AGENDA

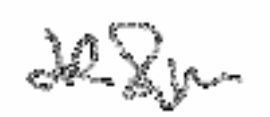
Meeting Title	Governing Body Part 1 Meeting	**Date**	Wednesday 8 June 2022
Chair	Dr John Pepper	**Time**	2pm
Minute Taker	Corporate PA	**Venue/ Location**	Via Livestream

A=Approval R=Ratification S=Assurance D=Discussion I=Information

Reference	Agenda Item	Presenter	Purpose	Paper	Time
GB-22-06.042	Introduction and Apologies	John Pepper	I	Verbal	2:00
GB-22-06.043	Members' Declarations of Interests	John Pepper	I	Enclosure	
GB-22-06.044	Minutes from previous meetings: • Shropshire Telford and Wrekin CCG Governing Body Meeting – 9 March 2022	John Pepper	A	Enclosure	
GB-22-06.045	Action Tracker and Matters Arising from previous meeting	John Pepper	A	Enclosure	
GB-22-06.046	Questions from Members of the Public Guidelines on submitting questions can be found at: https://www.shropshiretelfordandwrekinccg.nhs.uk/about-us/governing-body/governing-body-meetings/	John Pepper	I	Verbal	2:10
GB-22-06.047	Interim Accountable Officer's Report	Mark Brandreth	I	Enclosure	2:15
Assurance Reports					
GB-22-06.048	Quality and Performance Quality and Performance Integrated Report	Zena Young / Julie Garside	S	Enclosure	2:25
GB-22-06.049	Ockenden Final Report	Zena Young	S	Enclosure	2:35
GB-22-06.050	LeDeR Annual Report	Claire Parker	A	Enclosure	2:45

	Finance				
GB-22-06.051	2021/2022 Month 12 Financial Position	Claire Skidmore	S	Enclosure	2:55
GB-22-06.052	2022/23 Financial Plan	Claire Skidmore	S	Enclosure	3:05
	Governance				
GB-22-06.053	• Annual Accounts 2021/22 • Annual Report 2021/22	Claire Skidmore Alison Smith	S/D S/D	Enclosure Enclosure	3:15
GB-22-06.054	ICB Constitution – Proposal to NHS England	Mark Brandreth / Alison Smith	R	Enclosure	3:25
GB-22-06.055	CCG Transition to Integrated Care Board – Due Diligence Assurance Report	Alison Smith	S	Enclosure	3:35
GB-22-06.056	Board Assurance Framework 2022/23	Alison Smith	A/S	Enclosure	3:45
GB-22-06.057	Patient Services – Complaints and Enquires	Alison Smith	S	Enclosure	3:55
Strategic Transformation and other reports					
GB-22-06.058	Primary Care Appointments – Shropshire, Telford and Wrekin	Claire Parker	S	Enclosure	4:05
GB-22-06.059	EPRR Annual Statement	Sam Tilley	S	Enclosure	4:15
Decision Making					
There are no items to report					
OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY (Issues or key points to be raised by exception with the Chairs of the Committees or report authors outside of the Governing Body meetings)					
GB-22-06.060	Quality and Performance Committee – 5 January, 23 March, 27 April and 25 May	Meredith Vivian	S	Enclosure	
GB-22-06.061	Finance Committee – 27 April	Geoff Braden	S	Enclosure	
GB-22-06.062	Audit Committee – 16 March and 20 April	Geoff Braden	S	Enclosure	
GB-22-06.063	Primary Care Commissioning Committee – 4 May	Ash Ahmed	S	Enclosure	4:25
GB-22-06.064	Summary of CCG Locality Forum Meetings held in – 24 March and 24 May Shrewsbury and Atcham North Shropshire South Shropshire Telford and Wrekin	Clare Parker	S	Enclosure	
GB-22-06.065	Assuring Involvement Committee – 24 March and 26 May	John Wardle	S	Enclosure	
GB-22.06.066	Any Other Business	John Pepper		Verbal	

RESOLVE:	*To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)*				



Dr John Pepper
Chair

Mr Mark Brandreth
Interim Accountable Officer

Members of NHS Shropshire, Telford and Wrekin CCG Governing Body

Register of Interests - 1 June 2022

Surname	Forename	Position/Job Title	Committee Attendance	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			SCC = Strategic Commissioning Committee FC = Finance & Performance Committee Q&PC = Quality & Performance Committee PCCC = Primary Care Commissioning Committee AC = Audit Committee RC = Remuneration Committee AIC = Assuring Involvement Committee	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From (ie review date form completed)	To	
Ahmed	Astakhar	Associate Lay Member for Patient and Public Involvement (PPI) - Equality, Diversity and Inclusion **Attendee**	SCC, F&PC, RC, AC					None declared	1.2.21		
Allen	Martin	Independent Secondary Care Doctor Governing Body Member	Q&PC, F&PC	X			Direct	Employed as a Consultant Physician by University Hospital of North Staffordshire NHS Trust, which is a contractor of the CCG	22.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Member of CRG (Respiratory Specialist Commissioning)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Chair of the Expert Working Group on coding (respiratory) for the National Casemix Office	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the Royal College of Physicians Expert Advisory Group on Commissioning	22.1.21	ongoing	Level 1 - Note on Register
				X			Indirect	Wife is a part-time Health Visitor in Shrewsbury and employed by the Shropshire Community Health Trust	22.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Board Executive member of the British Thoracic Society	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	NHSD. Member of CAB (Casemix Advisory Board)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	National Clinical Respiratory Lead for GIRFT NHS Innovation (NHSI)	22.1.21	ongoing	Level 1 - Note on Register

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					X		Direct	Member of the Long Term Plan Delivery Board (respiratory) with responsibility for the pneumonia workstream	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of National (regional reporting and program) and Regional Long Covid Boards	01.04.21	ongoing	Level 1 - Note on Register
					X		Direct	Advisory Board Member (at request of RCP) for assessing mechanisms for innovation payment under the aligned incentive scheme (NHSE/I)	01.04.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the RCP and HQIP NACAP Board, including the coding and QI improvement agendas	01.04.21	ongoing	Level 1 - Note on Register
					X		Direct	Undertakes work with the AHSN (Academic Health Science Networks) in the West Midlands supporting respiratory	14.7.21	ongoing	Level 1 - Note on Register
Braden	Geoff	Lay Member for Governance & Audit - **Attendee**	F&PC, RC, AC, Q&PC				Direct	None declared	20.1.21		

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Brandreth	Mark	Interim Accountable Officer/ICS Executive Lead				X	Indirect	Close friends with Director of Innermost Consulting	2013	ongoing	Level 1 - Note on Register
						X	Indirect	Close friends with Corporate Team at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2012	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						X	Indirect	Partner is an employee of RJAH and also works with Shropshire Community Health NHS Trust (SCHT)	2022	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Bryceland	Rachael	GP/Healthcare Professional Governing Body Member	Q&PC	X			Direct	Employee of Stirchley and Sutton Hill Medical Practice	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Medical Staffing in the West Midlands region	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Dream Medical in the West Midlands region	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is a provider of executive coaching and consultancy	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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				X			Indirect	Husband is CEO of Tipping Point Training, provider of Mental Health First Aid	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Cawley	Lynn	Representative of Healthwatch Shropshire - **Attendee**	Q&PC					None declared	1.2.21		
Clare	Laura	Interim Executive Director of Finance	F&PC			X	Indirect	Sister is a physiotherapist at Midlands Partnership	27.1.21		Level 2 - Restrict involvement in any relevant commissioning
Davies	Julie	Director of Performance - **Attendee**	PCCC, Q&PC					None declared	1.2.21		
Ilesanmi	Mary	GP/Healthcare Professional Governing Body Member	SCC	X			Direct	GP Partner of Church Stretton Medical Practice	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Practice is a Member of the South West Shropshire PCN	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is a Locum Consultant in Obstetrics and Gynaecology at SaTH	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
James	Stephen	Chief Clinical Information Officer (CCIO)	SCC					None declared	20.1.21		
MacArthur	Donna	Lay Member for Primary Care	PCCC, RC, AC, SCC			X	Indirect	Son's partner is the daughter of a Director working at Wolverhampton CCG	20.1.21	ongoing	Level 1 - Note on Register
Matthee	Michael	GP/Healthcare Professional Governing Body Member	North Localty Forum, F&PC	X			Direct	GP Partner at Market Drayton Medical Practice	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	GP Member of North Shropshire PCN	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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				X			Indirect	Wife is Practice Manager at Market Drayton Medical Practice	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Noakes	Liz	Director of Public Health for Telford and Wrekin - **Attendee**		X			Direct	Assistant Director, Telford and Wrekin Council	29.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Honorary Senior Lecturer, Chester University	29.1.21	ongoing	Level 1 - Note on Register
Parker	Claire	Director of Partnerships - **Attendee**	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum			X	Indirect	Daughter worked as student temp in POD - 15/8/21 to 15/9/21	5.10.21	ongoing	Level 1 - Note on Register
Pepper	John	Chair	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum	X			Direct	Salaried General Practitioner at Belvidere Medical Practice (part of Darwin Group)	9.11.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Belvidere Medical Practice is a member of Darwin Group of practices and Shrewsbury Primary Care Network	9.11.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	NHS England GP Appraiser	9.11.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Associate Non-Executive Director, Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	01.07.22	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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						X	Indirect	Family member provided evidence to Ockenden Review	9.11.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions or discussions on historical issues raised within the scope of the Ockenden Review. This does not exclude from commissioning decisions or discussions on current maternity and neonatal services or any service provided by SaTH more generally.
Pringle	Adam	Vice Clinical Chair and GP/ Healthcare Professional Governing Body Member	PCCC, TW Membership Forum	X			Direct	GP Partner, Teldoc General Practice	2.2.21	4.8.21	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Teldoc is a Member of Teldoc Primary Care Network	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Work on a sessional basis for Shropshire Doctors Co-Operative Ltd (Shropdoc) an out of hours primary care services provider, which is a contractor of the CCG.	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Partner at Churchmere Medical Practice	22.3.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Property owner of Lawley Medical Practice site	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Robinson	Rachel	Director of Public Health for Shropshire - **Attendee**		X			Direct	Director of Public Health for Shropshire	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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Shepherd	Deborah	Interim Medical Director - **Attendee**	PCCC, Q&PC					None declared	19.1.21		
Skidmore	Claire	Executive Director of Finance	F&PC, AC, PCCC					None declared	17.09.21		
Smith	Alison	Director of Corporate Affairs - **Attendee**	AC, AIC, Q&PC			X	Indirect	Related to a member of staff in my portfolio structure who is married to my cousin. The individual is not directly line managed by me.	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Tilley	Samantha	Director of Planning - **Attendee**	SCC			X	Indirect	Brother in Law holds a position in Urgent Care Directorate at SATH	27.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Vivian	Meredith	Deputy Chair and Lay Member for Patient & Public Involvement (PPI)	Q&PC, RC, AC, PCCC, AIC		X		Direct	Trustee of the Strettons Mayfair Trust (voluntary sector organisation that provides a range of health and care services to the population of Church Stretton and surrounding villages)	26.1.21	ongoing	Level 1 - Note on Register
				X			Indirect	Wife is a part-time staff nurse at Shrewsbury & Telford Hospital NHS Trust (SATH)	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Warren	Audrey	Chief Nurse	SCC, Q&PC					None declared	1.4.21		
Young	Zena	Executive Director of Quality	SCC, F&PC, Q&PC, PCCC					None declared	22.1.21		

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MEMBERS WHOSE BOARD ROLE HAS CEASED OR WHO HAVE LEFT THE NHS SHROPSHIRE AND TELFORD AND WREKIN CCGs WITHIN THE LAST 6 MONTHS											
Evans	David	Joint Accountable Officer	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum, JSCC		X		Direct	Shared post - Joint Accountable Officer of Shropshire and Telford and Wrekin CCGs	2.2.21		Left SCCG and TWCCG on secondment on 31.3.21
					X		Direct	Member of the Telford and Wrekin Health and Wellbeing Board	2.2.21		
						X	Indirect	Wife is an employee of Tribal Education Ltd, which contracts with the NHS, but is not a contractor of the CCG	2.2.21		
Smith	Fiona	Joint GP/Healthcare Professional Governing Body Member	SCC	X			Direct	Advanced Nurse Practitioner at Shawbirch Medical Practice	20.1.21		Left STWCCG on 31.7.21
				X			Direct	Shawbirch Medical Practice is a Member of Newport/Central PCN	20.1.21		
					X		Indirect	Son-in-Law works as a technician for the Audiology Team at SaTH	17.2.21		
Trenchard	Steve	Interim Executive Director of Transformation	SCC, PCCC, F&PC					None declared	22.1.21		Left STWCCG on 30.11.21

NHS Shropshire, Telford and Wrekin CCG
Governing Body Part 1 Meeting

Wednesday 9th March, 2022 at 13:30pm
Via Microsoft Teams

Present from NHS Shropshire, Telford and Wrekin CCG:

Dr John Pepper	**Chair**
Mr Mark Brandreth	**Interim Accountable Officer**
Mr Meredith Vivian	**Deputy Chair and Lay Member for Patient and Public Involvement Governing Body Member**
Mr Ash Ahmed	**Lay Member for Patient and Public Involvement - Equality, Diversity and Inclusion Governing Body Member**
Mrs Donna MacArthur	**Lay member for Primary Care**
Mr Geoff Braden	**Lay member for Governance**
Mrs Audrey Warren	**Registered Nurse Governing Body Member**
Dr Michael Matthee	**GP/Healthcare Professional Governing Body Member**
Dr Adam Pringle	**Vice Clinical Chair and GP/Healthcare Professional Governing Body Member**
Dr Mary Ilesanmi	**GP Healthcare Professional Governing Body Member**
Mrs Rachel Bryceland	**GP Healthcare Professional Governing Body Member**
Mrs Claire Skidmore	**Executive Director of Finance**
Mrs Zena Young	**Executive Director of Nursing and Quality**
Dr Julie Garside	**Director of Performance**
Dr Matin Allen	**Secondary Care Doctor Member**

Attendees:

Dr Stephen James	**Interim Chief Clinical Information Officer**
Miss Alison Smith	**Director of Corporate Affairs**
Mrs Sam Tilley	**Director of Planning**
Dr Deborah Shepherd	**Medical Director**
Miss Lynn Crawley	**Chief Officer, Health watches Shropshire**
Mr Barry Parnaby	**Chair, Health watch Telford and Wrekin**
Mrs Liz Noakes	**Director of Public Health Telford Wrekin Council**
Mr Jonathan Rowe	**Executive Director Adult Social Care, Health Intergration and Wellbing**
Mrs Hayley Flavell	**Director of Nursing - SaTH**
Ms Cynthia Fearon	**Corporate Personal Assistant – Transcription of minutes**

Minute No. GB-22-03.021– Introduction and Apologies

1.1 Dr Pepper welcomed Governing Body members and members of the public to the NHS Shropshire, Telford and Wrekin CCG Governing Body meeting (taking place over Microsoft Teams and also being live-streamed via YouTube) a recording of which would also be available on the CCG's website following the meeting.

1.2 Apologies:

Ms Claire Parker	Director of Partnerships
Mr Simon Whitehouse	Interim Designate ICB Chief Executive
Ms Rachel Robinson	Director of Public Health Shropshire Council

1.3 Dr Pepper requested members to avoid using the chat function for discussion/comments as this is not visible to members of the public who maybe observing the meeting.

Minute No. GB-22-03.022– Members' Declarations of Interests

2.1 Members had previously declared their interests, which were listed on the CCG's Governing Bodies Register of Interests and was available to view on the CCGs' website at:

https://www.shropshiretelfordandwrekinccg.nhs.uk/about-us/conflicts-of-interest/

2.2 Dr Pepper requested that all Governing Body members ensure that their conflicts of interest are updated and remain relevant.

2.3 There were no conflicts raised for any agenda item or additional conflicts of interest declared.

Minute No. GB-22-03.023 – Minutes of the Previous Meetings – Shropshire, Telford and Wrekin CCG Governing Body Meeting – 12h January 2022

3.1 The minutes of the previous NHS Shropshire Telford and Wrekin CCG Governing Body meeting held on the 12th January 2022, were presented and approved as a true and accurate record of the meeting subject to the following amendments:

3.2 Dr Pepper made reference to 11.2 of the minutes. It should read - Dr Pepper clarified the NICHE paper rather than the NICHE report.

3.3 Dr Pepper made reference to 16.3 of the minutes. It should read 'of staff' not 'od staff'.

Minute No. GB-22-03.024 – Action Tracker and Matters Arising from previous meetings held on 12th January 2022.

4.1 Dr Pepper asked the Governing Body to note the updates as outlined in the action log which had been circulated with the papers, from the meeting held on 12thJanuary 2022.

4.2 The Governing Body noted the actions taken and agreed to those highlighted as completed.

Minute No. GB-22-03.025 - Questions from Members of the Public

5.1 Guidelines on submitting questions can be found at:

https://www.shropshiretelfordandwrekinccg.nhs.uk/about-us/governing-body/governing-body-meetings/

5.2 Dr Pepper stated that questions and answers from the last meeting are included in the circulation pack for this meeting. Dr Pepper highlighted, that he would like to thank members of the public that are coming forward with questions as it was really positive to get that level of engagement from the public.

5.3 Dr Pepper requested if Mrs Young could elaborate on the answer that was highlighted for question seven regarding maternity – "Births before Arrival". Mrs Young stated that the question was looking for any themes and any learning out of the incident. In terms of themes, Mrs Young stated maternal choice was a minor theme of what was identified. The numbers born before arrival is small and is something that is reviewed frequently every month with the Trust. Also, at various points a more consolidated deep dive is undertaken, which is due to be done soon. Mrs Young stated that she has agreed with the new Director of Midwifery of the Trust to undertake another themed review of all the factors that may have contributed to the numbers born before arrival. This will include taking a broader view of looking at the workforce piece, knowing that SaTH have reported a positive picture of their staffing recruitment. So there is an expectation that will translate into a more positive experience for women. Mrs Young also stated that she is currently involved in a piece of work with the Maternity Voices Partnership which gives a voice to the service users. Mrs Young has asked the MVP to undertake a piece on womens' experiences accessing these types of services. Bearing in mind that a lot of the services available are now reduced. Mrs Young intends to include that review into the BBA.

5.4 Dr Pepper mentioned that questions were received for this meeting and responses to those questions will be posted on the CCG website three weeks following today's meeting.

Minute No. – GB-22-03.026 Accountable Officer's Report – by Mr Mark Brandreth

6.1 Mr Brandreth congratulated Mrs Claire Skidmore who has recently been appointed as the new Integrated Care Board Chief Finance Officer.

6.2 Mr Brandreth confirmed that the ICB has now published the appointment of three non-executive directors.

6.3 Mr Brandreth highlighted from the 1st April 2022, there will be a move to the ICB operating in shadow form as much as possible between April and June. This will mean the ICB will develop it's governance more effectively and a continuation of the work that has been done as a CCG will support that as the work is in common to both. Mr Simon Whitehouse is hoping to announce further appointments to job roles within the next week. That information will be shared with Governing Body Members soon.

6.4 Mr Brandreth mentioned the disappointing news that there is now going to be a delay on the publishing of the Ockenden Report, that was due to be published on the 22nd March 2022. When a new date has been confirmed, it will be shared with Governing Body members.

