and to ensure effectiveness of primary care arrangements going forward. The challenge for the CCG was to drive the development of primary care services at pace, whilst continuing to build resilience and sustainability into the primary care arrangements developed during the year.

Financial Reporting

We noted that there were a number of significant risks to the position forecast at year end including Continuing Healthcare. The historical overspend and poor financial performance across the CCG, together with the current unmitigated risk of £5m and poor QIPP performance would require significant management over the final months if the CCG was to achieve its control total. In addition, issues were also noted regarding the quality of reporting to both Governing Body and Finance & Performance Committee, with the accompanying narrative being sparse and often not updated from one report to the next.

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

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

My review is informed by the work of the internal auditors, executive officers 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 independent views of the CCG's external auditors.

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 framework itself has undergone development during 2017/18 to improve its effectiveness, work that we will build on in 2018/19. The Assurance Framework is reviewed regularly 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 challenges within the environment in which we commission services, which has continued since 2016/17. However during 2017/18 very good progress has been made to address these challenges and this Annual Report highlights many of our achievements during this period. 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. This will include drawing on the expert advice which has been available to us recently via the Price Waterhouse Cooper due diligence review.

Simon Freeman
Accountable Officer

11.0 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 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 figures include the agency costs under expenses.

Table 6.1 Salaries and allowances 2017/18 (audited information)

Surname	First Name	Tilte	Appointment Details	Salary (bands of £5,000)	Expenses payments taxable (to 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)*	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 6.2 Salaries and allowances 2016/17 (audited information)

Name	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments taxable (bands of £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Mrs Brigid Stacey	Interim Accountable Officer	01/04/16 to 04/04/16	0	0	0	0	0	0
Mr David Evans	Interim Accountable Officer	04/04/16 to 31/10/16	45-50	9.4-9.5	0	0	0	50-55
Dr Simon Freeman	Interim Accountable Officer	01/11/16 to 31/03/17	60-65	47.9-48	0	0	0	65-70
Dr Julian Povey	Chair (Clinical)	01/04/16 to 31/03/17	90-95	1.0-1.1	0	0	0	90-95
Mrs Donna McGrath	Chief Finance Officer	01/04/16 to 31/03/17	120-125	0	0	0	65.0-67.5	185-190
Mr Andrew Nash	Interim Chief Finance Officer	20/04/16 to 04/11/16	95-100	58.8-58.9	0	0	0	100-105
Mr Ray Davey	Interim Chief Finance Officer	19/10/16 to 31/01/17	50-55	17.8-17.9	0	0	0	55-60
Mrs Deborah Hayman	Interim Chief Finance Officer	01/02/17 to 31/03/17	50-55	0	0	0	0	50-55
Mr Paul Tulley	Chief Operating Officer/Deputy Accountable Officer	01/04/16 to 31/03/17	100-105	0	0	0	75.0-77.5	175-180
Mrs Linda Izquierdo	Director of Nursing, Quality and Patient Experience	01/04/16 to 20/04/16	80-85	0	0	0	42.5-45.0	125-130
Mrs Linda Izquierdo	Director of Nursing	20/04/16 to 17/10/16	0	0	0	0	0	0
Mrs Linda Izquierdo	Director of Nursing, Quality and Patient Experience	17/10/16 to 28/02/17	0	0	0	0	0	0
Mrs Christine Morris	Director of Primary Care & Quality	20/04/16 to 17/10/16	0	0	0	0	0	0
Mrs Bharti Patel-Smith	Director of Governance & Involvement	01/04/16 to 20/04/16	115-120	0	0	0	42.5-45.0	155-160
Mrs Bharti Patel-Smith	Director of Communication & Engagement	20/04/16 to 17/10/16	0	0	0	0	0	0
Mrs Bharti Patel-Smith	Director of Governance and Involvement	17/10/16 to 14/02/17	0	0	0	0	0	0
Ms Alison Smith	Interim Director of Governance	20/04/16 to 17/10/16	0	0	0	0	0	0
Mrs Anne Dray	Interim Director of Contracting & Planning	26/10/16 to 05/01/17	70-75	32.6-32.7	0	0	0	75-80
Mrs Anne Dray	Interim Director of Corporate Affairs	06/01/17 to 31/03/17	0	0	0	0	0	75-80
Dr Julie Davies	Director of Strategy & Service Redesign	01/04/16 to 20/04/16	80-85	0	0	0	62.5 – 65.0	145-150
Dr Julie Davies	Interim Director for Performance & Delivery	20/04/16 to 17/10/16	0	0	0	0	0	0
Dr Julie Davies	Director of Strategy and Service Redesign	17/10/16 to 31/03/17	0	0	0	0	0	0
Mrs Fran Beck	Interim Director of Strategy	20/04/16 to 17/10/16	0	0	0	0	0	0
Prof Rod Thomson	Director of Public Health	01/04/16 to 31/03/17	0	0	0	0	0	0
Mr Michael Whitworth	Interim Director of Contracting & Planning	05/01/17 to 31/03/17	55-60	23.6-23.7	0	0	0	55-60
Ms Carrol Crowe	Director of Commissioning & Business Continuity	01/08/16 to 31/10/16	135-140	0	0	0	0	135-140
Dr Helen Herritty	Lay Member – Patient & Public Involvement & Engagement	01/04/16 to 31/10/16	5-10	0	0	0	0	5-10
Mr William Hutton	Lay Member – Audit Chair	01/04/16 to 31/03/17	15-20	0	0	0	0	15-20
Mr Keith Timmis	Lay Member – Governance & Performance	01/04/16 to 31/03/17	15-20	0	0	0	0	15-20
Dr Colin Stanford	GP Member/Clinical Chair – BCF	01/04/16 to 31/03/17	20-25	0	0	0	0	20-25
Dr Stephen James	GP Member/Clinical Director – Primary Care	01/04/16 to 31/03/17	80-85	0	0	0	32.5-35.0	115-120
Dr Jessica Sokolov	GP Member/Clinical Director – Womens & Children	01/04/16 to 31/03/17	25-30	0	0	0	0	25-30
Dr Geoff Davies	GP Member/Clinical Director – Urgent Care & Finance	01/08/16 to 31/03/17	15-20	0	0	0	0	15-20
Dr Finola Lynch	GP Member/Clinical Director – Communication & Engagement	01/08/16 to 31/03/17	20-25	0	0	0	160.0-162.5	180-185
Dr Alan Otter	Locality Chair – Shrewsbury & Atcham	01/05/16 to 28/02/17	55-60	0	0	0	0	55-60
Mr Kevin Morris	Locality Chair – North	01/04/16 to 31/03/17	10-15	0	0	0	0	10-15
Dr Stuart Wright	Locality Chair – South	01/04/16 to 31/03/17	10-15	0	0	0	0.0-2.5	10-15
Dr Ed Rysdale	Secondary Care Clinical Member	12/10/16 to 31/03/17	0-5	0	0	0	0	0-5
Graham Wallis	Turnaround Director	01/4/16 to 01/10/16	90-95	22.9-23.0	0	0	0	95-100