6.5 Mr Brandreth made reference to the letter that was written back to the Secretary of state regarding the hospital transformation programme. Mr Brandreth shared the letter with Governing Body members this week. Mr Brandreth highlighted that the original letter was written as a public letter from the Secretary of State to the Governing Body and the Governing Body wished to reply in public, which has now been done. The letter has also been shared with CCG partners, NHS England and in real time for the local media. The letter clearly sets out the position of HTP, particularly, regarding provision of urgent care services in Telford on a 24/7 basis.

6.6 Mr Brandreth made reference to the letter Dr Pepper wrote on behalf of the Governing Body members to the Chairperson of SaTH, around the strategic outline case. The letter has been included in the circulation pack for this meeting. The letter is also published on the CCG website. SaTH will continue to take forward what is outlined in the letter with purpose. Once things have been done regionally, the way the programme will be funded will be referred through the national team for consideration. Mr Brandreth also mentioned that they continue to keep colleagues from Wales, particularly from Powys Health Board cited on that and there will be a meeting of the Independent Oversight Group. The Independent Oversight Group meeting is chaired by Mr Mark Brandreth and supported by Mrs Claire Skidmore.

6.7 Mr Brandreth made reference to the challenges of Covid. Mr Brandreth stated that there are more patients with Covid in hospital in Shrewsbury and Telford this week than there were last week and the week before. The numbers were around fifty five, so there are now two full wards of Covid patients in these hospitals which is proving very difficult to manage.

6.8 Mr Brandreth made reference to the work that continues around urgent care. Gold meetings continue to take place three times a week. Silver meetings take place four times a week under Mrs Sam Tilley's leadership.

6.9 Mr Brandreth asked the Governing Body to note the intention to undertake more work on the urgent care challenges within the system, with a particular focus out of hospital care on a 24/7 basis. Over the next six months or so the intention is to undertake a review to look particularly at the primary and community urgent care services.

6.10 The review will consider how the system can have a better coordination of NHS111, Minor Injury Units and out of hours services. This review will take the time to design a fully integrated service that is suitable and fit for purpose, importantly including significant patient and public involvement. Following the review, the ICB as the successor to the CCG will need to undertake a robust procurement exercise.

6.11 In order to enable this important work to happen the Governing Body has agreed to make a direct award to Shropdoc for GP Out of Hours care for a period of twelve months (June 22-June23). Importantly this will support the safe continuation of the current out of hours arrangements.

6.12 Mr Brandreth mentioned the next and last Governing Body meeting for the CCG, will be on the 8th Jun 2022. In the morning a session will be held for CCG staff and ICB staff to mark the end of the CCG. Invitations will be extended to Governing Body members who wish to attend. The Governing Body Board Meeting will commence at 2.00pm face to face. Further details to follow. This will take place at the Albrighton Suite at the Mercure Hotel Shrewsbury.

6.13 Mr Brandreth highlighted that there is still staff deployed and supporting colleagues across the system and that he was very grateful for their efforts. Mr Brandreth added, that as a system there needs to be an emphasis on staff to complete their mandatory training. A process has now been put in place that by the end of May 2022, every member of staff is up to date with their mandatory and statutory training.

6.14 Mr Brandreth gave special recognition to his director colleagues who have worked extremely hard, especially over the winter period.

Quality and Performance

Minute No. GB-22-03.027 - Quality and Performance – by Mrs Zena Young and Dr Julie Garside

7.1 Mrs Zena Young and Dr Julie Garside presented a detailed Quality and Performance report that outlined updates of key areas of performance, Urgent Emergency Care, Planned Care, Cancer Performance, Mental Health, Shrewsbury (SHIPP) and Telford and Wrekin Integrated Place Partnership (TWIPP), Quality, Maternity and Safeguarding. Mrs Young stated, for a comprehensive break-down of the report, it can be found in the enclosure circulated for this agenda item.

7.2 Dr Pepper opened the meeting for any questions Governing Body members wished to ask Mrs Young and Dr Garside.

7.3 Mrs Audrey Warren queried about data regarding maternity, which is highlighted on the tracker and also made reference to the data information on page 42 of the report where it states, “there was no Neo-natal exceptions reported, however, data is still limited at present”. Mrs Warren asked what is the hold up for the maternity unit to be able to have excellent accurate data, is it affecting the quality narrative and are those issues being benchmarked against national initiatives, such as saving babies lives bundles? Mrs Young responding by saying, in terms of the benchmarking, as a system staff would provide the information regionally. There is discrepancy around the data that goes in and the data that comes out of the report, which is not unique to the system. So the data quality at regional level is wider than the Shropshire system, which is known. Mrs Young added, when reference is made to the data, the detail is known behind it, which gives a level of assurance to the regional chief midwife who chairs the regional Perinatal Quality Group. Mrs Young stated regarding the delay of the maternity unity getting good data, some of it is due to the roll out of Badger net. Badger net was implemented last year and has been seen as a real positive assurance step. Badger net keeps a record of maternity information electronically - which will provide audit details over a period of time. Mrs Young highlighted that the Badger net roll-out is not yet complete. However, additional focus has been given to monitor that. Mrs Young highlighted, that it is also about availability of staff, collecting data to do the audit. Another factor is that there is a newly appointed Director of Midwifery, who is now five weeks into her post. Mrs Young is now in discussions with her on how things can be improved for moving forward.

7.4 Dr Michael Matthee made reference to page 43 of the report, about the MLUs across the county. Dr Matthee stated it refers to operational MLUs but Mr Matthee thought some of the MLUs were now shut. Mrs Young responded by saying, that all the MLUs are now providing anti-natal and post-natal care. The Shrewsbury MLU birthing unit is now closed for intrapartum care, due to a risk assessment that has

been undertaken which has involved the CCG. The MLU at the Princes Royal Hospital – the Wrekin maternity unit is open for intrapartum care intermittently, in line with the availability of clinical staff. Patients are kept fully informed of when the MLU will be open to provide the appropriate care. In addition to that, home deliveries have been maintained throughout all the service closures. Mrs Young highlighted, when the Wrekin MLU is closed from a midwife led experience, the women attending in labour can still achieve a midwife led birth on the consultant unit.

7.5 Dr Pepper highlighted that this paper would normally go to the Quality and Performance Committee. However, because of responding to the accelerated vaccination delivery programme and the system pressures that had not happened.

7.6 Mr Vivian queried the IAPT and eating disorder services. Mr Vivian stated that he thought that we were a little passive around the services. Mr Vivian asked whether Mrs Young or Dr Garside could give some assurances that these services were able to deliver. Dr Garside responded by saying, that there is a lot of work that the commissioners and the performance team are currently doing in that area of work. Dr Garside highlighted, regarding IAPT there is a lot of work underway. There have been two slightly different models across the county, which are now being brought together to create one single model of care. It is envisaged that this will give huge benefits to patients. The big question around mental health services are around the demand and capacity question. Dr Garside mentioned that they are working with the Trust to gain some information on that. Regarding eating disorders, it is slightly more complicated to address the issues around that. Dr Garside's understanding of that, is to use the additional investment around mental health and eating disorders, which links into the tier 4 provisions that is commissioned by NHS England. Also, working with specialised commissioning colleagues to look at this and to see where they can be an increase in that area. Mrs Young suggested that both herself and Mrs Garside provide more background detail to the Quality and Performance report for the next scheduled meeting.

7.7 Mrs Donna MacArthur stated that she would like see more background detail to this report, specifically around the cancer targets, as there are some difficulties in reaching those targets. Dr Garside mentioned that they are currently working on the alternative presentations around that information. Dr Garside added that they are working with, colleagues and Shrewsbury Hospital and, with Cancer West Midlands Alliance. Dr Garside stated they were doing fairly well with performance up until last Christmas. The performance was impacted by the omicron covid virus variant and winter pressures. As a system, all improvement plans are currently being reviewed by Tumour Site. A summary of the outcome from that review will go to the Quality and Performance Committee.

7.8 Regarding primary care, Mrs MacArthur suggested that an update could be covered in this report for the next scheduled meeting. Mrs Young mentioned that they have a report going to the Primary Care Committee, for the March meeting. The report will be around quality and primary care. Mrs Young highlighted from that report, that Highley Medical Practice was visited and inspected by CQC. They published a report on their website, on the: 14th January 2022 and so didn't meet the CCG timelines for reporting into the January Governing Body meeting. The medical practice was rated as inadequate for a number of safety reasons. The report outlined high risk in medicines management and management of long term conditions. The CCG has provided significant support to Highley Medical Practice, which they have been very receptive to the plan that has been put in-place for them. Highley Medical Practice has provided actions to the CQC in response to their report. CCG colleagues now thinks the practice is now making good progress as they work through their actions with the support of the CCG.

7.9 Miss Lynn Crawley, stated as of the current time, Healthwatch Shropshire have not received any comments from patients from Highley Medical Practice. Healthwatch are currently running a call-out for comments and experiences of IAPT services. That includes people that have not being able to access them. Healthwatch have just published their children and young people's crisis mental health report, which can be accessed on the Healthwatch website.

7.10 Dr Michael Matthee requested an update on access to x-rays for cancer patients. Dr Garside responded that currently there is no open access to that service due to the current climate. However, there are currently measures in place for patients that need to access that service urgently - such as chest X-rays. Those measures have been communicated to GP Practices. Regarding diagnostic, SaTH have recruited eight international radiographers. Unfortunately, two have dropped out, so they currently have six.

7.11 Regarding the infection and prevention control at Robert Jones, Mrs Young mentioned that they have had a second MRSA outbreak. Which have been reported through the CCG Quality and Performance Committee. A quality assurance visit was undertaken in February 2022, organised by the CCG. Which staff from NSHE/I from the regional team were involved in. NSHE/I have been providing dedicated support to the Trust and the chief nurse, since the first outbreak. It was found from the quality assurance visit that there was a lack of assurance on progress with the action plan. Concerns were also raised around fundamentals of infection and prevention control. Since that time, the regional team have met with the Trust, and they remain not assured on the progress and the grip on quality governance. There has been an Infection Prevention Control review undertaken by an independent person for the Trust. That governance review now needs to be implemented. The Trust has now commissioned some additional leadership, to support the chief nurse with that. NSHE/I will be meeting with the system (the quality leadership) to be assured on the plan moving forward. The Trust remains red on the NSHE/I Internal infection Control Matrix.

7.12 Mr Martin Allen stated that he was concerned with the update that Mrs Young gave on Robert Jones. Mr Allen, queried if there would be implications on long waits on surgery, such as spinal operations. Dr Garside stated, that nothing has been raised to them as a risk for long waits. Dr Garside mentioned that they have been working with NSHE/I and there was an offer of some capacity at the national orthopaedic Stanmore. Seven patients, have taken up those offers. Dr Garside also mentioned, with the wider west and east midlands with NSHE/I to have a combined spinal surgery waiting list. So patients on a broader scale can be treated based on clinical priority. Robert Jones are also in discussion with an independent sector provider in Chester, to carry out some of the lower complexity spinal surgery procedures.

Action: Mrs Young and Dr Garside to provide more background detail to issues raised around eating disorders when presenting the Quality and Performance report for the next scheduled Governing Body meeting.

Recommendations/Action Required:

Governing Body noted the content of the report and the actions being taken to address the issues identified.

Minute No. GB-22-03.028 – Ambulance Handover Performance Report by Dr Julie Garside and Mrs Sam Tilley

8.1 Dr Garside stated the purpose of this report is to highlight key risks that our 999 ambulance provider West Midlands Ambulance Service NHS University Trust currently hold for Shropshire Telford and Wrekin System and to provide assurance and awareness of the mitigating actions the whole system is taking to address these risks.

Key points

- Excessive ambulance waits for patient handover, understanding the issue
- Ambulance lost resource is impacting upon the ability to respond to patients in the Community, factors that affect ambulance performance
- Patient experience and the reputation of the system with excessive delays

8.2 Dr Mary Ilesanmi stated, by reading the full report, it seemed to be very much SaTH focused. Dr Ilesanmi requested if clarification could be given as to what sections of the report related to West Midlands Ambulance Service and what they intend to do about the problem.

8.3 Dr Garside stated that the system has had a challenge with West Midlands Ambulance service over a long period of time. However, it has got a lot better over the past twelve months. Dr Garside added that the problem is not just a Telford, Shropshire and Wrekin challenge but the challenge with the ambulance service is a national issue across this country, over the past few months. Dr Garside highlighted that the ambulance service are working with the system to make improvements in that area. The Ambulance Service has been involved in the campaign “hear and treat”. They have also provide support in, the Hospital Ambulance Liaison Officer (HALO) which has happened at both sites. The ambulance service has also helped in corhorting at peak times. Mrs Sam Tilley added that the relationship with the ambulance service and the system is now better formed and they are now working more collaboratively together. The West Midlands Ambulance Service is now very much engaged in a number of things that the system would like to take forward such as the single point of access where they have been very involved in developing that piece of work.

8.4 Mrs Rachel Bryceland, queried that in the report it outlines in the last three months STW have achieved nineteen days when a patient handovers for the ambulance had not exceeded thirty minutes. But on those days, that did not reflect in the constitutional response standards. Dr Pepper added that it was mentioned in the report that, once ambulance waits are minimised outside of A&E, the projection is that it would release an additional thirty to forty operational hours within the community, which in his estimation would equate to between one and a quarter or one and two third additional crews working over twenty-four hours. This still does not seem to be enough to provide the resource, for instance the category ones. Dr Pepper queried whether there is a conclusion that there are not enough resources of ambulance availability, even when potentially the issues are solved around the waits outside the hospitals. Dr Garside responded by saying, that it is not only preventing the system achieving the targets, but clearly, having that resource back out and responding quickly to 999 calls is what is beneficial to patients. However, it is more difficult to achieve those targets in the more rural areas because of the distances needing to be covered from an operational point of view. That is why it is commissioned on a regional basis (rural and urban) as opposed to locally.

8.5 Mrs Tilley stated with all that has been said that it also needs to be looked on from another perspective; what is driving the demand, activity and what other options might there be to reduce that. So, for example looking at the two hour community response and other alternatives around category three and four, there are further opportunities that can provide intervention to patients that would not necessary need an ambulance.

8.6 Dr Matthee queried the cost highlighted in the report of funding one double crewed ambulance, costing approximately £700,000 per annum. Dr Garside replied that the estimation of that figure was correct. Dr Mathhee added, if it cost that much, what happens to community first responders if they still exist. Dr Garside stated, as far as she knows community first responders still exist.

8.7 Mrs Donna MacArthur made reference to the long waits as outlined in the report. Where it highlights that there were handovers in excess of ten hours Mrs MacArthur queried whether they were looking at those individuals to determine whether there was an alternative pathway that could have been suggested. Mrs Tilley stated that they may need to push West Midlands Ambulance Service for more detail in those incidents and the learning from them. Now that the single point of access is now in place, when ambulance delays get to a certain point, both SaTH staff and West Midlands Ambulance staff are encouraged to review everyone that is in those ambulance queues to see whether there are alternatives.

8.8 Miss Crawley, stated most of the comments that Healthwatch receives from patients regarding West Midlands Ambulance Service. Is when patients dial for an ambulance and there is a long wait for response time for the ambulance to arrive to them as opposed to handover when they arrive at the hospital.

8.9 Mr Brandreth requested that the most up to date single point of access document to be circulated to Governing Body Members.

Action: Dr Garside and Mrs Sam Tilley to circulate the most up to date single point of access document, to Governing Body Members in advanced of the next scheduled meeting.

Recommendations/Action Required:

The Governing Body noted the current position and the actions agreed to reduce unscheduled care activity, prevent crowding in ED and improve discharges, in turn, these actions will reduce ambulance waits as a result of the improved patient flow. Progress against these actions will be monitored by the UEC board on behalf of the system.

Governing Body members request to see a continuation of the ambulance service and all parts of the system, including community response, work together with input from the lead commissioner. Also, for this to be taken forward within the ICS and that an offer of a revised paper incorporating the comments made in this meeting to be shared with the Health and Wellbeing Board.

Finance

Minute No. GB-22-03.029 – 2021/2022 Month 10 Financial Position by Mrs Claire Skidmore

9.1 Mrs Skidmore confirmed that the CCG control total for 21/22 is a £9.984m deficit, the current forecast actual position against this plan at M10 is a deficit of £5.082m and therefore there is a favourable variance of £4.902m.

9.2 The significant improvement shown in the forecast position at M10 is due to the release of system non-recurrent allocations that cannot be spent in year or carried forward and agreed return from Shropshire Community Trust of part of a block payment made as they have received late additional income from NHSE/I which is not required. The non-recurrent allocations were discussed with NHSE/I regional team at Month 9 and an estimate of underspend was flagged in the 'best case' position in our Risk Adjusted Forecast Outturn return. The main unspent allocations are the CDC (Community Diagnostic Centre) revenue allocation for the system project led by SATH, the Ageing Well allocation which was agreed by the system to be invested in the Alternatives to Hospital Admission project led by Shropshire Community Trust and the Additional Roles Reimbursement allocation in primary care which hasn't been spent due to difficulty in recruiting the required workforce.

9.3 The underspends on non-recurrent allocations and the previously reported non-recurrent prior year benefits are offsetting the running cost overspend and the individual commissioning overspend flagged as a risk in both the H1 and H2 plan submissions.

9.4 The underlying position against the sustainability plan remains the key focus across the system. As at Month 10 reporting the CCG is reporting a £2.8m adverse variance against the underlying expenditure control total for 21/22 due to the regional cost pressure from WMAS and the overspend on running costs. Risk around the underlying position is highlighted in this report.

9.5 Work continues to develop and refine the 22/23 financial plan following guidance that was published on 24th December. A separate update to Finance committee was provided in February with regards to current progress for the March draft plan submission.

9.6 As part of the annual accounts process each CCG Governing Body member must make certain declarations and these are outlined in paragraph 37. Mrs Skidmore stated that we would usually take these declarations at Governing Body post: 31st March but due to timings of meetings this year the next Governing Body meeting will be too late. If between the agreement of the declaration and the signing of the accounts anyone believes things to have changed, they are asked to please flag concerns directly with the Executive Director of Finance – Mrs Claire Skidmore or the chair of the Audit Committee - Mr Geoff Braden.

9.7 Mr Adam Pringle queried the deficit against plan and requested if Mrs Skidmore could give further clarity regarding the position. Mrs Skidmore responded by saying, the CCG and SaTH are both in deficit at the moment. Robert Jones and Shrop Com have a small surplus. The CCG underlying position the two key drivers is due to the West Midlands contract spend and some of the running cost issues which are currently being worked through. Mrs Skidmore added, overall in the year when the performance is reviewed against the plan, the CCG has been able to reduce the forecasted deficit (from £10 million to £5 million). That is purely based on the volume of income received for this year and have not been able to spend or unable to carry forward into next year for example not being able to get projects off the ground like CDC and some of the workforce issues regarding recruitment and not being able to appoint people for posts. The CCG are currently in a precarious position and a lot of work needs to be done for 2022/23 to get in a better position.

Recommendations/Action Required:

The Governing Body:
- Noted the Month 10 financial position against plan
- Noted the work in progress to develop the 22/23 financial plan
- Approved the annual accounts declarations set out in paragraph 37

Planning and Restoration by Mrs Sam Tilley

Minute No. - GB-22-03.030 – 2022/23 System Operational Plan Position Statement by Mrs Sam Tilley

10.1 Following a departure from the usual NHS England (NHSE) planning round in 2021/22, 2022/23 Mrs Tilley stated that they will see more familiar planning round arrangements. This paper sets out the key expectations in relation to this planning round, summarises the guidance, highlights key dates and sets out the local approach to delivering the system Operational Plan.

10.2 Annually NHSE publish a set of planning guidance (usually at the end of Q3 or very early in Q4) This guidance sets out the expectations of organisations regarding the development of plans for the following 12 month period and the submission to and ratification of those plans by NHSE. The guidance comes with submission templates and a timetable.

10.3 As has been the norm, this planning round reverts to a single plan covering the 12 month period of 1 April 2022 to 31 March 2023. However, it continues the requirement adopted in 21/22 of a whole system planning submission. The NHSE timetable for the 22/23 planning is outlined in the enclosure that relates to this agenda item, that was circulated with papers for this meeting.

Recommendations/Action Required:

The Governing Body supported the proposed operational planning approach for 2022/23.

Minute No. GB-22-03.031 Elective Recovery Report by Dr Julie Garside

11.1 Dr Garside highlighted that the elective recovery is continuing but has come under increasing pressure as Covid hospitalisation levels and other emergency pressures increased at the end of Q3 and into Q4. STW has delivered good elective recovery in outpatients, day cases and most diagnostic modalities compared to the original plan and but has struggled with elective inpatients due to a combination of theatre staffing levels and medical escalation into elective beds during the winter. The system has continued to maximise the use of Insourcing capacity, modular diagnostics units, the independent sector (both in and out of area) and the vanguard unit at SaTH but staffing absence due to the new Omicron variant has affected the rate of recovery across both our main acute providers.

11.2 The system has continued to focus on patients with the highest clinical need and on the longest waits to minimise those waiting >104wk waits. Particular pressures there relate to spinal surgery and the system is working closely with the regional team in NHSEI on this. The system had an original forecast of having 241 >104wk waiters at the end of March 22 (139 of which were spinal). STW is now on track to have 172 >104wk waiters at the end of March 22 (98 of which are spinal).

11.3 Further work is now being underway across the system to develop the operational plan for 22/23. Alongside this in conjunction with the regional and national recovery teams detailed longer-term demand and capacity models are also being developed. All systems have also been asked to submit bids to NHSE/I for dedicated elective hub capacity that could further improve the rate of recovery. STW submitted its bid as requested on the: 18th February and is currently awaiting feedback from the region.

11.4 In addition PWC have recently been appointed to provide additional consultancy support for STW as part of a national arrangement to the development of the system elective recovery plan initially for 22/23.

11.5 Dr Pepper made reference to page nine of the report, regarding receiving funding for ERF 21/22. Dr Garside responded that NHSE/I underwrote extra costs that were incurred regarding elective recovery in the financial year. They were unable to do all the extra activity that was planned, due to a lot of staffing issues with covid over the winter months. Dr Garside mentioned that there is a new monthly meeting formed for the Elective Cancer Recover Meeting with NHS England. The first meeting took place on Friday. The update from the regulators were very positive and what has been achieved with the Elective Cancer Recovery group, given all that challenges with covid and the winter pressures.

Recommendations/Action Required:

The Governing Body noted the content of the report and received partial assurance regarding the STW system's delivery of its elective recovery plan in 21/22. It also noted on page nine of the report an update to be provided of the report on elective recovery plans including ERF 22/23.

Governance

Minute No. GB-22-03.032 Board Assurance Framework by Miss Alison Smith

12.1 The purpose of the report is to present to the Governing Body the latest iteration of the Board Assurance Framework (BAF) as presented to the Audit Committee at its November meeting to provide; assurance that the principle risks of the CCG not meeting its strategic priorities have been captured and are actively being managed and to allow the Governing Body to review the detail of the risks set out in the document.

12.2 The CCG has in place a Board Assurance Framework (BAF), supported by the Directorate Risk Register (DRR) which are the mechanisms used to record high

level strategic and directorate level risks and opportunities across all functions of the CCG, including delegated co-commissioning of primary care.

12.3 The BAF and DRR are linked to the defined objectives of the CCG, the Primary Care Commissioning Risk Register is linked to the defined objectives of the Primary Care Strategy and together reflect the risk appetite of the organisation.

12.4 The BAF was updated by the strategic risk owners during December 2021/January 2022 as part of the routine bi-monthly review cycle, in addition further work has also been undertaken to review risks associated with commissioning and transformation which were presented to the Audit Committee at its meeting in January 2022.

12.5 The following report highlights the changes and updates to the BAF which are shown in more detail as tracked changes text in red on the BAF appended to this report. This was presented to the Audit Committee for assurance purposes at its meeting on: 19th January 2022 and the Committee recommended the BAF with the highlighted changes as, outlined in the report circulated with papers for this meeting.

12.6 The Governing Body is asked to note that following discussion on the BAF at the last Governing Body meeting in January, action has been taken to review the BAF content and amend where required by the Interim Accountable Officer and the Director of Corporate Affairs and these changes will be presented to the Audit Committee meeting being held on the: 16 March 2022.

12.7 Mrs Young stated that her updates were not captured in the BAF report, particularly on the section of looked after children. Miss Smith stated, that the BAF report presented to this meeting, was the BAF report that went to the January 2022 Audit Committee meeting. The next review and updated BAF report will be going to the Audit Committee next week which will include the information Mrs Young has referenced. Miss Smith added that the BAF report is constantly been updated on a bi-monthly basis.

Recommendations/Action Required:

The Governing Body:

- Reviewed the BAF and did not identify any additional assurances thought to be necessary that the risks to the strategic objectives are being properly managed.
- Accepted assurance from the CCG Audit Committee that the principal risks of the CCG not achieving its strategic and operational priorities and have been accurately identified and actions taken to manage them.

Minute No. GB-22-03.033 – The Shrewsbury and Telford Hospital NHS Trust CQC Inspection Report – Published 18 November 2021 Action Plan By Mrs Hayley Flavell

13.1 Mrs Flavell made reference to SaTH most recent CQC inspection. Mrs Flavell stated that SaTH have had several CQC inspections and have been in special measures since 2018. The most recent inspection was in July 2021. The inspection reviewed end of life on both sites, urgent and emergency care on both sites, maternity on PRH Site and medical care on both sites. Prior to that inspection in July 2021, SaTH also had a focused inspection on children and young people with mental health in February 2021.

13.2 Mrs Flavell highlighted that the ratings were consolidated over the seven core areas (over both sites) to get the overall rating. The overall rating also took into consideration, the ratings over core services over previous inspections. The report outlines SaTH remaining overall inadequate as an organisation. However, the report highlights significant improvements within the core areas. Such as the PRH site

with medicine and ED.

13.3 Mrs Flavell mentioned from the July 2021 inspection they had a list of seventy-one 'must do' actions but they did not have any enforcement notices on the back of the inspection. SaTH also had seventy 'should do' actions. They are broken down across the CQC domain, which can be viewed in the report and was also shared at the Meetings in Common. Mrs Young stated, that the report that Mrs Flavell was speaking to was not included in the pack although Mrs Flavell sent it to be circulated. Mrs Young added that the report was an internal document to SaTH and felt it would not be right and proper to share at this meeting as it was a public meeting. Mrs Young suggested that some additional information can be provided to Governing Body members after the meeting by way of updating the presentation with certain elements. Mrs Young stated that both herself and Mr Brandreth had previously gone through the inspection report regarding the rating from the inspection. Mr Brandreth added, as they have received and gone through the inspection report once Mrs Flavell did not need to resend it to Governing Body Members.

13.4 Mrs Flavell made reference to the section 31 conditions as highlighted in her PowerPoint presentation. Conditions Imposed following CQC Focused Inspection CYP Mental Health in February 2021. The same 6 Conditions imposed at each Hospital Site under the Regulatory activity for CYP detained under the Mental Health Act were also imposed under the Regulated Activity for the treatment of disease, disorder and injury. Again all conditions have been removed with the exception of Condition 2. As outlined below:

Must not admit patients:

- Patients <18 years of age who present with isolated acute mental health needs.
- Do not have physical health needs that require inpatient assessment and treatment.

A further breakdown of other key areas to this presentation was circulated in the pack for information.

13.5 Mrs Young stated that the information presented is a lot to take in and is quite complex. Mrs Young added that they have a detailed discussion regarding that information at the SOAG Meetings. SOAG has given assurance that SaTH is making good progress. Mrs Young also, added, that the rating for the Trust overall has not changed. In part, that is due to the limited inspections they have had. So that will take some time for SaTH to convert their score card. However, what is seen in the CQC report is an improved narrative, which is important and the reduction in conditions, which shows that good progress has been made. Mrs Young stated that she would like to give assurance to Governing Body members as this information is kept under review by the CCG quality team.

13.6 Mrs Warren highlighted that the Trust got an overall rating inadequate for safety. Mrs Warren queried, whether there needs to be a specific narrative for the public around that and how the Trust is being moved out of inadequate and getting to the next level. Mrs Flavell stated that there has been an improvement for safety, which has been captured in the narrative of the CQC report. That includes end of life care, where there has been significant improvements within that area.

13.7 Dr Matthee queried whether the children section of the report fed into the review of the children's mental health services. Mrs Flavell stated, as previously mentioned, patients under 18 years of age who present isolated acute mental health needs, SaTH are unable to provide that support. However, SaTH can admit patients under 18 years of age who have mental health needs with physical needs. Mrs Young highlighted that CQC inspects organisations and not pathways of care.

13.8 Ms Crawley mentioned that there is a piece of work by Healthwatch Shropshire and Healthwatch Telford and Wrekin, regarding children and young people crisis mental health services which was instigated by Mrs Flavell and SaTH as an opportunity to hear directly from young the people. Unfortunately, they were not a great response from young people. However, the report outlined the issues and complexities and challenges for the system of meeting the needs of these young people.

The Governing Body noted the update provided.

Minute No. GB-22-03.034 – Integrated Care System Progress Report by Simon Whitehouse

14.1 Mr Whitehouse was unable to attend this meeting, due to national commitments. Mrs Skidmore provided an update on behalf of Mr Simon Whitehouse. Mrs Skidmore made reference to the work that is continuing to be developed with the governance around the Integrated Care Board.

14.2 A lot of work is being undertaken regarding the due diligence with the CCG being handed over to the ICB. Miss Smith is currently doing substantial work on this, with the intention that there will be a smooth transition from the CCG to the ICB. There is also a due diligence piece being undertaken from the ICB perspective taking on the additional things from the CCG.

14.3 There is a key milestone coming up at the end of March for submissions of the latest readiness to operate Statement and system development plan.

14.4 ICB will be operating in shadow form from the 1st April 2022.

14.5 A lot of work is currently going on regarding communications and engagement strategy for the system. The roll out is planned for May 2022.

14.6 A workshop was held a couple of weeks ago for the current attendee of the ICS Shadow Board, where Mr Whitehouse took the opportunity to, reconfirm the priorities of the system.

14.7 The Chief Executives had a session with Mike Farrow, looking at their development as a group within the system.

14.8 Miss Crawley stated the communications and engagement piece is really important, as there is bound to be some anxiety from the public as to what the ICS will mean for them. Miss Crawley emphasised that there needs to be more information circulated as soon as possible.

The Governing Body noted the update.

OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY

15.1 The following reports from the Chairs of the Governing Body Committees were received and noted for information only. To note:

- GB-22-03.035 - Quality and Performance Committee – 24 November by Mr Meredith Vivian
- GB-22-03.036 - Finance Committee – 26th January 2022 by Mr Geoff Braden
- GB-22-03.037 - Audit Committee – 19 January 2022 by Geoff Braden
- GB-22-03.038- Primary Care Commissioning Committee – 1 December 2021 by Donna MacArthur
- GB-22-03.039 - Summary of CCG Locality Forum Meetings held in November 21 and February 22: Shrewsbury and Atcham North Shropshire South Shropshire Telford and Wrekin by Clare Parker
- GB-22-03.040 - Assuring Involvement Committee – 25 November 2021 and 27 January 2022 by John Wardle

Minute No. GB-22-03.041 – Any Other Business

16.1 There were no further matters to report.

Date and Time of Next Meeting

It was confirmed that the date of the next scheduled Governing Body Part 1 meeting is: Wednesday 8th June 2022, at the Albrighton Suite in Shrewsbury, in person at 2.00pm.

***RESOLVED**: To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)*

Dr Pepper officially closed the meeting at 14:47pm.

SIGNED …….. DATE ……

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Submitted Questions by Members of the Public
for the Governing Body meeting on: 09.03.22

Name, Date and time	Submitted questions
Darren Childs 07.03.22 at 8.17am	**In January my 12 month old daughter had a seizure and stopped breathing it took over 40 minutes for an ambulance to arrive in Ludlow South Shropshire. Could the CCG please answer the following questions and also answer what they are doing to rectify and hold WMAS accountable thanks you:** **1) What happened to rapid response vehicles in Ludlow? Why were they gotten rid of, they don't transport patients so they can attend quickly to assess.**
CCG Summary Response	The CCG is very sorry to hear about the difficulties experienced by Mr Childs. Although it would not be appropriate to address specific patient cases in this response we have received the following response from West Midlands Ambulance Service (WMAS) WMAS along with other emergency ambulance providers phased out rapid response vehicles some years ago and replaced with emergency ambulances in line with the change in response to standards put in place by NHS England in 2017 known as the Ambulance Response Programme (ARP). ARP replaced a categorisation system that was largely concentrated on getting to calls very quickly, but not necessarily with the right resource. A good example of this would be a stroke patient; a rapid response vehicle would get there quickly but not be able to deliver the definitive care needed if the patient were to be FAST positive, what they actually needed was an ambulance to take them to a hyper-acute stroke unit for immediate care and in doing this it would have an improved lifelong outcome. Prior to 2017 the rapid response vehicle would arrive and prepare the patient for transporting, sometimes the car would wait for hours for an ambulance to arrive. The ambulance service was able to report that statutory targets had been met, however the qualitative outcomes weren't equally represented. A further resource that should be noted is the Community First Response (CFR's), a group of volunteers with a similar function/role to that of a retained fire fighter. Individuals that are trained and accredited to deal with immediate life threatening situations. This is a recognised model for an emergency 999 response not just for rural, but urban communities too. WMAS have recruited and trained such volunteers for nearly two decades, with on-going work to help support communities with immediate lifesaving interventions. This programme of work has never been viewed as a replacement for a physical location or ambulance response, as under the new standards CFR's do not stop an

	ambulance response or clock. The benefit with CFR's is that they only serve the community in which they live, unlike an emergency response. The CCG is working with WMAS via the regional commissioners of ambulance services and the Local Authorities via the Health and Wellbeing Boards to develop the CFR schemes across Shropshire.
Darren Childs 07.03.22 at 8.17am	**2) Response times for ambulances in Ludlow are getting slower and slower month on month people are now waiting 45 minutes minimum two hours for emergency blue light 999 help. What are you doing do improve this?**
CCG Summary Response	The CCG is working closely with the regional commissioners and WMAS to improve response times. In particular we have initiated a Single Point of Access for clinical referrers which provides alternatives to conveyances to A&E and has enabled ambulances to be released back into the community to respond to calls more quickly. Please see the latest response times for the Ludlow area (below). As Ambulance handover delays attribute to a large proportion of lost resource hours, there has been a work locally to support patients that dial 999 or 111 to the right care first time. Since late December the local NHS has introduced a virtual clinical hub that clerks and deals with lower category patients, signposting or responding to patients with an Urgent Community Response Model or a General Practitioner should the need arise. Since January the Clinical HUB Known as the Single Point of Access (SPA) has treated 1500 patients and as a direct consequence has reduced crowding in the Emergency Departments by reducing foot fall and ambulance conveyance. Work needs to continue, with an emphasis on dealing with 25% of all 999 activity. This action, particularly in conjunction with other local initiatives will help drive down ambulance handover delays, placing more resource back into the communities and enabling patients across all pathways to receive the right care first time.

1st Oct - 31st Dec 2021

	Category 1			Category 2			Category 3			Category 4	
	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	90th centile (mm:ss)	Inc Count
SY8	20:28	34:44	69	80:27	157:35	363	191:34	402:11	108	319:28	6
SY7	22:52	39:06	34	83:12	170:51	211	257:16	574:43	58	586:05	3

January 2022

	Category 1			Category 2			Category 3			Category 4	
	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	90th centile (mm:ss)	Inc Count
SY8	27:59	40:19	12	66:59	125:00	119	163:32	483:35	45	361:18	3
SY7	16:40	30:23	7	70:25	128:01	54	171:37	609:58	18	703:37	2

February 2022

	Category 1			Category 2			Category 3			Category 4	
	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	90th centile (mm:ss)	Inc Count
SY8	19:54	34:17	14	58:35	121:17	104	220:03	676:20	32	58:35	1
SY7	18:42	40:15	9	76:59	160:53	50	287:39	557:17	18	-	-

Darren Childs 07.03.22 at 8.17am	**3) WMAS blame the hand over times at Shrewsbury and Telford hospitals as the reason for the delayed response times. What are the CCG doing to help rectify these delays?**
CCG Summary Response	Ambulance handover times are part of a cycle of activity which relies on good flow within the hospital and the ability to discharge patients home and into community settings. If any parts of the cycle are under pressure it has a knock on effect on other parts. We have seen rising

	levels of demand on all parts of the cycle which has been exacerbated by the high number of patients will Covid in hospital, Covid related staff absence and outbreaks in community settings like care homes and community hospitals. This has inevitably has an impact on the flow of people moving in and out of the Shrewsbury and Telford hospitals and the ability of ambulances to offload patients on arrival. The CCG has been supporting the implementation of a range of measures to mitigate these issues including: funding additional capacity in primary care, purchasing additional Domiciliary Care packages and community beds, securing additional staff and focusing the staff we have on areas of highest pressure, enhancing our 2 hour community response service and increasing direct access to specialties in the Acute Trust therefore avoiding A&E. This list is not exhaustive but gives a snapshot of the steps the CCG has been taking. We are beginning to see some performance improvements as a result of this work.
Darren Childs 07.03.22 at 8.17am	**4) As response times have increased significantly since closing Bridgnorth, Ludlow, Craven Arms, and Oswestry ambulance bases and removing rapid response vehicles. Can you request WMAS return them?**
CCG Summary Response	There is no evidence that the closure of the sites above has had an impact upon response times, seasonal demand pressures increase response times as activity increases combined with pressures at the receiving hospitals. The ambulances across Shropshire, Telford and Wrekin are fully utilised, therefore only return to base locations at the start and finish of their shifts.
Darren Childs 07.03.22 at 8.17am	**5) WMAS turned down the fire stations offers to have a hubs at the stations to reduce costs, giving a room to restock and driver to have a break (this was free and was in the Shropshire start). But WMAS turned this down. Can you suggest other avenues for WMAS to look into to return hubs?**
	Whilst the CCG works closely with WMAS in relation to service developments, the CCG is not in a positon to answer this question as it relates directly to decision making within WMAS. However, WMAS have provided us with the following response: In the ambulance service, once a crew leaves a hub the only time it will return is for their meal break or at the end of their shift. The rest of the time crews will either be with patients or waiting at hospital. Using Fire Stations would provide no positive impact, but only reduce the time that ambulances are available to respond. Crews already have the ability to get a drink and use toiletry facilities in any case.
Darren Childs 07.03.22 at 8.17am	**6) Why isn't WMAS using the area at Bridgnorth police station as it has an ambulance area and stock room?**
CCG Summary Response	The CCG is not in a positon to answer this question as it relates directly to decision making within WMAS. However, WMAS have provided us with the following response:

	There is a common misconception that where an ambulance starts or finishes a shift will have a substantial impact on the area that it is based in. However, as soon as an ambulance is available it will be sent to the nearest case so that we can minimise the time a patient waits to be seen. Recently, we had a Dudley ambulance in Malvern and a Hereford vehicle that had gone to Birmingham Children's Hospital then getting a case in Birmingham itself as it was the nearest ambulance available. If you look at the data from the first six months of the year, for the three CAS sites in Shropshire, you find the following: **Bridgnorth** Total cases: 27,156 Cases attended by Bridgnorth ambulance: 1,112 Percentage: 4.1% **Craven Arms** Total cases: 20,319 Cases attended by Craven Arms ambulance: 884 Percentage: 4.4% **Market Drayton** Total cases: 28,026 Cases attended by Market Drayton ambulance: 1,128 Percentage: 4.0% **Oswestry** Total cases: 20,722 Cases attended by Oswestry ambulance: 1,185 Percentage: 5.7% When a crew comes on shift at one of the WMAS Hubs they will get into an ambulance that is fully fuelled, clean, stocked and ready for the full shift. In contrast, when crews start at a CAS site, they are in a vehicle that has already been used for half a shift. The crew coming on

<table>
<tr><td></td><td>will have to check over what stock they have on board before they start responding, reducing the amount of time they are available. They will then lose further time because twice a day the crew have to go to a Hub to exchange their vehicle for a newly stocked vehicle.</td></tr>
<tr><td>Darren Childs 07.03.22 at 8.17am</td><td>7) Why does WMAS have such a high turn-over of staff?</td></tr>
<tr><td>CCG Summary Response</td><td>The regional Commissioners (not the CCG) monitor ambulance performance including staff turnover as part of the contract. It would appear that WMAS does not have a high turnover of staff. Figures show that the number of staff leaving the organisation is down on previous years. The data shows that apart from July 2021, the number leaving for other organisations or retiring is less than last year and compared to other ambulance trusts and other NHS organisations is lower.