Table 6.3 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 age 60 at 31 March 2018 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	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

Table 6.4 Pension benefits as at 31 March 2017 (audited information)

Name and Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2017 £'000	Cash Equivalent Transfer Value at 1 April 2016 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Mr Paul Tulley Chief Operating Officer	2.5-5.0	0	35-40	95-100	598	561	36	0
Dr Stephen James GP Member, Clinical Director of Primary Care	0.0-2.5	2.5-5.0	10-15	40-45	317	283	34	0
Mrs Donna McGrath Chief Finance Officer	2.5-5.0	0	25-30	70-75	374	349	25	0
Dr Julie Davies Director of Strategy and Service Redesign	2.5-5.0	0	10-15	30-35	221	198	22	0
Mrs Linda Izquierdo Director of Nursing, Quality and Patient Experience	0.0-2.5	2.5-5.0	25-30	85-90	577	540	37	0
Mrs Bharti Patel-Smith Director of Governance and involvement	0.0-2.5	2.5-5.0	30-35	95-100	658	619	39	0
Dr C Stanford GP Member, Clinical Chair of BCF	0	0.0-2.5	5-10	25-30	200	190	10	0
Mrs Finola Lynch GP Member, Clinical director of Communications & Engagement	5.0-7.5	20.0-22.5	10-15	25-30	154	45	108	0
Dr Stuart Wright Locality Chair South	0	0	5-10	15-20	111	107	3	0

Cash equivalent transfer values

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

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

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

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation on early retirement or for loss of office

The CCG made no contractual payments in lieu of notice or for loss of office in 2017/18 (Two payments were made in lieu of notice in 2016/17 with a value of £87,754).

Pay multiples

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 2017-18 was £143,879 (2016-17, £142,500). This was 4.32 times (2016-17, 3.28) the median remuneration of the workforce, which was £33,313 (2016-17, £43,453). The change to the median was largely due to the appointment of senior staff into positions in the year.

In 2017/18, no employees (2016-17, 0) received remuneration in excess of the highest paid member of the CCG Governing Body. Remuneration ranged from £16,104 to £143,879 (2016/17, £15,516 to £142,500). There are no employees who have been paid in excess of £143,879 during the financial year.