<table>
<tr><th></th><th colspan="4">Benchmarking - Turnover % FTE (by month)</th></tr>
<tr><th>Month</th><th>Trust</th><th>Region</th><th>Country</th><th>National</th></tr>
<tr><td>Apr-21</td><td>0.7%</td><td>0.9%</td><td>1.1%</td><td>1.1%</td></tr>
<tr><td>May-21</td><td>0.6%</td><td>1.1%</td><td>1.1%</td><td>1.2%</td></tr>
<tr><td>Jun-21</td><td>0.7%</td><td>0.9%</td><td>1.0%</td><td>1.0%</td></tr>
<tr><td>Jul-21</td><td>0.9%</td><td>0.9%</td><td>1.2%</td><td>1.2%</td></tr>
<tr><td>Aug-21</td><td>1.1%</td><td>2.3%</td><td>2.6%</td><td>2.5%</td></tr>
<tr><td>Sep-21</td><td>0.9%</td><td>1.1%</td><td>1.4%</td><td>1.4%</td></tr>
</table></td></tr>
<tr><td>Darren Childs 07.03.22 at 8.17am</td><td>8) WMAS are not meeting targets for Cat 1 and Cat 2 calls consistently in Ludlow. What are you doing about this and why are they not being held to account for failing to meet them?</td></tr>
<tr><td>CCG Summary Response</td><td>Please see the response given in the answer to Question 1, 2 & 3.

The CCG previously hosted at system level a series of meetings with providers to include West Midlands Ambulance Service our 999 and 111 provider. The purpose of these meetings was to provide scrutiny relating to the constitutional standards of care and oversight metrics/frameworks. The CCG in its development to become an Integrated Care Board by July 2022 will continue to apply the governance</td></tr>
</table>

	and assurance processes that will ensure all partners/providers and commissioners of these services will continue to provide oversight and opportunities for improvement. In addition to monitoring metrics, the CCG's quality function monitors serious incidents that are reported from WMAS or other partners regarding ambulance care and affect Shropshire Telford and Wrekin residents. This is to ensure incidents are investigated to a high standard, and lessons are learnt to minimise the risk of the same incident happening again. It also ensures that families are communicated with appropriately and assurances can be sought (eg training data, patient feedback). Incidents reported may relate to patients whose care has not been delivered with in the national ambulance standards as well as other patient safety incidents. The STW CCG Quality Team are represented at an ambulance quality meeting monthly with other CCGs to who WMAS also provides a service to and meeting these national standards to ensure a quality service is key to these discussions. These are led by Black Country CCG who hold the contract on behalf of the region and to who concerns are directly escalated as required and both WMAS and the system partners contribute to solutions.
Darren Childs 07.03.22 at 8.17am	**9) Can you vote for no confidence in WMAS as they are failing the people of Ludlow?**
CCG Summary Response	The CCG is keen to promote a collaborative approach to addressing service developments and improvements as a health and care system and we will continue to work with WMAS.
Darren Childs 07.03.22 at 8.17am	**10) Will you publicly support our petition of over 4000 signatures along with Shropshire council who have already joined. We are asking for WMAS to return the ambulance hubs and rapid response vehicles to Ludlow?**
CCG Summary Response	Please see the response to question 9 above.
Alison Hiles 07.03.22 12 noon	**The ambulance service has undergone profound change in recent years.** **Currently, all shifts start and end at Shrewsbury or Donnington. Staff return to Shrewsbury or Donnington for rest breaks. A majority of ambulance call-outs result in conveyance to hospital, almost always Shrewsbury or Telford (with a minority of conveyances further afield). There will of course be a greater concentration of ambulance call-outs in the urban centres of Shrewsbury and Telford. There is a strong gravitational pull of ambulances to Telford and Shrewsbury throughout a working shift. Ambulances are therefore inevitably less likely to be within easy reach of smaller market towns and rural areas.** **1)What are mortality rates for Category One calls in rural areas of STW?**

CCG Summary Response	Around half of patients that WMAS attend go to the hospital. Over 45% are discharged at the scene or were given telephone triage only, this does mean that an Ambulance will come available in the community as well as Shrewsbury or Telford Hospitals. There are too many variables to understand mortality v Category 1 calls, what we do understand is that there are safety/quality measures that indicate a 'treatment' or 'intervention' within a given timeframe, generally 60 minutes from onset for Cardiac, Stroke and Trauma, given the topography this target is difficult to achieve as the more rural locations can be in excess of a 60 minute drive to a treatment centre. As a system, we monitor 'harm' via our Quality and Performance committee, a delay in response or arrival at a treatment centre has not been raised as a theme.
Alison Hiles **07.03.22** **12 noon**	**2) Do they differ from mortality rates in STW's urban areas? How about Category Two calls?**
CCG Summary Response	As for question 1 above
Alison Hiles **07.03.22** **12 noon**	**3) If the CCG does not monitor these outcomes, can you be confident you commission a service that is fit for purpose?**
CCG Summary Response	As a health and care system we continue to work with our service providers to increase productivity. For WMAS, enabling them to make further improvements in response standards. The CCG monitors WMAS against a range of performance indicators and as described in responses above we also support performance improvement by working with partners to implement schemes that will realise these improvements
Gill George **07.03.22** **12.06pm**	**Ambulance Provision to Rural Areas** **The paper on ambulance handover performance includes this paragraph:**

	"There is an understanding of the underlying risk in the ability to meet the nationally recognised 999 constitutional response standards in many rural health systems. This has been well documented in the past by the CCG but the system must strive for the best performance possible despite the geographic challenge, for the resources available." **1) Can I clarify the meaning of this?**
CCG Summary Response	WMAS have provided us with the following response: If you live in a rural area you will not get the same level of provision as if you live in an urban area as has always been the case. WMAS have offered the example that petrol often costs more in a rural area because there are not so many people buying it. Performance standards are aggregated across the region. The CCG would add that smaller areas such as Shropshire, Telford and Wrekin benefit from a collective approach to commissioning services such as these which would otherwise be unaffordable if commissioned in isolation
Gill George 07.03.22 12.06pm	**2) Is this an acknowledgement by the CCG that rural communities in Shropshire do not have an ambulance service that is consistent with national performance targets?**
CCG Summary Response	Please see the response to the question above All areas nationally are subject to the same performance targets
Gill George 07.03.22 12.06pm	**3) Is this also an acknowledgement that the CCG lacks the resources to provide our rural communities with a service that meets national response time targets?**
CCG Summary Response	The CCG continues to develop services and pathways that direct patients away from an ambulance response where it is not needed and an alternative more appropriate pathway for the patient can be sought. Early data from our newly established Single Point of Access service shows a significant number of patients treated through this service from WMAS can have their need met in another way. We will also continue to develop our communications campaigns seeking to change the way that the public use services to ensure that the capacity that we commission is utilised in the right way and can realise the maximum benefits for patients
Gill George	**4) Will the CCG ensure that this information is shared with Shropshire Council, local MPs, and NHS England?**

07.03.22 12.06pm	
CCG Summary Response	Yes
Linda Senior 07.03.22 12 noon	**In 2013/14, WMAS provided services from 15 operational hubs and over 100 community ambulance stations scattered across the West Midlands. The information is from the WMAS Annual Report. By 2020/21, there were 15 operational hubs and only 13 community ambulance stations. Since then, another 4 community ambulance stations have been closed (Craven Arms, Market Drayton, Oswestry and Bridgnorth).** **WMAS has evidently had a policy of centralisation, presumably for reasons of efficiency. The WMAS model is in sharp contrast to that used by the Welsh Ambulance Service, which currently has 90 ambulance stations across Wales.** **Does the CCG believe that the WMAS highly centralised model meets the needs of rural Shropshire more effectively than the Welsh model of local services?**
CCG Summary Response	WMAS maintain that the service they provide is comparable to the service provided in Wales and have advised that the performance standards in Wales are very different to those in England. WMAS have advised that in their opinion the current system in Shropshire, Telford & Wrekin is preferable to the one in Wales
Linda Senior 07.03.22 12 noon	**Has the CCG 'rural proofed' the ambulance service it commissions?**
CCG Summary Response	Yes, within the constraints previously mentioned.
Linda Senior 07.03.22 12 noon	**Will the CCG share its data on ambulance performance – which surely must be monitored by the CCG – showing differential performance by postcode over the last three years?**

CCG Summary Response	Ambulance performance data is presented, in public, to each CCG Governing Body meeting as part of the quality and performance report This includes validated data regarding WMAS response times. WMAS have also recently shared postcode related data to the Council's Health Overview and Scrutiny Committee (HOSC).

NHS Shropshire, Telford and Wrekin CCG

ACTIONS FROM THE GOVERNING BODY MEETINGS HELD IN PUBLIC: 09.03.22

	Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
1.	08.09.21 Assurance Reports Quality and Performance Minute No. GB-21-09-059 – Quality and Performance Exception Report	Mrs Young advised members that in terms of data quality, there was a reliance on SaTH as the data owners for the quality of the data. Mrs Young advised that there was increasing line of sight and a capacity to triangulate data with a variety of sources of assurance to ensure quality. Mrs Young reported that Quality Governance is receiving support, and that insights which increase confidence and access to data, is available (which is being validated) that shows that the still birth rate is coming down. Further Information on this matter to be shared at a future meeting of the CCG Board.	Zena Young	8th June 2022	This will be included on the agenda at the appropriate time. A report on maternity and neonates data quality assurance is scheduled planned for the January LMNS Programme Board and an update will be included in the papers for March Governing Body meeting. 12/01/2022 – Action remains open until next update in March 2022 meeting. 09/03/22 - A full report on data quality is not yet available for this meeting. CCG, trust and NHSEI working together to understand some of the data quality issues. A detailed update was received at SOAG 23/02/22 and NHSEI at system quarterly review 24/02 provided feedback on high level of assurance on progress made in terms of maternity governance and quality assurance. Proposed that this matter is passed (via email) to ICB for further consideration.

	Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
2.	12.01.22 Minute No. GB-22-01.009 - Niche Recommendations	NHS Shropshire, Telford and Wrekin CCG PROPOSED to share Niche Recommendations report with Integrated Care Board to be considered and followed up after the dissolution of the CCG. Also, to approve the Shropshire Telford and Wrekin response detailed in section 4 of the paper. Mrs Zena Young to share Niche Recommendations with Integrated Care Board to be considered and followed up after the dissolution of the CCG – 30th June 2022. A further update on the Niche Report will be brought back to the CCG Governing Body post March 2022.	Zena Young	After 30th June 2022	09/03/22 – This action is just not just about NICHE piece. But also around the system's End of Life Care Strategy and the improvements required at SaTH in accordance with their CQC report. Which identified their End of Life Care as inadequate. Action remains open until next update after June 2022. 08/06/22 – The information required is as yet not available as it has not been published. Proposed that this matter is passed (via email) to ICB for further consideration.
3.	09.03.22 Minute No. GB-22-03.027 - Quality and Performance	Mrs Young and Dr Garside to provide more background detail to issues raised around eating disorders when presenting the Quality and Performance report for the next scheduled meeting.	Mrs Zena Young/Dr Julie Garside	June 2022 Meeting	08/06/22 - Additional funding has been allocated to improve the waiting list but recruitment challenges are making progress difficult. A detailed paper on CYP eating disorders is going to the June Q&P Committee for a more thorough review and discussion on the options for improvement. Proposed to close action and ask Q&P committee to include in handover to ICB.
4.	09.03.22 Minute no. GB-22-03.028 – Ambulance Handover Performance Report by Dr Julie Garside and Mrs Sam Tilley	Dr Garside and Mrs Sam Tilley to circulate the most up to date single point of access document, to Governing Body Members in advanced of the next scheduled meeting.	Dr Garside/Mrs Sam Tilley	June 2022 Meeting	08/06/22 - To be circulated with the Board Papers. Complete. Close.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.047	Interim Accountable Officer Report

Executive Lead (s):	Author(s):
	Mark Brandreth

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary (key points in the report):

I intend to update the Governing body on number of items including:

1. **Care Quality Commission (CQC) v The Shrewsbury and Telford Hospital NHS Trust**

Shrewsbury and Telford Hospital NHS Trust was summoned to appear before Telford Magistrates Court on the 18th May 22.

The Trust appeared in court to answer three charges brought by the CQC in relation to failures of care of service users, including a named patient, and, for additional failures in respect of safe care and treatment of a further named patient. The deaths of the two patients relating to the charges took place in October 2019, and May 2020 respectively.

The CQC was seeking to prosecute the Trust for these offences under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in respect of its role as Registered Provider responsible for the Royal Shrewsbury Hospital.

The Trust accepted full responsibility and entered a guilty to the charges brought against it.

The Trust has apologised to the families of the patients concerned and offered its sincere condolences.

In relation to both cases, the Trust has confirmed it has implemented a series of actions following internal investigations and an external review to address the failings. These changes are being fully embedded across the Trust to ensure they continue to improve the quality of care they provide.

As part of its assurance work the CCG can confirm:

- The Trust now has a strengthened serious incident reporting process which involves the CCG meeting weekly to review all incidents. Terms of reference are agreed, and this is now well established.
- The CCG has strengthened its standard operating process to ensure assurance that Duty of Candour is applied robustly.
- The CCG has written to all four local NHS Trusts to reiterate the importance of timely reporting, duty of candour.

- The above will be included in system quality metrics discussed at System Quality Group and Quality Performance and Committee.

2. Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)

The CCG received formal notification from NHS England on the 12 May that RJAH had been moved into Single Oversight Level 3 and an Improvement Director has been allocated to work with and support the organisation with its improvements.

We understand that further work has been undertaken by NHS E and the Trust to finalise the formal enforcement undertakings which underpin that decision. Subsequently a set of undertakings have been developed.

The CCG understands an MRSA outbreak declared in August 21 led to an NHSE review where RJAH was escalated to red on NHSE IPC matrix. Additional support was offered from NHSE and improvements were made, including a full Infection Prevention and Control (IPC) governance review, but a further review by NHSE conducted in February 22 showed improvements had not sustained or extrapolated across all the organisation.

The Trust reports that an IPC Improvement plan is in place and covers nine themes (leadership & culture, workforce, governance, cleanliness, estates, equipment, and storage, hand hygiene/below the elbows, training, communications and trust wide learning).

Additional Executive and Board oversight has been put in place and strengthened including an IPC Assurance committee chaired by a Non-Executive reporting directly to the Board.
The CCG will seek assurance on these changes by through the Quality team and the Quality and Performance Committee. This will ensure a handover to the Integrated Care Board.

As part of its assurance work the CCG can confirm:

- Monthly visits by the CCG are planned to gain assurance on planned improvements.
- 2 wards have undergone refurbishment.
- The CCG are attending Infection Prevention and Control Committees at the Trust.
- RJAH did not meet their C diff objective this year with 3 cases against an objective of 1. RJAH 22/23 objective is set at 2 cases. The current environmental actions undertaken are appropriate to support this.
- The action plan is reviewed monthly at Quality and Performance Committee.

3. CCG Staff Event

The CCG will be holding a workshop for staff on the 8th June. It will include an opportunity to hear from the ICB Chair designate and the Interim Chief Executive designate. I will update further at the meeting.

4. Mandatory Training

CCG staff have worked hard to update their statutory and mandatory training. I will provide an update on the latest improved position in the meeting.

5. Hospital Transformation Programme

SATH has now submitted the Strategic Outline Case (SOC) to colleagues at NHS England. With this report we have published with the papers for this meeting a further letter of support that the CCG submitted to SATH recently.

The CCG understands that the SOC should be published in public once NHSE have completed their work.

Recommendations/Actions Required:
The Governing Body is asked to note the report.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	Yes
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	Yes
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	Yes
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	Yes

5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	Yes

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Tel: 01952 580300

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Our Ref: JP/CAT

19 April 2022

Dr Catriona McMahon
Chair
Shrewsbury and Telford Hospital NHS Trust
Trust Headquarters
Royal Shrewsbury Hospital
SHREWSBURY
Shropshire
SY3 8XQ

Dear Catriona

Letter of Support to the Board of SATH in relation to the Updated Strategic Outline Case (SOC) for the Hospital Transformation Programme

The Governing Body of Shropshire, Telford and Wrekin CCG met on Wednesday, 13 April 2022, to consider the updated SOC presented by your team with a view to considering CCG support. As you are aware, we are presently the statutory commissioning body charged with this responsibility. However, mindful of the Integrated Care Board (ICB) formation from 1 July 2022 we have sought to make senior ICB designate colleagues aware of our considerations.

Many thanks to your team for providing the opportunity for us to consider the work that has been undertaken since we last met to consider the SOC in September last year.

It was helpful to see how the case has been refined to best balance the complexities of competing stakeholder priorities, ambitions and objectives. The Governing Body is assured by the fact that following the refinements made to the options appraised, the options still enable delivery of the core objectives and ambitions.

The Governing Body have reviewed the options in the SOC and believe that the preferred option noted (Option 2 – "core DMBC requirements") provides the greatest opportunity at present to secure much needed capital funds for the Shropshire System. If approved, the option will deliver the core DMBC objectives and requirements, in line with the outcome of the Future Fit consultation, and will unlock £312m of capital funding. Set alongside the c.£24m we are working to secure through the Elective Hub bid recently submitted for 2022/23, and the already funded reconfiguration of dialysis services at The Princess Royal Hospital, this would bring much needed capital investment into our hospitals.

The Governing Body note that the Trust is keen to pursue other additional sources of funding for future years such that, over time, it can seek to address other key estates risks that have been identified and the ambition for further integration of services. We recognise, however, that these would be subject to appropriate governance and other processes in place at the relevant time, which would include considerations as to 'strategic fit' with local system priorities, value for money and affordability.

As was the case in September, we recognise that the document shared with the Governing Body at this stage is a draft and will be subject to a regional and national review process to finalise it. We do not expect this process to result in any material changes to the substance of the case and would expect to be notified if this were to be the case.

Taking the above into account, the Governing Body can, therefore, confirm its support for the current draft SOC and the preferred option identified.

The CCG's support of the SOC and preferred option is subject to the commitment to progress a number of important matters during the OBC phase of this programme:

- Continued alignment of the activity and other key assumptions with those set out within the NHS Long Term Plan (LTP), including the aspirations within the LTP around outpatients, elective and non-elective care. This will need to take into account any infection prevention measures assumed to be in place in the longer term as a result of the COVID19 pandemic and any learning taken from our experience of caring for patients safely during this time.

- Further work around the options for delivery of the scheme and the financial affordability for SATH and for the STW system recognising the need to achieve a balanced position across the system as a whole.

- Delivering robust and ambitious workforce transformation plans across the system and assurance around their deliverability and affordability - this needs to include where appropriate new or expanded roles.

- Continued alignment of the SOC/OBC with the system's Local Care model and SATH's engagement with our wider aspiration for Place Based Care.

- Active engagement, participation and leadership of SATH in STW ICS, in particular facilitating and encouraging the clinical body of SATH to be actively involved in the development of our care models.

- Further details that help the public understand what the care model will mean for patients in Shropshire, Telford and Wrekin. For example (but not limited to), how urgent and emergency services will operate for residents of Shropshire, Telford and Wrekin across both hospital sites.

- Linked to the point above, specifically, further engagement with key stakeholders and the wider public about the enhanced urgent care service (A&E Local model) at PRH, to ensure that there is a clear understanding of the service offering and that clinical risks can be managed appropriately.

In addition to these points, the CCG Governing Body understands that colleagues in the ICB, once established, will continue to ensure that they play a leadership role in convening our partners (including Local Authority, community, mental health and primary care) to work together in delivery of the System's vision for care in the county. The Hospital Transformation Programme remains an important part of this much broader scope of work and we understand the ICB intends to continue to engage with partners (including those in Wales) and the public to maintain transparency and encourage support for progress of this vision.

To conclude, the CCG Governing Body supports the urgent need to progress with the HTP and the recommended way forward outlined in the draft Strategic Outline Case. We are fully committed, and we would expect the emerging ICB to be equally committed, along with our system partners, to working with regulators, the Department of Health and Social Care and the Treasury to secure the required funding.

As the programme develops, the Governing Body would expect that the ICB will continue to seek assurance that delivery of the HTP is in line with the model that was consulted on and that the points above are being addressed.

Yours sincerely

Dr John Pepper
Chair
Shropshire, Telford and Wrekin CCG

cc Mark Brandreth
Neil Mckay
Simon Whitehouse
Louise Barnett
Chris Preston

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire Telford, and Wrekin CCG Governing Body meeting 8 June 2022**

Item Number:	Agenda Item:
GB-22-06.048	Quality & Performance Report April 2022

Executive Lead (s):	Author(s):
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Action Required (please select):

A=Approval		R=Ratification		S=Assurance	x	D=Discussion	x	I=Information	x

History of the Report (where has the paper been presented:		
Committee	**Date**	**Purpose (A, R, S, D, I)**
Quality & Performance Committee	25/05/22	SDI

Executive Summary (key points in the report):

PERFORMANCE

Covid: The disruption and pressure continue despite the reduction in numbers, constraints still exist across system wide capacity. The Demand and Capacity Group are looking at Bed Modelling, a retrospective and forecasted position using Population Health data, verbal updates to follow.

Primary Care: Primary care appointments remain broadly in line with the annual Mean, the % of those attended is above target those seen face to face at c.63% and home visits remain double the target. Workforce remains a constraint and risk for the system, mitigations are in place.

Shropshire Doctors: Key Performance Indicators remain green; concerns continue with staffing which have actions to mitigate. The Single Point of Access/Referral is working well with c.3250 patients through the combined (CCC & SPA) service since January with a 94% non-referral to the Emergency Department outcome.

Shropshire Community Services: No update supplied this month due to short term capacity issues within the CCG Performance team.

Ambulance and 111: WMAS hear and treat remains c.16% and see and treat @34%. Category 1 and Category 2 call response times (Mean) is a significant risk for the system but has shown some improvement as the pressures ease with managing COVID and the surge of planned care recovery. Long ambulance waits remain a concern, St John started at PRH to cohort and release ambulances, but this has had little impact.

Urgent and Emergency Care (UEC): All operational standards remain relatively stable (still below standard), concerns regarding the % of patients spending >12hrs in the emergency department which should be <2% is currently 9%, some mitigating actions exist to address Acute Medical flow which should have a significant impact on this.

Cancer Care: The majority of the metrics remain stable but below current targets. There has been a slight improvement in Breast symptom referral c.2% on last month, some evidence that the new pathways are starting to work, and demand has reduced slightly from recent highs. Urgent referral and screening 62d have significantly improved on last month c.25%. Key risks still exist in two week waits, 28-day Faster Diagnosis and Tumour Pathways, all of which have actions to mitigate the current position but are dependent on Diagnostic capacity/workforce.

Planned Care: UEC pressures are still impacting upon planned care recovery, but they are finally starting to ease, albeit slowly. No significant change in overall RTT performance, which remains at around 60% against a national target of 92%. The total number of waits therefore continues to increase, particularly in key specialties such as orthopaedics and general surgery. There are continued signs of recovery in ophthalmology, in which numbers are now starting to fall. The admitted waiting list continues to be clinically prioritised. The STW system is managing its P2 and P2C clearance times to levels better than the regional averages but due to capacity constraints and UEC pressures little progress has been made with P3 and P4 waits. Key risks remain in Referral to Treatment (RTT), long waiters (>104wks) and diagnostics, all of which have actions to improve but are workforce capacity dependent.

Mental Health: Children with an Urgent Eating Disorder are waiting for longer than 1 week, and whilst the CCG and provider agreed funding for a remedial plan to reduce the number of children waiting the trust have as yet been unable to successfully recruit to the roles. This is also having an impact on the wider system especially in Acute services as well as in the place of safety suite at Redwoods which is normally used for adults at risk but is increasing being used by a child, and therefore cannot hold any adults. The Quality and Performance Committee are to receive a detailed report on eating disorders at their June meeting. IAPT access continues to be lower than targets, and Physical Health checks for patients with an SMI (Serious Mental Illness) levels remain below national targets, although there have been small improvements made in Q4.

Shrewsbury (SHIPP) and Telford and Wrekin Integrated Place Partnership (TWIPP): Further progress has been made with placed based metrics; TWIPP and SHIPP now have internal operating dashboards that reflect both local and national targets, with system level key metrics and reporting in final stages of development. A summary dashboard for the system containing 19 key metrics and CQC compliancy reports for each local authority is being finalised and it is expected that these will be reported to the ICS Board from June.

Elective Recovery Framework (ERF): No Report, as not in place for Month 1 due to the planning timetable.

Year End position against planned trajectories: The system has started to gather key metrics to review, year-end performance is not yet ready for publication/review by the wider system, the Performance, Contracting and Transformation team have taken an action

to review the position as soon as the data becomes available and submit findings/plans to the next Quality and Performance Committee.

QUALITY

SATH: NHSE/I will be undertaking their annual IPC assurance visit to the trust in July, the trust is currently rated GREEN on the NHSE/I internal risk matrix. The CQC have advised the Trust that the total number of CQC conditions has been significantly reduced, with some of the remaining conditions being varied to reflect a requirement for reduced reporting

Maternity: The Trust provided a Maternity and Neonatal Dashboard exception report at May's Peri-natal Quality Surveliillaince Group. Data quality whilst it remains an issue shows an improving view this month with clearer assurance provided in relation to key safety metrics.

SATH IPC: The CCG IPC team joined two trust Exemplar assurance visits to maternity wards at PRH during May, Suboptimal IPC standards were noted on both the ante-natal and post-natal ward, actions will be monitored through attendance at the trusts IPC Operational Group. A follow up visit in June to the maternity unit is being undertaken by the CCG Senior IPC Lead and Perinatal Senior Quality Lead & Patient Safety Specialist.

RJAH: The Trust had an on-site visit from NHSEI and the CCG on 11th of February where it was found that IPC standards were not where they should be with several themes being identified. The Trust has undertaken immediate actions and has completed 72 of the 124 actions identified in a combined action plan. The remaining actions are in progress, the CCG is providing support to the IPC team and there is a further quality assurance visit scheduled for June.

Safeguarding Adults: NHS Provider Adult Safeguarding Dashboards have been refreshed for 2022-23. Q1 performance is expected soon and will be reviewed in the next report to the Systems Quality Group The national consultation into the Regulations and Draft Code of Practice for the Liberty Protection Safeguards is proceeding. As per the plans there is to be an ICS wide response to this whilst also encouraging agencies to submit their own specific responses. The work taking place in support of the consultation has been the subject of a paper to the Systems Quality Group and NHSE have commended the approach taking place by our ICS. Briefings have also gone to Primary Care colleagues as well. The 2022-23 schedule of Adult Safeguarding Quality Assurance visits has commenced. Two are planned for June with different Trusts and another Trust have already received the report and recommendations from their visit and a meeting has been scheduled to review the findings with them. Further details will be reported via the Systems Quality Group.

Safeguarding children: Compass Multi-Agency Safeguarding Hub (MASH) has recruited a health team. Two urgent Child Safeguarding Practice Rapid Responses and Reviews completed this month. Shropshire mock Joint Targeted Area Inspection in progress. Two Shropshire and Telford and Wrekin (STW) safeguarding initial scoping/ rapid reviews have been completed with

initial learning identified and further CSPR implementation planned. A joint learning event was held for two cases and the learning briefing sent to the National Panel.

STW System Quality: The System Palliative and End of Life Care Strategy is being developed and is due to be launched at Healthwatch first face to face public event in relation to end of life in May 22. System Quality Metrics are evolving. The System Quality Roadmap is being developed. The system quality risk registers in development. The virtual ward implementation plan is in place. The draft system quality strategy is in development System Quality Metrics continue to be developed

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation?	No
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:
Governing Body is asked to note the content of the report and the actions being taken to address the issues identified. It is also asked to note that a separate report on eating disorders is to be taken to the Quality & Performance Committee in June.

1 Key Performance (December/January)

1.1 Primary Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	2020/21 YTD	2021/22 YTD	Nov-21	Variance Previous Month	YTD Variance	Variance with Mean
Total Primary Care Appointments	Mar 22	256176	-			220567	227107	230513	268039	4.43%	1.50%	15.94%
% of PC Appointments Attended	Mar 22	92.3%	91.3%			91.9%	92.4%	92.4%	91.5%	0.99%	1.08%	0.45%
% of PC Appointments DNA'd	Mar 22	3.8%	3.8%			4.2%	4.6%	4.0%	4.25%	9.76%	14.08%	-6.58%
% of PC Appointments Unknown	Mar 22	3.9%	5.2%			4.0%	4.0%	3.7%	3.80%	1.59%	-8.48%	-3.46%
% of PC Appointments Seen a GP	Mar 22	51.2%	53.7%			48.6%	48.6%	50.6%	49.01%	4.66%	5.06%	4.26%
% of PC Appointments Seen other medical staff	Mar 22	47.4%	45.2%			49.0%	49.0%	47.7%	49.40%	-4.09%	-2.61%	-3.24%
% of PC Appointments Seen Unknown	Mar 22	1.5%	3.1%			2.0%	2.4%	1.7%	1.60%	-8.15%	-28.68%	-26.03%
% of PC Appointments Seen Face-to-Face	Mar 22	63.0%	53.7%			64.6%	80.7%	59.0%	65.25%	-3.45%	-26.87%	-2.52%
% of PC Appointments Seen Home Visit	Mar 22	1.4%	0.6%			1.2%	1.3%	1.2%	1.19%	18.75%	-5.06%	14.56%
% of PC Appointments Telephone	Mar 22	31.4%	41.7%			29.2%	13.7%	33.3%	29.34%	6.93%	143.02%	7.40%
% of PC Appointments Video/Online	Mar 22	0.0%	0.4%			0.0%	0.0%	0.0%	0.03%	-19.99%	3467.51%	31.66%
% of PC Appointments Unknown	Mar 22	4.2%	3.6%			4.2%	4.3%	4.2%	4.20%	0.10%	-0.40%	0.97%

Analyst Commentary

Primary care appointments remain broadly in line with the annual mean. The proportion of those attended is above target, in particular those seen face to face at around 63%, and home visits at twice the target.

1.2 Shropshire Doctors

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Variance with Mean
Group 1 metrics							
Total Cases	Apr 22	4451	-			4219	5.51%
Cases closed by Shropdoc	Apr 22	4308	-			4001	7.68%
Cases closed with acute hospital admission	Apr 22	143	-			218	-34.32%
Cases referred on to A&E	Apr 22	74	-			50	46.73%
Cases referred to 999	Apr 22	77	-			90	-14.03%

Analyst Commentary

KPI's are broadly being met cases referred to ambulance and closed with an acute admission still remain lower than predicted.

1.3 Shropshire Community

Bed Occupancy remains a challenge, however some success in the avoidable admissions work with the 2-hour community response running above capacity and the advanced care planning showing an excellent reduction on the call for ambulance (c-.30%). The inclusive dashboard is in development and expected in the next report.

1.4 Ambulance and 111

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	2019/20 YTD	2021/22 YTD
% WMAS See and Treat	Apr 22	30.7%	34.0%			36.1%	35.1%	33.0%
% WMAS Hear and Treat	Apr 22	16.3%	7.0%			6.3%	2.8%	11.4%
% WMAS See and Convey	Apr 22	53.0%	59.0%			57.6%	62.1%	55.5%
Total 111 cases triaged	Apr 22	12807	-			10821	10987	10070
111 Cases referred to ED/ Cases resulting in ambulance dispatch	Apr 22	2727	-			2444	2479	2252
% of NHS111 cases to ED/Ambulance	Apr 22	21.3%	23.3%			22.6%	22.8%	22.2%
111 Cases recommended to Attend PRH/RSH ED	Apr 22	1054	-			802		802
% of NHS111 cases recommended to attend PRH/RSH ED	Apr 22	8.2%	6.5%			7.5%		8.1%
NHS 111 Cases recommended to Attend GP/UTC	Apr 22	6157	-			5251		5176
NHS111 Cases for MH/substance misuse problems signposted to PRH/RSH	Apr 22	5	-			3		4
NHS111 Cases for MH/substance misuse problems signposted to MH Providers	Apr 22	49	-			28		31
NHS 111 First ED Refereral Appointments Completed	Apr 22	0	-			32		28
NHS 111 first MIU Appointments Completed	Apr 22	30	-			33		28

Analyst Commentary

WMAS hear and treat, combined with the SPA is exceptional and exceeding National standards.

WMAS response for CAT 1 and CAT 2 are currently not meeting the constitutional standard.

111 is broadly in line with the KPI's with no real exceptions.

1.5 Urgent & Emergency Care

Front Door Metrics

	20 Apr	27 Apr	4 May	11 May
A&E performance	66.2%	65.5%	64.2%	64.5%
A&E perf with booked appts	66.6%	66.0%	64.7%	64.8%
A&E attendances	3,551	3,518	3,798	3,260
A&E breaches	1,199	1,214	1,358	1,157
ArrivingByAmbulance	685	732	742	639
Handover delays 30 - 60 mins	189	175	192	152
Handover delays over 60 mins	234	215	276	188
Number of delays for admission 4-12 hours	276	299	293	221
Number of delays from decision to admit	100	24	70	41
Over 12 hours from arrival (SitRep)	290	248	331	400
Proportion > 12hrs (%) (ECDS)	13.1%	9.8%	12.4%	9.8%
Proportion CR1P < 60Mins (%) (ECDS)				
Proportion TTIA < 15mins (%) (ECDS)	35.3%	33.9%	26.9%	20.0%

	20 Apr	27 Apr	4 May	11 May
A&E Patients Streamed	495	470	603	416
4-hour breaches in streaming service	28	36	49	28
Type 1 Attendances seen within 60 minutes	347	384	379	280
Total admissions	1,067	1,045	1,165	941
Emergency Admissions	1,030	1,001	1,118	898
Emergency Admissions via A&E	688	675	699	592
Conversion Rate	28.3%	27.4%	26.7%	26.4%
A&E attendances	3,551	3,518	3,798	3,260
A&E attendances type1	2,428	2,467	2,616	2,240
A&E attendances type2	0	0	0	0
A&E attendances type3	1,123	1,051	1,182	1,020
Attendances Major Type 1	1,309	1,380	1,414	1,144
Attendances Minor Type 1	592	527	583	553
Attendances Paeds Type 1	478	496	658	407
Attendances Resus Type 1	49	65	61	56

Analyst Commentary

A&E performance remains below standard but stable.

The proportions of >12hrs is showing special cause variation and the % total time > 12hrs remains above the current national expectation of 2%

There has been a steady increase in type 3 activity

Re-admission remains stable c.5% <7days and arrival to admission conversion c.26%

STW remains a challenged system and is the bottom quartile of the region for its urgent care performance, this in turn is impacting upon the ability to respond to 999 calls promptly due to Ambulance waits which remains a significant risk for the system. The UEC improvement plan has been reviewed and updated and was signed off at the UEC board at the end of May.

1.6 Cancer Care

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Urgent referral to first OPA (2WW)	Mar 22	75%	93%			86%	78%	95%
Breast symptom referral (2WW)	Mar 22	16%	93%			48%	13%	84%
28-day Faster Diagnosis Standard	Mar 22	57%	75%			71%	59%	84%
Diagnosis to first treatment (31d)	Mar 22	92%	96%			96%	90%	102%
Urgent referral to treatment (62d)	Mar 22	64%	85%			69%	51%	86%
Screening to treatment (62d)	Mar 22	68%	90%			71%	17%	125%
Consultant upgrade to treatment (62d)	Mar 22	74%	0%			82%	70%	95%
104-day breaches of 62-day pathway (SaTH)	Mar 22	19	0			11	-3	24
Subsequent treatment - surgery (31d)	Mar 22	80%	94%			86%	70%	103%
Subsequent treatment - drugs (31d)	Mar 22	91%	98%			99%	95%	103%
Subsequent treatment - radiotherapy (31d)	Mar 22	68%	94%			96%	89%	103%

Analyst Commentary

Most metrics had inconsistent performance throughout the year. Every metric was short of target in quarter 4, albeit with modest improvement in 62-day waits in March. The number of 62-day waits going beyond 104 days at SaTH remains in double figures.

With continued pressure resulting from managing COVID and winter pressures, the cancer performance has started to see a decline. Improvement plans by tumour site are now in place and delivery being monitored weekly.