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 (audited information)

Pay Band	Head count
Band 8 – range C	6
Band 8 – range D	1
Band 9	1
VSM	13
Medical Pay scale	10
Governing Body (off payroll)	1
Total	**32**

Staff numbers and costs (audited information)

Employee benefits 2017-18

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	6,920	4,712	2,208
Social security costs	487	487	0
Employer contributions to the NHS Pension Scheme	542	542	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**7,950**	**5,741**	**2,208**

Employee benefits 2016-17

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	6,402	4,172	2,230
Social security costs	417	417	0
Employer contributions to the NHS Pension Scheme	485	485	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**7,305**	**5,075**	**2,230**

Staff composition including composition by gender (audited information)

Shropshire County CCG: Workforce 2017/18

Staff Analysis by Gender (based on staffing at 31/03/2018)

	Head count by gender			% by Gender	
Staff grouping	**Female**	**Male**	**Totals**	**Female**	**Male**
Governing Body	10	11	21	47.6%	52.4%
Other Senior Management (Band 8c+)	10	1	11	90.9%	9.1%
All Other Employees	98	24	122	80.3%	19.7%
	118	36	154	76.6%	23.4%

Senior Staff Analysis by Band (based of staffing at 31/03/2018)

Pay Band	Head count
Band 2	3
Band 3	20
Band 4	15
Band 5	22
Band 6	19
Band 7	16
Band 8 – range A	18
Band 8 – range B	9
Band 8 – range C	6
Band 8 – range D	1
Band 9	1
VSM	13
Medical Pay Scale	10
Governing Body (off payroll)	1
Total	**154**

All our staff are classified as Administrative and Estate staff in the context of the CCG.

Governing Body (off payroll) pertains to Governing Body Members without a pay record in the CCG Electronic Staff Record (ESR) system. Only Professor Rodney Thomson who is employed by Shropshire Council is categorised under this for 2017/18.

Sickness absence data (audited information)

		2017/18
	Average of 12 months	3.1%
	Average FTE	106.46
From ESR (calendar days)	FTE days available	38770.35
	FTE days lost to sickness absence	1198.86
	Average sick days per FTE	11.26
Proxy working days	FTE days available	23952.52
	FTE days lost to sickness absence	740.66
	Average sick days per FTE	6.96

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 the CCG family-friendly or flexible working policies. The average sickness rates have reduced from 2016 to 2017 and a lot of effort is being put to reduce this further.

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

Work on developing plans regarding Organisational Development has continued in 2017/18 with a re-established Organisational Development Group, chaired by the Lay Member for Transformation. The Group has focused on the delivery of staff wellbeing programmes, a refreshed Staff newsletter and revitalised monthly staff briefings. During 2018/19 it is planned that an Organisational Development Strategy will be developed.

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.

Expenditure on consultancy

Expenditure on consultancy is disclosed in note 5 to 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.

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	7
Of which, number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	1
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	1

Shropshire CCG can confirm that all existing off-payroll engagements have at some point been subject to appropriate risk assessment and assurance as to whether the individual in receipt of the off payroll engagement is paying the right amount of tax.

Table 2: New Off-Payroll Engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, 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 April 2017 and 31 March 2018	29
Of which:	
No. assessed as caught by IR35	6
No. assessed as not caught by IR35	23
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	3
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.	28

Exit packages, including special (non-contractual) payments

The CCG did not incur contractual payments in lieu of notice during 2017/18.

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 Annual Accounts of this report at Note 18. An audit certificate will be received from our auditors following submission of the Annual Accounts.

12.0 Annual Accounts 2017/18

Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(1,085)	(2,178)
Other operating income	2	(1,082)	(894)
Total operating income		**(2,168)**	**(3,072)**
Staff costs	4	7,950	7,305
Purchase of goods and services	5	456,654	444,520
Depreciation and impairment charges	5	84	17
Provision expense	5	104	0
Other Operating Expenditure	5	810	1,413
Total operating expenditure		**465,602**	**453,255**
Net Operating Expenditure		**463,434**	**450,184**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**463,434**	**450,184**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**463,434**	**450,184**
Comprehensive Net Expenditure for the year ended 31 March 2018		**463,434**	**450,184**

"The CCG has not achieved the planned in-year deficit of £19.4 million and has concluded the year with an in-year deficit of £27.1 million and a cumulative deficit of £59.7 million, following the application of the cumulative deficit brought forward from previous years of £32.6 million.

The clinical commissioning group has a residual cash balance of £197k on 31 March 2018 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 92 to 116 form part of this statement.

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	13	0	84
Trade and other receivables	14	0	0
Total non-current assets		**0**	**84**
Current assets:			
Inventories		0	0
Trade and other receivables	14	4,074	5,161
Cash and cash equivalents	15	197	122
Total current assets		**4,271**	**5,284**
Total assets		**4,271**	**5,368**
Current liabilities			
Trade and other payables	16	(30,850)	(23,157)
Provisions	17	(104)	0
Total current liabilities		**(30,954)**	**(23,157)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(26,683)**	**(17,789)**
Non-current liabilities			
Trade and other payables	16	0	(273)
Total non-current liabilities		0	(273)
Assets less Liabilities		**(26,683)**	**(18,063)**
Financed by Taxpayers' Equity			
General fund		(26,683)	(18,063)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(26,683)**	**(18,063)**

The notes on pages 92 to 116 form part of this statement.