1.7 Planned Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total incomplete waits at mor	Mar 22	57206	-			44556	41661	47452
Clock stops in month (admitte	Mar 22	1992	-			1197	578	1815
Clock stops in month (non-ed	Mar 22	10398	-			8639	6155	11123
New patients added to RTT w	Mar 22	13784	-			10866	7171	14561
STW patients waiting (SaTH)	Mar 22	30562	-			25173	23206	27139
STW patients waiting (RJAH)	Mar 22	9978	-			8149	7573	8726
Incomplete waits < 18 weeks	Mar 22	60.0%	92.0%			60.1%	51.8%	68.4%
Diagnostics more than 6 week	Mar 22	38.7%	1.0%			41.2%	30.0%	52.3%
Incompletes at month end (u	Mar 22	3817	-			3108	2796	3411
Incompletes at month end (o	Mar 22	7817	-			6482	5513	7351
Incompletes at month end (g	Mar 22	5894	-			4620	4145	5095
Incompletes at month end (T	Mar 22	12861	-			9911	9070	10751
Diagnostics >6wks: SaTH color	Mar 22	60.0%	-			41.7%	16.5%	67.0%
Total Diagnostics >6wks: SaTH	Mar 22	658	-			247	89	405
Diagnostics >6wks: SaTH MRI (	Mar 22	53.6%	-			42.3%	21.3%	63.4%
Total Diagnostics >6wks: SaTH	Mar 22	2055	-			1144	450	1838
Diagnostic waits 13 weeks or	Mar 22	2217	-			2468	736	4200
Total waiting for MRI - STW	Mar 22	4929	-			3425	2635	4216
Total waiting for ultrasound (	Mar 22	4868	-			3771	3286	4256
Total waits for Computed Tom	Mar 22	1991	-			1996	1386	2607
Waits 6+ weeks for diagnostic	Mar 22	24.8%	1.0%			31.2%	23.1%	39.2%

Analyst Commentary

No significant change in overall RTT performance, which remains at around 60% against a national target of 92%. The total number of waits therefore continues to increase, particularly in key specialties such as orthopaedics and general surgery. Ophthalmology numbers waiting appeared to have peaked in the summer and subsequently reduced each month until month 11.

Numbers awaiting diagnostics at month end have been above 14K since October 2021; more than half of these were waiting for MRI or non-obstetric ultrasound.

Elective care is facing similar challenges, the system is working hard to maximise its delivery with the use of additional independent sector capacity and third-party insourcing to improve its elective rate of recovery. The admitted and diagnostic waiting lists continue to be clinically prioritised. The system is working hard to continue to clear its >104wk waiters but has a current risk of 106 (96 spinal patients at RJAH and 10 at SaTH) for the end of June. This remaining cohort is made up of 97 complex cases and 9 patient choice This has reduced over recent weeks from 124. Daily reviews of this are in place within our providers and the system meets weekly to support delivery with weekly monitoring by NHSE.

1.8 Mental Health and Learning Disabilities

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Dementia Diagnosis rate (STW)	Mar 22	60%	67%	F	L	64%	63%	66%
Dementia Diagnosis rate (England)	Mar 22	62%	67%	F	L	64%	64%	65%
IAPT Recovery Rate (MPFT)	Mar 22	52%	50%	?		52%	42%	61%
Finished IAPT first seen < 6 weeks (MPFT)	Mar 22	95%	75%	P		96%	93%	100%
Finished IAPT first seen < 18 weeks (MPFT)	Mar 22	99%	95%	P		100%	99%	101%
IAPT starting treatment < 18 weeks (MPFT)	Mar 22	99%	0%		H	99%	94%	103%
CYP Eating Disorder seen < 1 week (urgent, MPFT)	Jan 22	50%	95%	?	L	97%	80%	113%
CYP Eating Disorder seen <4 wks (routine, MPFT)	Mar 22	0%	95%	?	L	89%	57%	122%
CPA patients followed up <1wk after discharge (M	Mar 22	97%	95%	?		97%	94%	101%
SMI patients with Health Checks in past 12 months	Apr 22	1462	2229	F	H	1014	882	1145

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Analyst Commentary

Metrics from un-validated MPFT reports show that waiting times for IAPT are consistently met for initial treatment starting, however the national access target for people starting treatment is not being met. Recovery rates are meeting the 50% target. Follow-ups for CPA patients met target in Q4, where these were previously not being met (August to Dec)

Dementia Diagnosis Rate target (official figures from NHS Digital) has not been met since the pandemic began, with rates falling nationally and locally.

Physical Health checks for patients with SMI – performance remains significantly below target, although improvement in Q4 (39.5% compared to 29.4% in Q3)

Access to Eating Disorder services is case for concern and a separate report is being taken to the Q&P Committee in June.

2 Quality

SATH:

The Trust has had a number of CQC conditions placed on them since 2018 covering a range of services. The CQC have advised the Trust that the total number of conditions has been significantly reduced, with some of the remaining conditions being varied to reflect a requirement for reduced reporting. Improvements at the Trust have been made; however, are still rated as inadequate by CQC overall. NHSE/I will be undertaking their annual IPC assurance visit to the trust in July, the trust is currently rated green on the NHSE/I internal risk matrix.

SATH Maternity Quality Metrics

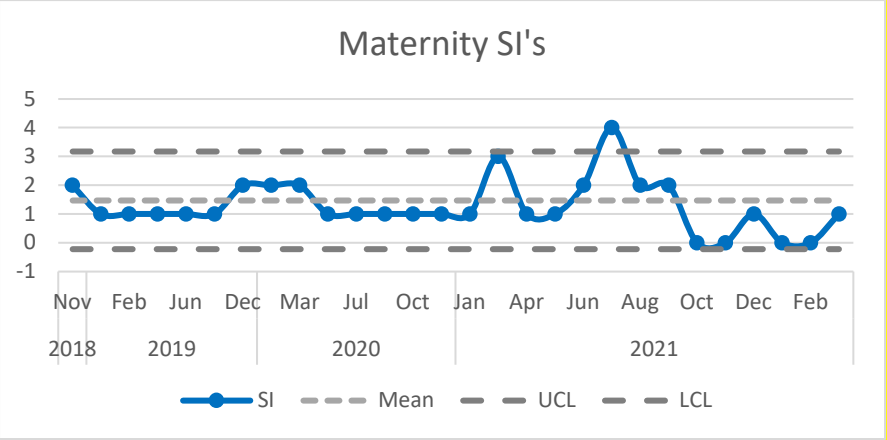
The table below identifies the parameters which are or have recently been outside of the expected target range when reviewed against either local or national expected figures /targets.

Indicator	Standard Figure	Mar 22	Action
Total number of bookings	440	477	There has been a significant increase in bookings this month, up 99 from last month. Close monitoring of this is required to understand if normal variation or additional actions required if sustained picture over the coming months.
Induction of labour (IOL)	29.2% (NMPA 2019)	35%	Nationally increasing rates. Increased comorbidities nationally recognised. Care bundles such as SBL and the national ambition to reduce SB and NND impacts IOL rate along with potentially the changes to the NICE IOL guideline and ensuring that women are offered the option to make informed choices. **The revised clinical dashboard is looking at standards that as a trust we should be setting for IOL rates as the NMPA 2019 standard is now old data to benchmark against.** **HES (hospital episode statistics) data: rate in 2019-20 = 39% taken from recent GIRFT data report.**
Caesarean Section rate of Robson Group 1 deliveries.		25 %	Group 1- Nulliparous, single cephalic, ≥37 weeks, in spontaneous labour. Primip term women. A recent study showed that groups 2, 5, and 1 were the major contributors to the overall CS rate. This can be influenced by maternal choice, which is nationally supported. The rate for group one in the past few months appears to be higher than the expected norm. Interrogation of our own data and the data reported to the MSDS (as visible on Public View) shows a large discrepancy. Further investigation found that this issue is not peculiar to SaTH and has been raised by another LMNS in the region with NHS Digital. This work offers assurance that the rates reported to SaTH are not abnormally high and show only common cause variation.

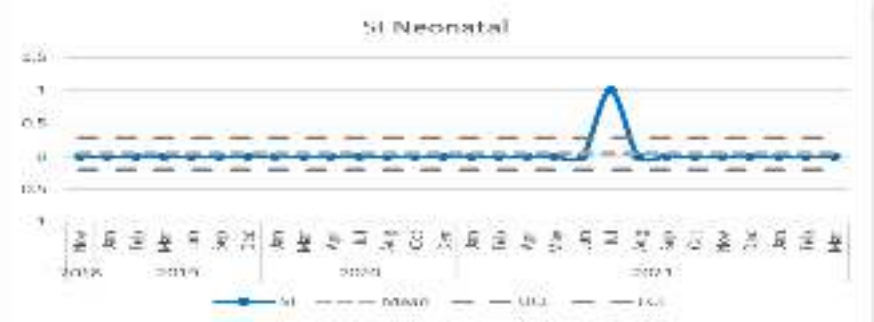
Caesarean Section rate of Robson Group 2 deliveries.		40%	Group 2 - Nulliparous, single cephalic, ≥37 weeks, induced or caesarean section (CS) before labour. Representative of higher IOL rate – corresponding with failed IOL. This figure is significantly higher this month however within the expected range.
Caesarean Section rate of Robson Group 5 deliveries		60%	Group 5 - Previous CS, single cephalic, ≥ 37 weeks. Ongoing work to review and monitor this data in conjunction with the performance team is taking place. SaTH informatics team to liaise with the West Midlands Region and NHS Digital re the discrepancies. Remove the target lines (as dictated by Public View) from SaTH SPC charts, accept common cause variation and act only if there is special cause variation.
Rate of PPH greater than 1500mls	2.9% Public View	2.5%	All cases are reported via datix and reviewed at NOIR; any learning will then be shared with the teams. The recognition and management of postpartum haemorrhage is part of the mandatory PROMPT training undertaken by all clinical maternity staff.
Born before arrival	3- Locally agreed.	2	All BBAs are being reviewed for any issues with care and levels monitored. All will be reviewed via NOIR or locally by ward managers for deeper understanding. Learning will be shared with teams.
Babies born at SaTH <27w 6 days	0	2	All multiple pregnancies less than 28 weeks, singleton pregnancies less than 27weeks and birth weight of less than 800grams should be transferred to a tertiary unit for birth if possible. As a unit we have to complete an exception reporting form If babies deliver here outside of the above criteria, and this is sent to the West Midlands Operational Delivery Network. This is completed by the neonatal consultant.
Delivery Suite (DS) acuity	85% (Birth Rate Plus)	50 %	**It is important to note that this acuity report is for DS only, the unit acuity data is assessed at the SMT huddle twice daily, where staff are deployed to areas with high acuity to manage safety within the unit.** From July this acuity level is taken from a rolling 13-week period to reflect accurate data. 50 % DS have been in positive acuity. 38% DS have been in Amber acuity (up to 2 mws short) 12 % in red acuity. (>2mws short) **In the month of March 22, the data is showing a decline in acuity on month**. 45% DS have been in positive acuity 40% DS have been in Amber acuity (up to 2 mws short) 15% DS in red acuity. (>2mws short) All have been appropriately escalated and managed to maintain safety across the unit. All aspects of the escalation policy have been followed and consideration to use diversion of services have been discussed at appropriate levels.

			The MLU service is open when staffing levels allow, this is monitored daily, and decision made to divert if required. A maternity daily Sitrep is completed and submitted to the region and internally to ensure oversight of the service and benchmark our position within the region. **A further 2.6 WTE band 6 midwives are starting this month. Recruitment is ongoing for substantive band 6 positions. 26 band 5 midwives have been recruited to commence in the autumn.**
DS red flags	No target range	107	**Red flags are indicators that staffing levels are not quite right in area. Also, may reflect occupancy on delivery suite.** Twice daily SMT huddles in place, increased to 3 when acuity and staffing needs closer monitoring. Records of all huddles and decisions made are stored centrally and communicated daily with managers of the areas to share with staff at their ward huddles. **A review of March red flag data suggest that 20 women accounted for 86 red flag events related to delays in ARM/augmentation. These were affected by a delay of more than 8 hours.** **This information has been reviewed against datix for red flags in March and there were 17 datix submitted related to at least 20 women experiencing delays > 8 hours for ARM/Augmentation as many datix referred to multiple women who were awaiting transfer to DS.** 86 – delays in ARM/Augmentation 8 delays in commencing PROM 1 delay with time critical care 10 Coordinator not supernumerary 2 One to one care not provided. 0 Delay in providing pain relief >30 mins All red flags have been reviewed and actions were taken to maintain safety of women and babies- for example movement of staff, escalating to the MOC, utilisation of escalation policy and calling on call midwives into support unit.

Maternity Serious Incidents overtime



Neonatal Serious Incidents overtime



It was noted that there has been an increase in Maternity Serious Incidents reported during 2021 which is reflected regionally and nationally. SI's and incident reporting are shared at Peri Natal Quality Surveillance Group (PNQSG) and Local Maternity and Neonatal System (LMNS) as a combined report, the CCG are seeking assurance regarding any themes identified as well as shared learning across the System.
The CCG also attend the Review, Action, and Learning from Incidents Group (RALIG) weekly. The purpose of RALIG is to review incidents and near misses in the trust in an objective, thematic and clinically focussed forum. To discuss and agree actions that improve safety and quality of clinical care for our patients and to agree, share and implement learning points and themes across all Divisions and the wider organisation and to provide assurance to the Quality, Safety and Assurance Committee (QSAC).

Top 4 Maternity incidents reported in March 2022

Maternity top 4 incident categories	March 2022
Staffing	18
Delay of more than 8 hours for ARM/Augmentation	16
Care/treatment delay	16
Communication	10

Top 3 Neonatal incidents reported in March 2022 (total of 35 incidents reported in month)

Neonatal top 3 incident categories	March 2022
Staffing	4
Treatment complications (same patient)	2
Unexpected admission to NNU	2

SATH IPC:

The CCG IPC team joined two trust Exemplar assurance visits to maternity wards at PRH during May, Suboptimal IPC standards were noted on both the ante-natal and post-natal ward, actions will be monitored through attendance at the trusts IPC Operational Group. A follow up visit to the maternity unit is being planned in June by the CCG Senior IPC Lead and Perinatal Senior Quality Lead & Patient Safety Specialist.

RJAH:

The Trust had an on-site visit from NHSEI and the CCG on 11th of February where it was found that IPC standards were not where they should be with several themes being identified which included IPC team structure, estates, storage, patient equipment cleaning and non-compliance with hand hygiene and bare below the elbow. The Trust has undertaken immediate actions and has completed 72 of the 124 actions identified in a combined action plan. The remaining actions are in progress, many of which are estates related work and the reordering of equipment. The CCG is providing support to the IPC team, assurance visits to wards and theatres have been undertaken and areas of improvement noted. There is a further quality assurance visit scheduled for June. The CCG will also be providing support to the Trust with their peer audits. There has been a reduction in SSIs reported by the trust, the One Together surgical assessment tool which the trust used to demonstrate infection prevention compliance across the surgical pathway as a way of quality improvement in practice has been completed. Following the One Together report a multi-disciplinary surgical site infection prevention working group has been set up, and an interactive action log has been developed to track progress of related actions. The CCG Senior IPC Lead continues to monitor the actions through trust visits and attendance at Infection Control & Cleanliness Committee.

Safeguarding Adults:

- NHS Provider Adult Safeguarding Dashboards have been refreshed for 2022-23. Q1 performance is expected soon and will be reviewed in the next report to the Systems Quality Group
- The national consultation into the Regulations and Draft Code of Practice for the Liberty Protection Safeguards is proceeding. As per the plans there is to be an ICS wide response to this whilst also encouraging agencies to submit their own specific responses. The work taking place in support of the consultation has been the subject of a paper to the Systems Quality Group and NHSE have commended the approach taking place by our ICS. Briefings have also gone to Primary Care colleagues as well.
- The 2022-23 schedule of Adult Safeguarding Quality Assurance visits has commenced. Two are planned for June with different Trusts and another Trust have already received the report and recommendations from their visit and a meeting has been scheduled to review the findings with them. Further details will be reported via the Systems Quality Group.

Safeguarding Children:

- Compass Multi-Agency Safeguarding Hub (MASH) has recruited health team with a Safeguarding Band 7 professional to support health MASH team employed by Shropshire Community Health Trust.
- NHS Providers COVID 19 change deployment monitoring in safeguarding teams and safeguarding capacity face to face front line staff visiting improvements.
- Two urgent Child Safeguarding Practice Rapid Responses and Reviews completed this month. Shropshire mock Joint Targeted Area Inspection in progress with initially 30 cases identified and then 5 cases to be analysed in depth.
- Two Shropshire and Telford and Wrekin (STW) safeguarding initial scoping/ rapid reviews have been completed on 18th May 2022 with initial learning identified and further CSPR implementation planned.
- Shropshire Safeguarding Children Partnership (SSCP) have 7 on-going Local Child Safeguarding Practice Reviews (LCSPR). A joint learning event was held for two cases and the learning briefing sent to the National Panel. The SSCP Strategic Governing Group have been informed 7 LCSPRs request for full reports on the 7 on-going cases with the Business Unit reporting they do not have the capacity to write these reports. The Business Unit have added a risk and issues column to the ongoing Statutory Case Reviews update report.
- Telford and Wrekin Safeguarding Children Partnership have 6 LCSPRs ongoing with a Joint CSPR Thematic Review being implemented 25th May 2022 too. They have reported the risk of their business unit limited capacity with the rise in initial scoping/ rapid reviews

STW System Quality

- The Shropshire Telford and Wrekin (STW) Integrated Palliative and End of Life Care (Adults) 2022 – 2025 is an output of a Shropshire Telford and Wrekin system review of end of life care and as a recommendation from a System Senior leaders' summit which recognised the need to improve the care for people in the last year of life, in addition the Regional NHSE Palliative and End of Life Care Clinical Network support strategy development for all Integrated Care Systems in the West and East Midlands. The STW Palliative and End of Life Care Steering Group is currently working through the processes to develop an Integrated Children and Young Persons Palliative and End of Life Care Strategy which is expected to be completed in the first quarter of 2022/23. Following ratification of the STW Palliative and End of Life Care Strategy for Adults, a launch has been arranged at the Shropshire Health Watch Annual Event in May, this event will have a focus on death and dying.
- System Quality Metrics are evolving, system partners have discussed the first set of metrics which are in line with the National Quality Toolkit and will build further metrics to give a comprehensive overview of quality. Work continues to develop these further. Updates regarding issues and actions being undertaken are required from individual providers. This work is being supported by CSU in regard to collating business intelligence remit.
- The System Quality Roadmap is being developed establishing processes in line with national guidance on Quality in the structure of the ICB. There is good progress with implementation.
- The system quality risk register in development.
- The virtual ward implementation plan is in place. A trajectory to get to 149 virtual ward beds by March 2024 is in place with 100 of those beds in place by March 2023. This is a new nurse/AHP led model with digital being key to development to remotely monitor patients in the community. The stipulated requirements to meet the NHSE funding are being met currently and recruitment has commenced
- The draft system quality strategy is in development
- System Quality Metrics continue to be developed

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.049	Ockenden Final Report

Executive Lead (s):	Author(s):
Zena Young, Director of Nursing and Quality	Vanessa Whatley Deputy Director of Nursing and Quality

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion	x	I=Information	

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary (key points in the report):

An independent investigation into Maternity Services at Shrewsbury and Telford Hospital NHS Trust (the Trust) was commissioned by the Secretary of State for Health in 2017 following the concerns raised by 23 families. Donna Ockenden led the review resulting in two published reports, the first report in December 2020 and the final report in March 2022. During the course of the Ockenden Review many more families came forward. Their experiences, published in the reports, contain truly shocking accounts of poor care resulting in harm or death to women and babies.

Amongst other external reviews, Shropshire Clinical Commissioning Group (CCG) and Telford and Wrekin CCG jointly commissioned a review into maternity service at the Trust in 2013. This report has subsequently been found to be fundamentally flawed.

Shropshire Telford and Wrekin Clinical Commissioning Group (the CCG) is extremely sorry for the role of its predecessor bodies and its own role in these failings to ensure high quality in standards of care for these families.

There is a substantial governance process in place with public and staff involvement, however further work is needed to ensure the CCG supports the refinement of the governance processes for the emerging Integrated Care Board.

Recommendations/Actions Required:
1. The Governing Body is asked to reflect on the role of its predecessor organisations as referred to in the final Ockenden report and consider what lessons it can share by way of learning with the ICB. 2. The Governing Body notes the progress by SATH with the implementation of the finding from Ockenden 1. 3. The Governing Body notes the intention for the SATH Board to consider the final report recommendations in June. The CCG will ensure that the oversight is passed to the ICB. 4. The Governing Body asks the Chair and Accountable Officer to write to the Chair and Chief Executive of the ICB by way of handover to suggest the ICB seeks assurance on two specific issues: • Staffing of the maternity service at SATH with a particular focus on continuity of carer • Organisational culture, seeking specific and measurable improvements 5. The Governing Body is asked to note that all Trusts have been asked to submit midwifery continuity of carer (MCoC) plans by 15 June 2022 to demonstrate that safe midwifery staffing plans are in place. The CCG will seek assurance from SATH on this and will ensure that this is handed over to the ICB.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	~~Yes~~/No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).* The Ockenden report recommendations are substantial and require investment across maternity services. National resource is provided, largely managed by the LMNS.	Yes/~~No~~
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).* The Ockenden Improvement Plan will be delivered at pace to ensure the report is met in full. The CCG and ICB will hold provider services to account to ensure this achieved in a timely way through a robust governance structure.	Yes/~~No~~

4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).* The governance structure described in this paper aims to promote safe, high-quality care. It is noted that Operation Lincoln continues.	Yes/~~No~~
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).* Women, families and babies have a right to safe, effective care. The CCG and ICB will hold provider services to account to ensure this achieved in a timely way through a robust governance structure.	Yes/~~No~~
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).* There is clinical engagement through the governance arrangements described in this report.	Yes/~~No~~
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).* Women and families are represented thoughout the governance structure that supports the Ockenden Implementation Plan. The Ockenden Report Assurance Committee (ORAC) is held in public.	Yes/~~No~~

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities.. *(If yes, please provide details of how health inequalities have been reduced).* Inequalities in maternity care are monitored through a number of methods including the MBRRACE (mothers and babies: reducing risk through audits and confidential enquiries across the UK) reporting structure. This is integral to the governance process described in this paper	Yes/~~No~~
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).* Through safe effective care of women and babies the outcome will be monitored via the maternity dashboard, improvement plan delivery and experiential feedback through the described governance structure.	Yes/~~No~~
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).* Through safe effective care of women and babies the outcome will be monitored via the maternity dashboard, improvement plan delivery and experiential feedback through the described governance structure.	Yes/~~No~~
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).* Partners as integrated into the governance structure as described in this paper.	Yes/~~No~~
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	~~Yes~~/No

1. Purpose of Paper

This paper provides an update to the CCG Governing Body on progress made by Shrewsbury and Telford Hospital NHS Trust following the publication of the final Ockenden report.

The Governing Body is asked to reflect on the final report, the former CCG's processes and the current assurances in place. The Governing Body will wish to consider the handover to the Integrated Care Board.

2. Executive Summary

An independent investigation into Maternity Services at Shrewsbury and Telford Hospital NHS Trust (the Trust) was commissioned by the Secretary of State for Health in 2017 following the concerns raised by 23 families. Donna Ockenden led the review resulting in two published reports, the first report in December 2020 and the final report in March 2022. During the course of the Ockenden Review many more families came forward. Their experiences, published in the reports, contain truly shocking accounts of poor care resulting in harm or death to women and babies.

Amongst other external reviews, Shropshire Clinical Commissioning Group (CCG) and Telford and Wrekin CCG jointly commissioned a review into maternity service at the Trust in 2013. This report has subsequently been found to be fundamentally flawed.

Shropshire Telford and Wrekin Clinical Commissioning Group (the CCG) is extremely sorry for the role of its predecessor bodies and its own role in these failings to ensure high quality in standards of care for these families.

There is a substantial governance process in place with public and staff involvement, however further work is needed to ensure the CCG supports the refinement of the governance processes for the emerging Integrated Care Board.

3. Background

The Ockenden Review was commissioned following a number of serious clinical incidents, beginning with a new-born baby who died in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. In subsequent years from 2009 until 2014 several further investigations and reviews (internal and external) were also undertaken to confirm whether appropriate investigations were conducted.

By the time it concluded, the Ockenden Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust had reviewed the accounts of 1,486 families, the majority of which were patients at the Trust between 2000 and 2019. In total 12 maternal deaths and 498 cases of stillbirth were reviewed.

One in four stillbirth cases were found to have major concerns in care that, if managed appropriately, might or would have resulted in a different outcome. None of the mothers had received care in line with best practice at the time.

The report found that women and families voices were not listened to, serious incidents were not addressed or learned from, governance procedures and leadership were inadequate, national guidelines were not followed, there was a poor organizational culture and a lack of accountability and compassion when things went wrong. Findings fall into four key pillars:

- Safe staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families

The recommendations are extensive. The final report provides 60 actions for the Trust but also recognised 15 areas where wider improvement is needed across NHS services. This i2019s multiplied when individual actions are pulled out to over 200 actions for the Trust. It must be recognised that actions can be monitored to completion and closed, but it is the collective action to improve safety, professional communication and organisational culture that is more challenging to measure. Involvement of the Shropshire Telford and Wrekin Maternity Voices Partnership and family and staff feedback is essential to this area, and their health and wellbeing needs require particular attention to ensure they are resilient to speak out to advocate for women and babies.

The Maternity Services Review (2013) was one of several reports undertaken into the Trust's maternity services. The investigation team for this report included external obstetric and midwifery experts, patient representatives (Healthwatch), and CQC and NHSE as regulators of these services. The review was commissioned by the two CCGs' in the county at the time, following concerns over an increased incidence of serious clinical adverse events and the safety of the model of maternity care in Shropshire. The report methodology was flawed, and the reviewers had limited access to patient data. This was particularly around clinical outcomes conclusions which were based on small data sets and the report also only considered patient information from 2012-2013, which did not show the full extent of the picture. This is an area of significant regret for the CCG.

In detail from the report:

- Page 6, paragraphs 1.16- 1.22 there is reference to the 2013 CCG review undertaken by the former two CCGs. The report's view is that the Trust was routinely downgrading incidents and failing to report them properly, as a result of this the Review concludes the CCGs' 2013 review would have underestimated the scale and volume of incidents.

The CCG agrees with this finding and is invited to consider what lessons can be learnt for the future.

- In paragraph 1.18 the Review notes that, although the CCGs did make recommendations in their 2013 report (particularly that babies of less than 27 weeks gestation should be transferred to an appropriate unit after stabilisation, and also that the Trust must "ensure serious incident reporting is congruent with the national patient safety agency") there is no evidence provided by the Trust that this recommendation was actioned, nor that the CCGs held the Trust to account for meeting these recommendations.

The CCG agrees with this finding and is invited to consider what lessons can be learnt for the future.

- It was noted that the CCGs did undertake a patient feedback survey, but that the sample size of 47 women was very small and that negative feedback which was similar to that heard by the review was not investigated further.

The CCG agrees with this finding and is invited to consider what lessons can be learnt for the future.

- On page 41 of the Ockenden Review, questions whether the 2013 CCG review was fit for purpose as the 2013 review found the Trust was a safe and good quality service contrary to the findings of the Ockenden Review Report.

The CCG agrees with this finding and is invited to consider what lessons can be learnt for the future.

The Final Ockenden report is a call to action for every CCG, Integrated Care Board, NHS Trust and Local Maternity and Nursing System to rapidly review its services and approach to governance and assurance.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have fully considered the findings and actions from the Ockenden Report.

4. Assurance from Shrewsbury and Telford Hospital NHS Trust

The SATH Trust Board receives a monthly report into progress with actions. The last report was 10th May 2022. This Ockenden Board Report does not currently offer assurances against the final report due to its recent publication and sequence of assuring committees.

The Maternity Transformation Assurance Committee (MTAC) meets monthly to monitor actions. This is chaired by the Director of Nursing in SaTH and has representatives from across the system including the Maternity Voices Partnership and LMNS.

The first Ockenden Report set out 27 Local Actions for Learning (LAFL's), which were specifically for the Trust to implement and 7 Immediate and Essential Actions (IEA's), comprising twenty-five sub-actions, which were for every provider of NHS Maternity Services to implement, including this Trust.

In total, there were fifty-two actions for SATH to implement. The Trust has delivered all the actions it is the lead for (45/52) (position as at May 2022).

8 actions remaining are dependent on external agencies which are being closely monitored against expected completion dates. 5 of these actions relate to a national decision or policy change.

The Final Ockenden Report (2022) set out new actions:

- 66 Local Actions for Learning (LAFL's), which were specifically for this Trust to implement
- 15 Immediate and Essential Actions (IEA's), comprising ninety-two sub actions, which were for every provider of NHS Maternity Services to implement, including the Trust.
- In total, there are 158 actions for this Trust to implement from the second report.

A gap analysis was undertaken by the Trust to assess the new actions and undertaking a gap analysis against each of them. We understand that this comprised of the Women and Children's Division comprising, doctors, midwives, LMNS, managers and maternity transformation programme colleagues. This analysis assessed that of those 158 actions 19 actions were delivered but not yet evidenced (amber). Remaining actions were to be developed into a consolidated action plan.

This shows a provisional view due to the fact that each of these actions have yet to be validated formally through the Maternity Transformation Assurance Committee (MTAC). The following table shows the provisional position (May 2022).

Report	Domain	Total Number of Actions	Not Yet Delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
[illegible]	LAFL	27	1	4	22
[illegible]	ILA	25	6	1	18
[illegible]	BOTH	52	7	5	40
Final Report 2022 (Provisional)	LAFL	88	81	5	0
Final Report 2022 (Provisional)	ILA	92	78	14	0
Final Report Sub Total (Provisional)	BOTH	180	139	19	0
Total Both reports (Provisional)	ALL	210	146	24	40

Quarterly workforce action reports are received by the CCG relating to women's and children's services including:

- Attrition rates of staff
- Freedom to speak up numbers
- Exit interviews and themes
- Recruitment
- Leadership programme uptake
- Staff support uptake

The workforce report is triangulated with the incident monitoring undertaken by the Perinatal Quality and Surveillance Group (PQSG). This Group view safety metrics which are included in a Maternity Dashboard monthly. Statistical Process Control (SPC) graphs are used to show trends and national benchmarks, where applicable. Papers are circulated prior to meeting to inform discussion and the CCG has honorary contracts with two experienced quality midwives who provide independent advice to the CCG. The patient safety specialist/Quality lead for maternity attend and the LMNS SRO/STW CCG Director of Nursing and Quality chairs.

5. CCG Oversight/Governance

The CCG has established a quality governance structure together with the Trust (Appendix 1) for the monitoring of Ockenden actions and quality concerns. Several key groups review and assure the detailed maternity information:

- The Local Maternity and Nursing System (LMNS)

Statutory oversight and networking of maternity and neonatal services

- The Perinatal Quality Surveillance Group (PNQSG)

Oversight of maternity services to gather learning and insight to inform quality improvement for women and babies.

- The Maternity Transformation Assurance Committee (MTAC)

Monitors and provides assurance in relation to the Okenden reports and Clinical negligence Scheme for Trusts (CNST).

- Ockenden Recommendations Assurance Committee (ORAC)

Public committee with oversight of progress and assurance of Ockenden recommendations.

The CCG has a Patient Safety Specialist who is the nominated maternity and neonatal safety champion and, with the Trust's Maternity Safety Champions undertakes a schedule of monthly quality assurance visits to maternity and neonatal services in the Trust. The LMNS and Maternity Voices Partnership are also represented. A standard operating procedure supports the visits, feedback, and escalation from a national toolkit. Additional visits take place as required and agreed by the Trust.

This information is collected quarterly, and themes, trends and progress fed back to the System Quality Group and following their discussion, to the ICB Quality and Performance Committee.

The Perinatal Quality Safety Surveillance Model is a best practice model supported by a toolkit and has now been implemented by the Trust with support of the wider system. The outcome is to be reported through the PNQSG in June. The use of a recognised assurance tool is a sustainable method of monitoring quality as Ockenden actions are completed.

The clinical voice on the new ICB, namely the Chief Nursing Officer and Chief Medical Officer, hold responsibility for the clinical strategy, and as part of a unitary board, aimed at improving outcomes in the population for health and healthcare.

6. Response to national requirements

Action is required in relation to a letter from Amanda Pritchard, Ruth May and Professor Stephen Powys which has been sent to the CCG, along with the Trust and other organisations which requires three steps to be taken:

1. All staff in every organisation to be encouraged to read the Ockenden Review. – **complete via CCG Briefing session, staff huddle and email**
2. Every organisation's public board to set out its progress against the 15 immediate and essential actions (IEAs) set out in the first Ockenden Report, and this to be done by end of March 2022 and discussed with the ICS by 15 April 2022. **Complete**
3. Trusts to submit midwifery continuity of carer (MCoC) plans by 15 June 2022 to demonstrate that safe midwifery staffing plans are in place. – **due 15th June 22 from SaTH**

7. Summary of actions to date and those remaining

There are a number of outstanding actions at this stage since the final report was published in March 2022. Assessment of safety culture is currently coved by the actions described but requires careful consideration by the system on how to gain full assurance.

MTAC monitors action against Ockenden monthly while PNQSG measures outcomes for women and babies. There is cross working between the CCG, LMNS and Trust with Maternity Voices Partnership involvement. ORAC discusses the actions, progress and patient experience in public.

The following are key issues which are expected or require focussed attention:

- The Regional Perinatal Quality Team and Regional Chief Midwife will undertake an 'insights review' of the Trusts Maternity Services on 13th July 2022
- Operation Lincoln the police investigation into maternity Services at the Trust, is in progress
- No CQC dates for re-inspections are currently known
- Staff experience remains a challenge to ensure that the voices of staff are being consistently heard
- Level of scrutiny and rigor at PNQSG needs to be sustained
- SI monitoring as part of Trust's serious incident review meetings needs to be sustained
- An audit of emergency Caesarean Sections has been undertaken jointly with the Trust and the outcome will be further considered
- Quality midwives and CCG Quality Lead has been completed with findings to be presented in June.

8. Recommendations

1. The Governing Body is asked to reflect on the role of its predecessor organisations as referred to in the final Ockenden report and consider what lessons it can share by way of learning with the ICB.

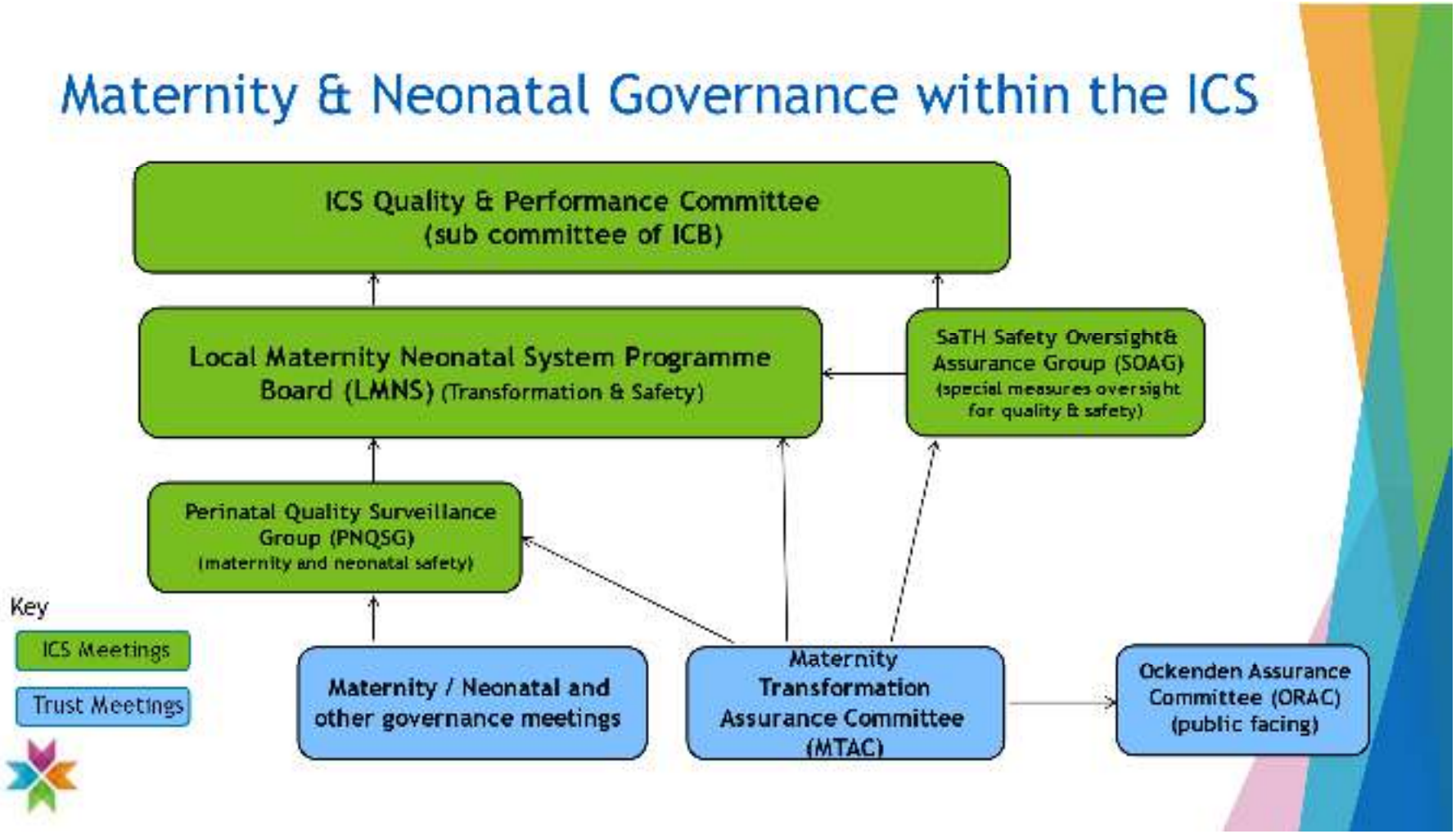
2. The Governing Body notes the progress by SATH with the implementation of the finding from Ockenden 1.

3. The Governing Body notes the intention for the SATH Board to consider the final report recommendations in June. The CCG will ensure that the oversight is passed to the ICB.

4. The Governing Body asks the Chair and Accountable Officer to write to the Chair and Chief Executive of the ICB by way of handover to suggest the ICB seeks assurance on two specific issues:
    - Staffing of the maternity service at SATH with a particular focus on continuity of carer
    - Organisational culture, seeking specific and measurable improvements

5. The Governing Body is asked to note that all Trusts have been asked to submit midwifery continuity of carer (MCoC) plans by 15 June 2022 to demonstrate that safe midwifery staffing plans are in place. The CCG will seek assurance from SATH on this and will ensure that this is handed over to the ICB.