The financial statements and notes on pages 87 to 116 were approved by the Audit and Governance Committee on 24 May 2018 and signed on its behalf by:

Simon Freeman
Accountable Officer

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 31 March 2017	**(18,063)**	**0**	**0**	**(18,063)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 01 April 2017	**(18,063)**	**0**	**0**	**(18,063)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(463,434)	0	0	(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	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to/(from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(463,434)**	**0**	**0**	**(463,434)**
Net funding	454,814	0	0	454,814
Balance at 31 March 2018	**(26,683)**	**0**	**0**	**(26,683)**

Statement of Changes In Taxpayers Equity for the year ended 31 March 2018 (continued)

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 31 March 2016	**(14,455)**	**0**	**0**	**(14,455)**
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 01 April 2016	**(14,455)**	**0**	**0**	**(14,455)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(450,184)	0	0	(450,184)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain/(loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to/(from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(450,184)**	**0**	**0**	**(450,184)**
Net funding	446,575	0	0	446,575
Balance at 31 March 2017	**(18,063)**	**0**	**0**	**(18,063)**

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(463,434)	(450,184)
Depreciation and amortisation	5	84	17
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains/(losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	14	1,087	6,942
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	16	7,419	(3,256)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	17	0	0
Increase/(decrease) in provisions	17	104	0
Net Cash Inflow/(Outflow) from Operating Activities		**(454,740)**	**(446,481)**
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	(30)
(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
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**	**(30)**
Net Cash Inflow/(Outflow) before Financing		**(454,740)**	**(446,511)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		454,814	446,575
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
Net Cash Inflow/(Outflow) from Financing Activities		**454,814**	**446,575**
Net Increase/(Decrease) in Cash & Cash Equivalents	**15**	**75**	**64**
Cash & Cash Equivalents at the Beginning of the Financial Year		**122**	**58**
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		**197**	**122**

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements for clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the financial statements have been prepared in accordance with the Group Accounting Manual 2017/18 issued by the Department of Health. 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 2017/18 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 2017/18:

- 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 2017/18 and 2018/19;
- the CCG has an agreed Constitution that directs the governance of its activities;
- the CCG has submitted a revised plan for 2018/19 in line with the requirements set by NHS England. This plan shows the CCG remaining within the necssary deficit set by NHS England, and identifies the challeneges, risks and potential mitigations available in doing so including identifying sufficient QIPP schemes to address identified cost pressures;
- the CCG has been allocated indicative allocations to 2020/21; 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 Acquisitions & Discontinued Operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

No activities were discontinued or acquired by the CCG in 2017/18.

1.4 Movement of Assets within the Department of Health 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) would not be 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 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.

1.5 Charitable Funds

Under the provisions of IAS 27: Charitable funds held within the CCG are consolidated into the accounts of the CCG.

1.6 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.

1.7 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.

1.7.1 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.

1.7.2 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 NHSBA 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.

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. Where income is received for activities to be delivered in the following year, such income is treated as deferred.

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the year in which the service is received from employees. This includes bonuses and other benefits earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the financial year is recognised and provided for 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 Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. The scheme is, therefore, accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirement, 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.

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 did not own property or significant plant and equipment. During the year 2017/18 IT equipment owned was fully depreciated.

1.11.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;"
  - It is expected to be used for more than one financial year;
  - The cost of the item can be measured reliably; and,
  - The item has a cost of at least £5,000; or,
  - Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,"
  - Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost."
  - Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 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 2017/18.

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.

The Clical Commissioning Group did not have property and plant for the year 2017/18. Depreciation charged for the financial year was for equipment.

1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

The CCG did not hold any donated assets during 2017/18.

1.15 Government Grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

NHS Shropshire CCG did not receive government grants during 2017/18.

1.16 Non-current Assets Held For Sale

NHS Shropshire CCG did not hold any non-current assets for sale during 2017/18.

1.17 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.

1.17.1 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.

NHS Shropshire CCG did not lease property, plant or equipment during 2017/18.

1.17.2 The Clinical Commissioning Group as Lessor

The CCG did not hold any leases as lessor.

1.18 Inventories

NHS Shropshire CCG does not hold any inventories.

1.19 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.

1.20 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:

- Timing of cash flows (0 to 5 years inclusive): Minus 2.42% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

All percentages are in real terms.

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.

1.21 Clinical Negligence Costs

"NHS Resolution (previously known as the NHS Litigation Authority) operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group. At the end of 2017-18 NHS Resolution held a provision of £35k for clinical negligence cases that are still to be settled."

1.22 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.

1.23 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 2017/18.

1.24 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.25 Contingencies

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, contingencies are disclosed at their present value.

1.26 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 fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and
- Loans and receivables.

The carrying amount of the following financial assets and liabilities is considered a reasonable approximation of fair value:

- trade and other receivables
- cash and cash equivalents
- trade and other payables

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.26.1 Financial Assets 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 assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

NHS Shropshire CCG did not hold any such financial assets during 2017/18.

1.26.2 Held to Maturity Assets

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

NHS Shropshire CCG did not hold any such financial assets during 2017/18.

1.26.3 Available For Sale Financial Assets

Available For Sale Financial Assets are non-derivative financial assets that are designed as available for sale or that do not fall within and of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains are recycled to surplus/deficit on de-recognition.

NHS Shropshire CCG did not hold any such financial assets during 2017/18.

1.26.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

NHS Shropshire CCG did not issue loans during 2017/18.

1.27 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.

1.27.1 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 2017/18.

1.27.2 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 the Profit and Loss during 2017/18.

1.27.3 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, 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.

1.28 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.

1.29 Foreign Currencies

The clinical commissioning group's functional currency and presentational currency is sterling. 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 2017/18.

1.30 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.

1.31 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).

1.32 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.

1.32.1 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 £29.1m in 2017/18. 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 Shropshre 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 £19.6m.

1.32.2 Primary Care Commissiong

On 17 March 2015, NHS England issued the 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.

1.33 Research & Development

Research and development expenditure is charged in the year in which it is incurred, except in cases where development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

NHS Shropshire CCG did not conduct any major research and development work during 2017/18.

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2017/18. Some of the standards are still subject to consultations:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the financial statement of the CCG for 2017/18, were they to be applied where relevant.

2 Other Operating Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	1,085	24	1,061	2,178
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Non cash apprenticeship training grants revenue	0	0	0	0
Other revenue	1,082	213	869	894
Total other operating revenue	**2,168**	**238**	**1,930**	**3,072**

3 Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
From rendering of services	2,168	238	1,930	3,072
From sale of goods	0	0	0	0
Total	**2,168**	**238**	**1,930**	**3,072**

4 Employee benefits and staff numbers

4.1.1 Employee benefits 2017-18

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	6,920	4,712	2,208
Social security costs	487	487	0
Employer Contributions to NHS Pension scheme (net of recharges)	542	542	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**7,950**	**5,741**	**2,208**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total – Net admin employee benefits including capitalised costs	**7,950**	**5,741**	**2,208**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**7,950s**	**5,741**	**2,208**

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	6,402	4,172	2,230
Social security costs	417	417	0
Employer Contributions to NHS Pension scheme (net of re-charges)	485	485	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**7,305**	**5,075**	**2,230**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total – Net admin employee benefits including capitalised costs	**7,305**	**5,075**	**2,230**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**7,305**	**5,075**	**2,230**

4.1.2 Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in 2017/18 (£0 in 2016/17)

4.2 Average number of people employed

	2017-18		2016-17	
	Total number	Permanently employed number	Other number	Total number
Total of the above	144.53	118.20	26.33	129.00
Number of whole time equivalent people engaged on capital projects	0	0	0	0

4.3 Exit packages agreed in the financial year

The CCG made no payments in respect of exit packages in 2017/18 (£87,754 in 2016/17 for contractual payment in lieu of notice): The CCG has made no special payments in respect of employee departures (nil in 2016/17).

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 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant Financial Reporting Manual 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £610,415 were payable to the NHS Pensions Scheme (2016-17: £485,172) at the rate of 14.3% 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 2012. These costs are included in the NHS pension line of note 4.1 (net of recharges to other organisations).

5 Operating expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	6,203	3,255	2,948	5,692
Executive governing body members	1,747	1,747	0	1,612
Total gross employee benefits	**7,950**	**5,002**	**2,948**	**7,305**
Other costs				
Services from other CCGs and NHS England	2,499	1,208	1,291	3,608
Services from foundation trusts	84,087	0	84,087	79,826
Services from other NHS trusts	199,984	0	199,984	192,398
Services from other WGA bodies	0	0	0	1
Purchase of healthcare from non-NHS bodies	60,166	0	60,166	59,785
Purchase of social care	0	0	0	0
Chair and Non Executive Members	244	244	0	42
Supplies and services – clinical	1,060	0	1,060	1,084
Supplies and services – general	7,181	140	7,041	8,408
Consultancy services	986	428	558	764
Establishment	1,412	464	948	1,283
Transport	148	1	147	148
Premises	764	518	246	600
Impairments and reversals of receivables	72	72	0	135
Inventories written down and consumed	0	0	0	0
Depreciation	84	84	0	17
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
Assets carried at amortised cost	0	0	0	0
Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	50	50	0	68
Other non statutory audit expenditure				
Internal audit services	54	54	0	0
Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	52,465	0	52,465	53,019
Pharmaceutical services	0	0	0	2
General ophthalmic services	345	0	345	306
GPMS/APMS and PCTMS	45,087	0	45,087	42,614
Other professional fees excl. audit	0	0	0	322
Legal and professional fees	336	260	75	0
Grants to Other bodies	247	0	247	245
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	30	17	13	39
Change in discount rate	0	0	0	0
Provisions	104	0	104	0
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	0	0	0	244
Non cash apprenticeship training grants	0	0	0	0
Other expenditure	247	2	245	992
Total other costs	**457,652**	**3,542**	**454,110**	**445,951**
Total operating expenses	**465,602**	**8,544**	**457,058**	**453,255**

The above includes expenditure dealt with under the pooled budget arrangement for the Better Care Fund as set out in Note 21. Health care expenditure includes an assessment of partially completed spells. Internal audit services are provided by CW Audit who are part of a Foundation Trust. External Audit Fees are inclusive of VAT. The auditor's liability for external audit work carried out for the financial year 2017/18 is limited to £2 million.

6 Payment Practice

6.1 Better Payment Practice Code

Measure of compliance	2017-18 Number	2017-18 £'000	2016-17 Number	2016-17 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	19,634	123,783	25,788	126,362
Total Non-NHS Trade Invoices paid within target	19,293	119,564	25,331	120,748
Percentage of Non-NHS Trade invoices paid within target	**98.26%**	**96.59%**	**98.23%**	**95.56%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,230	288,583	3,307	280,108
Total NHS Trade Invoices Paid within target	3,161	287,042	3,138	278,974
Percentage of NHS Trade Invoices paid within target	97.86%	99.47%	94.89%	99.60%

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

	2017-18 £'000	2016-17 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

The clinical commssioning group does not undertake income generating activities.

8 Investment revenue

The clinical commissioning Group receives no revenue from rental agreements or interest receivable (nil in 2016/17).

9 Other gains and losses

There are no other gains and losses for the financial year (nil for 2016/17).

10 Finance costs

The clinical commissioning group has not incurred any finance costs in the financial year (nil in 2016/17).

11 Net gain/(loss) on transfer by absorption

There have been no gains or losses incurred on transfer by absorption.

12 Operating Leases

12.1 As lessee

The clinical commissioning group occupies premises for which it paid rental value to NHS Property Services of £703k in 2017/18 (£573k in 2016/17). Minimum lease payments in the building category also include void and subsidy charges of £117.9k (£13.8k for 2016/17) from NHS Property Services.

12.1.1 Payments recognised as an Expense

	2017-18				2016/17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	703	8	711	0	573	4	577
Contingent rents	0	0	0	0	0	0	0	0
Sub-lease payments	0	0	0	0	0	0	0	0
Total	**0**	**703**	**8**	**711**	**0**	**573**	**4**	**577**

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charges 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.

12.1.2 Future minimum lease payments

	2017-18				2016/17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable								
No later than one year	0	0	3	**3**	0	0	4	**4**
Between one and five years	0	0	0	**0**	0	0	4	**4**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**3**	**3**	**0**	**0**	**8**	**8**

12.2 As lessor

The clinical commissioning group does not have any leasing arrangements as a lessor.

13 Property, plant and equipment

2017-18	Plant & machinery £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April 2017	3	373	376
Addition of assets under construction and payments on account	0	0	0
Additions purchased	0	0	0
Additions donated	0	0	0
Additions government granted	0	0	0
Additions leased	0	0	0
Reclassifications	0	0	0
Reclassified as held for sale and reversals	(3)	(259)	(262)
Disposals other than by sale	0	0	0
Upward revaluation gains	0	0	0
Impairments charged	0	0	0
Reversal of impairments	0	0	0
Transfer (to)/from other public sector body	0	0	0
Cumulative depreciation adjustment following revaluation	**0**	**114**	**114**
Cost/Valuation at 31 March 2018	**3**	**289**	**292**
Depreciation 01 April 2017			
Reclassifications	0	0	0
Reclassified as held for sale and reversals	(3)	(259)	(262)
Disposals other than by sale	0	0	0
Upward revaluation gains	0	0	0
Impairments charged	0	0	0
Reversal of impairments	0	84	84
Charged during the year	0	0	0
Transfer (to)/from other public sector body	0	0	0
Cumulative depreciation adjustment following revaluation	0	114	114
Depreciation at 31 March 2018	0	0	0
Net Book Value at 31 March 2018	**0**	**0**	**0**
Purchased	0	0	0
Donated	0	0	0
Government Granted	0	0	0
Total at 31 March 2018	**0**	**0**	**0**

13.1 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 clinical commissioning group 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 future.

14 Trade and other receivables

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000
NHS receivables: Revenue	1,503	0	1,911
NHS receivables: Capital	0	0	0
NHS prepayments	0	0	0
NHS accrued income	53	0	772
Non-NHS and Other WGA receivables: Revenue	970	0	1,450
Non-NHS and Other WGA receivables: Capital	0	0	0
Non-NHS and Other WGA prepayments	1,492	0	583
Non-NHS and Other WGA accrued income	102	0	454
Provision for the impairment of receivables	(222)	0	(135)
VAT	171	0	119
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0
Interest receivables	0	0	0
Finance lease receivables	0	0	0
Operating lease receivables	0	0	0
Other receivables and accruals	5	0	7
Total Trade & other receivables	**4,074**	**0**	**5,161**
Total current and non current	**4,074**	**0**	**5,161**

14.1 Receivables past their due date but not impaired

	2017-18 £'000
By up to three months	1,738
By three to six months	88
By more than six months	599
Total	**2,425**

The clinical commissioning group did not hold any collateral against receivables past their due date at 31 March 2018.

14.2 Provision for impairment of receivables

	2017-18 £'000
Balance at 01 April 2017	(135)
Amounts written off during the year	101
Amounts recovered during the year	0
(Increase)/decrease in receivables impaired	(188)
Transfer (to)/from other public sector body	0
Balance at 31 March 2018	**(222)**

15 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	122	58
Net change in year	75	64
Balance at 31 March 2018	**197**	**122**
Made up of:		
Cash with the Government Banking Service	197	122
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**197**	**122**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	0	0
Balance at 31 March 2018	**197**	**122**

16 Trade and other payables

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	2,950	0	2,212	0
NHS payables: capital	0	0	0	0
NHS accruals	2,340	0	1,492	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	7,019	0	6,476	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	17,202	0	12,075	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	81	0	49	0
VAT	0	0		0
Tax	72	0	46	0
Payments received on account	0	0	0	0
Other payables and accruals	1,185	0	808	273
Total Trade & Other Payables	**30,850**	**0**	**23,157**	**273**
Total current and non-current	**30,850**		**23,430**	

NHS payables include £1,328k in respect of partially completed spells (£1,328k in 2016/17).
Other payables include £318k outstanding pension contributions at 31 March 2018 (£325k in 2016/17).

17 Provisions

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	104	0	0	0
Other	0	0	0	0
Total	**104**	**0**	**0**	**0**
Total current and non-current	**104**	**0**	**0**	**0**

	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2017	0	0	0
Arising during the year	104	0	104
Utilised during the year	0	0	0
Reversed unused	0	0	0
Unwinding of discount	0	0	0
Change in discount rate	0	0	0
Transfer (to) from other public sector body	0	0	0
Transfer (to) from other public sector body under absorption	0	0	0
Balance at 31 March 2018	104	0	104
Expected timing of cash flows:			
Within one year	0	0	104
Between one and five years	0	0	0
After five years	0	0	0
Balance at 31 March 2018	0	0	104

18 Contingencies

	2017-18 £'000	2016-17 £'000
Contingent liabilities	0	674
Net value of contingent liabilities	0	674

The clinical commissioning group has no quantifiable contingency assets or liabilities as at 31 March 2018.

The clinical commissioning group recognises levels of risk associated with a number of complex care patients. Care packages are being reviewed by external assessors and a range of risk in relation to these cases has been calculated and incorporated into the CCG's accruals. In addition to these, a number of live challenges have been levied to the Local Authority relating to charges for packages raised towards the end of 2017/18. Hence there may be a liability however this is contingent on the resolution of the challenges.

The clinical commissioning group has a pending claim for clinical negligence which is lodged in the accounts of NHS Resolution (previously the NHS Litigation Authority).

19 Financial instruments

19.1 Financial risk management

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

Because the clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group Prime Financial Policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group and internal auditors.

19.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The clinical commissioning group has no overseas operations and therefore has low exposure to currency rate fluctuations.

19.1.2 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.

19.1.3 Credit risk

Because the majority of the clinical commissioning group 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.

19.1.3 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

19 Financial instruments cont'd

19.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	Loans and Receivables 2017-18 £'000	Available for Sale 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0	0
Receivables:				
NHS	0	1,557	0	1,557
Non-NHS	0	1,072	0	1,072
Cash at bank and in hand	0	197	0	197
Other financial assets	0	5	0	5
Total at 31 March 2018	**0**	**2,830**	**0**	**2,830**

Embedded derivatives	0	0	0	0
Receivables:				
NHS	0	2,683	0	2,683
Non-NHS	0	1,905	0	1,905
Cash at bank and in hand	0	122	0	122
Other financial assets	0	7	0	7
Total at 31 March 2017	**0**	**4,717**	**0**	**4,717**

19.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	Loans and Receivables 2017-18 £'000	Available for Sale 2017-18 £'000
Embedded derivatives	0	0	0
Payables:			
NHS	0	5,291	5,291
Non-NHS	0	25,406	25,406
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**30,697**	**30,697**

Non-NHS payables include payments due for pension contributions valued at £318k for 2017/18.

	At 'fair value through profit and loss' 2017-18 £'000	Loans and Receivables 2017-18 £'000	Available for Sale 2017-18 £'000
Embedded derivatives	0	0	0
Payables:			
NHS	0	3,705	3,705
Non-NHS	0	19,631	19,631
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**23,336**	**23,336**

20 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.

21 Pooled budgets

The clinical commissioning group in partnership with Shropshire Council contributes to a pooled budget for the Better Care Fund. The total value of this pool for 2017/18 is £29.3m, £19.6m of this being the CCG's contribution (£19.3m for 2016/17).

A summary of the CCG schemes is listed below:

	2017-18
Assistive Technologies	1,639
Care navigation / Co ordination	1,363
Carers Services	1
Enablers for intergration	3,233
Healthcare services to Care Homes	222
Integrated Care planning	1,793
Intermedicate Care Services	3,170
Personalised Healthcare at Home	332
Wellbeing Centres	50
L A Schemes	7,845
Total	**19,648**

22 Related party transactions

During 2017/18 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
2017/18				
Stephen James GP Member/Clinical Director – Primary Care for the CCG is a Member of the Shropshire Doctors Co-operative	8,677	48	88	0
Finola Lynch GP Member/Clinical Director – Communication & Engagement for the CCG is a GP Partner for Bishops Castle Surgery	748	0	0	0
Kevin Morris Locality Chair – North for the CCG is a Director of Cambrian Pharmacy	1,827	0	0	0
Jessica Sokolov GP Member/Clinical Director – Womens & Children for the CCG is a GP Partner for Drayton Medical Practice	2,509	0	0	0
Julian Povey Chair for the CCG is a GP Partner for Pontesbury Medical Practice	2,029	0	0	0
Andrew Timmis Non Executive Director for the CCG – his wife works for Shropshire Council	18,461	178	318	467
Edward Rysdale Non Executive Director for the CCG is GP Partner for Beeches Medical Practice	975	0	1	0
2016/17				
Governing Body Related Parties (GBRP):	0	0	0	0
Shropshire Council (GBRP – Prof R Thompson)	17,240	2,193	0	1,160
Shropshire Doctors Cooperative Ltd (GBRP – Dr S Hodson, Dr S James, Dr C Stanford, Dr S Wright, Dr A Otter)	5,462	2	22	1
Bridgnorth Medical Practice (GBRP – Dr S Wright)	2,194	0	0	0
Drayton Medical Practice (GBRP – Dr J Sokolov)	2,190	0	18	0
Cambrian Surgery (GBRP – Mr K Morris)	2,059	0	4	0
Pontesbury Medical Practice (GBRP – Dr J Povey)	1,971	0	0	0
Much Wenlock Surgery (GBRP – Dr C Stanford)	1,478	0	1	0
Clive Surgery (GBRP – Dr G Davies)	1,204	0	5	0
Riverside Medical Practice (GBRP – Dr S Hodson)	1,073	0	0	0
Accounting Logic LTD (GBRP – Mr A Nash)	22	0	0	0
Department of Health as Parent Department and Related Parties	0	0	0	0
Shrewsbury and Telford Hospital NHS Trust	0	0	0	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	0	0	0	0
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	0	0	0	0
Shropshire Community Health NHS Trust	0	0	0	0

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

These 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.

23 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.

24 Third party assets

The clinical commissioning group did not hold any third party assets in 2017/18 (nil in 2016/17).

25 Financial performance targets

The clinical commissioning group has a number of financial duties under the NHS Act 2006 (as amended).

Performance against those duties was as follows:

	2017-18 Target	2017-18 Performance	2017-18 Target (Y/N)	2016-17 Target	2016-17 Performance
Expenditure not to exceed income	438,559	465,602	N	420,664	453,255
Capital resource use does not exceed the amount specified in Directions	0	0	32	30	
Revenue resource use does not exceed the amount specified in Directions	436,391	463,434	N	417,560	450,184
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0	
Revenue administration resource use does not exceed the amount specified in Directions	6,636	8,306	N	6,647	7,764

26 Analysis of charitable reserves

	2017-18 £'000	2016-17 £'000
Unrestricted funds	0	0
Restricted funds	2	2
Endowment funds	0	0
Total	**2**	**2**

The clinical commissioning group holds a charitable donation of £2k for use towards staff welfare.

27 Losses and special payments

27.1 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 2017-18 Number	Total Value of Cases 2017-18 £'000	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	5	319	20	1,127
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	**5**	**319**	**20**	**1,127**

The main element of the above was the write-off of £245k owed by Shropshire Council on the basis of the Council agreeing to settle the remaining balance.

27.2 Special Payments

The clinical commissioning group has made no special payments in 2017/18 (nil for 2016/17).

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 2018 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 the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2018 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 2017-18; 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.

Who we are reporting to

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.

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 course of our work including that gained through work in relation to the CCG's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource 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 this other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office 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 Report 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 2017-18 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

NHS Shropshire CCG reported that its expenditure exceeded its income by £27.1 million in its financial statements for the year ended 31 March 2018, thereby breaching its duty 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.

The CCG reported a deficit of £27.1 million against its total in year revenue resource limit in its financial statements for the year ended 31 March 2018, thereby breaching its duty under the National Health Service Act 2006, as amended by 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 £1.7m in the year ended 31 March 2018, 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 25 April 2018 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to the CCG's breach of its revenue resource limit for the year ended 31 March 2018 and on 25 May 2018 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to the CCG's breach of its breakeven duty and its administration resource limit.

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 42 to 51, 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 the CCG lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the CCG.

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.

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 2018.

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 reported a deficit of £27.1 million in its financial statements for the year ended 31 March 2018, the CCG has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £ 13.3 million for 2018-19.
- the CCG does not have a substantive finance team in place which has resulted in a lack of financial controls contributing to inadequate financial forecasting to 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(3)(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 2018, 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.

Mark C Stocks
Partner for and on behalf of Grant Thornton UK LLP

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25 May 2018

Annual Report
2017/18

At the heart of Shropshire's health

NHS
Shropshire
Clinical Commissioning Group