Appendix 1 Maternity and Neonatal Governance Structure



NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire Telford and Wrekin CCG Governing Body Meeting held in Public on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.050	LeDeR Annual Report

Executive Lead (s):	Author(s):
Zena Young – Executive Director of Nursing and Quality and Senior Responsible Officer for LeDeR programme	**Tracey Slater** – Assistant Director of Quality and Local Area Contact for LeDeR programme

Action Required (please select):									
A=Approval	x	R=Ratification		S=Assurance		D=Discussion	x	I=Information	x

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A, R,S,D,I)**
Quality and Performance Committees in Common	25.5.22	A, D, I

Executive Summary (key points in the report):

The primary purpose of the Learning from Deaths of people with Learning Disability and Autism Review Programme (LeDeR) is to review the care each person has received leading up to their death and make recommendations that could help improve the care for other people and reduce premature deaths. Recommendations from each review are intended to highlight best practice and thereby support health and social care professionals and policy makers to implement positive change for people to have better experience of their care. This report is intended to share the Shropshire Telford and Wrekin (STW) findings from LeDeR reviews undertaken during 2021/22 and to report on the identified learning and the action we have taken to improve practice. During 2021/22 progress with reviews by Shropshire Telford and Wrekin Clinical Commissioning Group (STWCCG) has been a challenge. Local reviewers were redeployed due to the covid pandemic, changed roles, or retired and by end December 2021 none of our local reviewers were able to continue to commit to the LeDeR programme. The CCG received funding from NHS England for an external reviewer to undertake reviews and we would like to acknowledge the contribution that this made to the local LeDeR programme. In accordance with the requirements of the LeDeR policy (2021) STWCCG have awarded the contract to Southwest and Central Clinical Support Unit (SCWCSU) to undertake LeDeR reviews from 1st April 2022. The CCG will work closely with SCWCSU ensuring continued quality assurance of all reviews undertaken. The advent of a new STW LeDeR Governance Panel will enable scrutiny of the reviews and will feed into the LeDeR Steering Group who take the recommendations from reviews and have developed a priority plan for any required improvement work. Through the Shropshire Telford and Wrekin LeDeR Steering Group we have been proud to have people with lived experience and system partners who have engaged with the discussions and are passionately committed to making real changes across the health and social care system. We continue to strive to improve health outcomes for people with learning disabilities and autism/autistic with the aim to prevent people from dying prematurely, extend the average lifespan and to ensure that those with learning disability and autism/autistic are kept as healthy as they can be during their life.

The core principles and values of the LeDeR programme in STW are as follows:

- The programme overall must effect change and make an identifiable difference to the lives of people with learning disabilities and/or autism and their families.
- We value the on-going contribution of people with lived experience, their families, and carers to all aspects of our work and see this as central to the development and delivery of everything we do.
- We take a comprehensive approach, looking at the circumstances leading to deaths of people with learning disabilities and/or autism and do not prioritise any one source of information over any other.
- The key principles of communication, cooperation and independence are upheld when working alongside other investigations or review processes.

- The programme overall strives to ensure that reviews of lives and deaths lead to reflective learning which will result in improved health and social care service delivery.

From reviews undertaken during 2021/22 there are several examples of good practice taken from discussions with family, friends, and carer discussions during reviews. These include:

- "The care home delivered end of life care, in a compassionate and professional manner"
- "Once diagnosed things were put in place very quickly regarding medication and a referral and acceptance at the hospice was quick, our son was transferred, and family and carers were allowed to support him whilst there".
- "Our son was well known to community Learning Disability Team and had good support from both the nursing team and the dietician, who were involved up until time of his death"
- "The Palliative care nurses were supporting the care home staff and the district nurses were visiting on a regular basis to support and manage the syringe driver".
- "We had good support from our GP for both our daughter and the family"

This feedback demonstrates why the LeDeR programme is so important, it represents a real opportunity to improve the lives of people with learning disabilities and autism.

It is proposed that the key recommendations for 2022/23 are supported by the Integrated Care Board (ICB) and system partners enabling us to:

- Strengthen links with and reduce inequalities for people from minority ethnic communities. Every LeDeR steering group has been asked to identify a named lead for their area who will ensure that the challenges faced by people from minority ethnic communities are considered and addressed as part of local LeDeR work. Their role includes ensuring that reviewers understand the challenges faced by people with learning disability and autism in accessing services, establishing links with organisations that represent minority ethnic groups, raising the profile of LeDeR and increasing the notification of deaths from minority ethnic communities, proportionate to the local communities. This will be done in conjunction with the CCG/ICB Equality and Diversity lead and system organisations. The new LeDeR policy outlines the requirement to carry out a focused review for every person from a minority ethnic community to learn how to address any additional inequalities relating to race and ethnicity.
- Undertake further work to make improvements in all key areas we have identified this year, Health action plans, respiratory management, and cancer screening.
- Strive for better performance of Learning Disability Annual Health Checks (LDAHC) with an initial focus in quarter one (April- June) to reach those who are overdue with their LDAHC and to complete these as soon as possible. For 2022/23 the focus will be to engage the 14–18-year age group, working jointly with Special Educational Needs and Disability (SEND) Teams, specialist schools, The Local Authority and Parent & Carer groups to ensure LDAHC's are embedded within services i.e., Education Health and Care Plan (EHCP) and that young people are captured on the GP LD register and offered a LDAHC. Work will also take place to identify and understand local variation, continue to review, and improve quality, and increase the accuracy of LD registers. A schedule of LD quality practice visits will be undertaken by the CCG and practices will be encouraged to use the audit tool annually to support this work. An audit of annual health checks was carried out last year and will be completed again this year to look at quality assuring the reviews.
- Undertake a system review to ensure End of Life Pathways are appropriately used and fully involve people with learning disabilities and autism and their families, including the use of accessible information and ReSPECT plans.
- Work with system partners to embed sustained learning and improvement of care for people with learning disabilities and autism, ensuring learning identified from reviews informs day to day practice across our providers in health and social care.
- Continue to promote and share action learning with the aim of ensuring all people with a learning disability and/or autism experience good and excellent care.
- Widen the membership of the Steering Group and Governance Panel to include people with lived experience, valuing their contribution in making a difference to people with Learning disabilities and Autism.
- Deliver on the recommendations in the Oliver's McGowan's report, in particular the commitment to improve staff knowledge and confidence in making reasonable adjustments for people with a learning disability or autism.
- Deliver on the recommendations from Clive Treacey life and death review, themes were identified and will be discussed as part of the STW LD&A Board and where applicable will be escalated to

the ICB Mental Health LD&A Programme Board. Learning events and provider collaborative planning meetings have been scheduled by NHSE during June 22

- Deliver local service improvement, learning from LeDeR reviews about good quality care and areas requiring improvement at both regional and national level.
- Undertake a thorough review of the Steering Group action plan, setting clear priorities and agreement of those priorities across the whole economy for 2022/23
- Influence national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews.
- Work with NHSE/I regional and national LeDeR teams to quality assure our reviews.
- Work with SCW CSU on outcomes and findings from LeDeR reviews, ensuring all reviews are quality assured and share findings from the reviews from the newly formed Governance panel.
- Undertake a system review to ensure End of Life Pathways are appropriately used and fully involve people with learning disabilities and autism and their families, including the use of accessible information and ReSPECT plans.
- Greater emphasis on thematic review of LeDeR findings, aligning with national work
- Continue to promote and share action learning with the aim of ensuring all people with a learning disability and/or autism experience good and excellent care.
- We have a detailed local/system wide LeDeR action plan to take forward priority actions within set timeframes and named individuals responsible.
- We will work with NHSE/I regional and national LeDeR teams to quality assure our reviews. As per the policy requirements the Quality Assurance aims to ensure there are systems in place to assure quality of reviews and check that ICSs are producing stretching and challenging actions to reduce variation, ensuring consistent quality. Work within regional quality oversight arrangements to address any system quality and safety issues impacting on the performance of the regional LeDeR programme. Call in a random sample of reviews to quality assure reviews including both initial and focused reviews (LeDeR policy 2021). Monitor the percentage of reviews that translate from initial too focused reviews, co-ordinating with NHS England and NHS Improvement national team and colleagues across the country to ensure equity and parity.
- Consider resource implications for the LeDeR programme across STW ICS
- This report once signed off by the Governing Body will be published on CCG websites as per NHSEI request.
- It will also be shared with the CCGs Quality and Performance Committees in Common, System Quality Group and LD & A Board, LeDeR Steering Group

Recommendations/Actions Required:

Governing Body are asked to consider the following:

- That the key recommendations for LeDeR for 2022/23 are supported by the Integrated Care Board and system partners enabling us to deliver as per the LeDeR policy 2021.
- Approve this draft version of the LeDeR Annual Report for final version submission to NHSE

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No

5.	Are there human rights, equality and diversity requirements? Not sure *(If yes, please provide details of the effect upon these requirements).* The Annual report will be published in an Easy Read version. The LeDeR and LD&A Board governance structure supports the addressing of ED&I requirements in relation to those with Learning Disabilities and Autism	Yes
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).* This report will be shared with partner organisations across the system for learning and sharing the conclusions once approved.	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).* This report will be publicly published on the STW website. It will be presented at both the Local Authorities Health and Wellbeing Boards once approved.	Yes

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences, and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).* The report details how reducing health inequalities for peoples with LD & A will be addressed	Yes
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).* The report details how improving health outcomes for peoples with LD & A will be addressed	Yes
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	No

Shropshire, Telford and Wrekin
Clinical Commissioning Group

Shropshire Telford and Wrekin

Learning Disabilities Mortality Review (LeDeR) Annual Report

Learning from lives and deaths of people with a learning disability and autism

This report covers the period from 1st April 2021 to 31st March 2022

Document version control

Version	0.3 – DRAFT
Document history	LeDeR Steering Group- 24.5.22
	CCG/ICS Quality & Performance CiC 25.5.22 (awaiting final comments by cop 27.5.22)
	System Quality Group- FIO 1.6.22
Approved by	
Date approved	
Author	Tracey Slater Assistant Director of Quality and Local Area Contact LeDeR programme
Responsible Lead	Zena Young Executive Director of Nursing and Quality and SRO LeDeR programme

Contents

Executive Summary

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On behalf of Shropshire Telford and Wrekin Clinical Commissioning Group:

Zena Young – Executive Director of Nursing and Quality and Senior Responsible Officer for LeDeR programme
Vanessa Whateley- Deputy Director of Nursing and Quality
Tracey Slater – Assistant Director of Quality and Local Area Contact for LeDeR programme

Acknowledgements

Shropshire Telford and Wrekin CCG would like to acknowledge the support provided to the LeDeR programme by the following organisations, groups, and individuals:

- The families, friends, carers and health and social care professionals who have provided critical contributions to each LeDeR review. Their support has been invaluable.
- Our LeDeR reviewers. Without their expertise, experience, and passion we would not be where we are.
- Members of the LeDeR Steering Group,
- Northeast Commissioning Support (NECS)
- Primary Care colleagues across Shropshire Telford and Wrekin
- Shropshire County Council
- Telford and Wrekin Council
- Shropshire Telford & Wrekin Child Death Overview Panel (CDOP)
- Shrewsbury and Telford Hospitals NHS Trust
- Shropshire Community Health NHS Trust
- Midlands Partnership NHS Foundation Trust
- NHS England and Improvement National Team
- NHS England and Improvement Regional Team
- Ms. Y. Gray – LAC- LeDeR programme
- Mr R Gough - parent/carer

Introduction

The Learning from Deaths of people with Learning Disability and Autism Review Programme (LeDeR) was established to support local areas to implement a consistent format for the review of deaths of people with learning disabilities.
The key principles of the programme are to identify learning from the review of deaths, for learning to inform service improvement initiatives and for those initiatives to effect meaningful change in improving outcomes for local people. A LeDeR review is not a mortality review. It does not restrict itself to the last episode of care before the person's death. Instead, it looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. LeDeR reviews take account of any mortality reviews that may have taken place following a person's death. LeDeR reviews are not investigations or part of a complaints process, and any serious concerns about the quality of care provided should be raised with the provider of that service directly or with the Care Quality Commission (CQC).
The new national LeDeR policy, published March 2021, entitled 'Learning from lives and deaths – people with a learning disability and autistic people', sets out for the NHS, core aims and values of the LeDeR programme and the expectations of different parts of the health and social care system in delivering the programme from June 2021. The programme is funded by NHS England with responsibility devolved to Clinical Commissioning Groups. The LeDeR programme is delivered through local partnerships across health and social care organisations in Shropshire Telford and Wrekin. The policy outlines several changes to existing LeDeR processes. Some of these include changes to a web-based platform which went live on 1st June 2021, changes to staffing models and local governance arrangements. STW have implemented all required changes in accordance with the policy. The new policy, which looks at the life of a person as well as their death, now extends to include all people who are autistic – who do not also have learning disability. During the platform transition it was acknowledged regionally and nationally by NHSE/I that there were some challenges and changes to the functionality of the LeDeR platform that led to delays in completion of reviews. The functionality of the platform has not yet been fully resolved however NHSE/I are addressing these through a steering group.

The purpose of the LeDeR programme is to:

- Deliver local service improvements, learning from LeDeR reviews about good quality care and areas requiring improvement.
- Drive local service improvements based on themes emerging from LeDeR reviews at a regional and national level.
- Influence national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews.

The LeDeR process is summarised as follows:

- CCGs are responsible for ensuring that LeDeR reviews are completed of the health and social care received by people with a learning disability (aged four years and over) and autistic people (aged 18 years and over) who have died, using the standardised review process. ICB's will take over this responsibility from 1st July 22.
- Each LeDeR referral is allocated to a LeDeR reviewer. These are trained health and social care professionals experienced in working with people with learning disabilities and autism.
- The purpose of the 'Initial Review' is to identify key learnings and recommendations to improve local health and social care services. To do this the LeDeR reviewer will consider relevant case records and speak to family, friends, and carers to form a 'pen portrait' of the individual and a coherent narrative of their care in the lead up to their death.
- Before each initial review is approved it undergoes a quality assurance process.

- Where there were significant concerns about the person's health and social care service delivery further information can be gathered through a Multi-Agency Review (MAR) or focused review
- On completion of the review (Initial or MAR), recommendations are made, and an action planning process identifies service improvements that may be indicated.
- The CCG/ICB needs to identify good practice and what has worked well, as well as where improvements in the provision of care could be made.
- Local actions are taken to address the issues identified in reviews. Recurrent themes and significant issues are identified and addressed at a more systematic level, regionally and nationally.
- Learning and recommendations from every completed LeDeR review is fed into national and local 'Learning into Action'.
- Deaths for children with a learning disability are reviewed as part of the Child Death Overview Panel (CDOP) process. In STW this is achieved through CDOP panels the learning and recommendations are then fed into STW LeDeR Programme and implementation of priority actions.

This report provides an update on the progress and impact made across Shropshire Telford and Wrekin from 1st April 2021 to 31st March 2022. The report builds on the achievements made up to March 2021 and covers local progress in our first year as an integrated CCG across both Shropshire Telford and Wrekin and within the evolving ICB. The report reflects some of the extraordinary efforts of our partners to work together through a year that has continued to challenge health and social care providers. This includes the initial and subsequent peaks in the COVID-19 pandemic and some of the consequential implications of restrictions placed on services. It will undoubtedly take some time to fully appreciate the impact of COVID-19, on individuals health and on the health inequalities of people with learning disability and/or autism. The programme in STW is led locally by the CCG Quality Team, with a Local Area Contact (LAC) leading the work. During 2021/22 the CCG continued to support and train reviewers on the new platform to ensure reviews were completed within timeframe and fully capture the learning. The local reviewers aimed to maintain the high quality of reviews completed and ensure the learning from these reviews are embedded into practice to transform services for people with learning disabilities and autism with the aim of reducing health inequalities. Due to availability of reviewers and competing priorities of members of the steering group this has at times been a challenge. There has been Parent/Carer representation on the Steering Group. There has been co-production in processing the recommendations and agreeing the learning and priorities, where applicable each LeDeR reviewer has consulted with family, friends, and carers; information has been shared and noted as part of the recommendations. There have been several reviews where family members have required support which has been provided. Whilst the LeDeR review often focusses on the final episode of ill health, locally we feel it is equally important to review earlier in the person's journey to ensure all learning is captured. There has been significant learning which has resulted in changes being implemented across the system, this has been supported and monitored by the STW LeDeR Steering Group, which continues to meet on a regular basis with system wide membership. LeDeR is a standing agenda item on the Learning Disability & Autism Board with active membership from several parent, carer, and advocacy groups.

Our Statement of Purpose

- That LeDeR reviews are allocated and completed to a high standard within the stipulated programme timescales.
- Ensuring action is taken to address the recommendations emerging from completed reviews via action plans, dashboards and steering group meetings thereby improving the quality of health and social care services and reducing the health inequality faced by people with learning disabilities and autism.
- All our work includes the following principles: - co production, collaboration, person centred, learning and improvement, value and respect and lead through example.
- The overriding principle, clearly set out in the Terms of Reference for the Steering Group (appendix 1) to affect meaningful change and improve outcomes for local people, with the aim to extend the average lifespan of those with a LD and /or Autism and to ensure that those with LD&A are kept as healthy as they can be during their life.
- The outcomes that we are aspiring to achieve include supporting longer, healthier, and happier lives for people with a Learning Disability and Autism across our Integrated Care System.
- That all stakeholders, including people with learning disabilities and autism and their family, friends, and carers, feel an equal partner in the LeDeR programme.

Local progress in 2021/22

Last year's annual report stated the intention of the STW LeDeR programme for 2021/22 was to analyse the recommendations from the completed reviews and identify the key themes to undertake change and implement improvements. However, there have been several causal factors that have largely prevented putting all learning into action and making the desired improvements. The COVID-19 pandemic had a significant impact on the availability of reviewers, across STW provider organisations and local authorities to undertake reviews and attend the Steering Group. In April 2021 STW had eleven trained reviewers however this reduced to 4 by June 2021. In October 2021 the Local Area Contacts (LAC), left the programme and was replaced with a member of staff new to the role and the programme. The reviewers continued to reduce in numbers and by end of December 2021 the local reviewers could no longer commit to the programme. For this reason, no reviews took place in Q3 2021/22.
Between January 2021 and March 2022 following a successful bid from NHSE/I STWCCG employed an external reviewer who committed to reducing the number of outstanding reviews. The position as of 31st March 2022 was twenty reviews have been completed with eight outstanding reviews from 2021/22. There are also two reviews on hold (from 2020 & 2018) this is due to statutory investigations taking place.
Discussions have taken place with SCWCSU to ensure prioritisation of the reviews carried over.

Shropshire Telford and Wrekin progress with Oliver McGowan recommendations

Oliver McGowan was a teenager who had mild autism, epilepsy and learning difficulties, and was admitted to Southmead Hospital in November 2016 after having partial seizures. An independent LeDeR Review found that his death was 'potentially avoidable'.
In 2019, NHS England and Improvement commissioned an independent panel to review Oliver McGowan's previous LeDeR Review.

The rationale for the review related to what had been described as a number of inconsistencies in the local quality assurance processes for LeDeR, and specifically some of the draft reports for Oliver's LeDeR review that were sent to the family via the Freedom of Information Act in 2018.

Additionally, Oliver's family had expressed their concern about a lack of transparency within previous reports and processes. An independent investigation by Fiona Ritchie OBE, Chair on behalf of Oliver's Independent Panel found fundamental flaws in the LeDeR process and subsequently NHS England and NHS Improvement made recommendations for the national, regional, and local teams, particularly the governance arrangements surrounding local LeDeR programmes. One of the recommendations was each CCG must formally undertake, document, and review its own systems and processes against the learnings and recommendations arising from Oliver's re-review. In response to these recommendations the STW integrated workforce strategy will be updated to include a training plan to improve staff knowledge and confidence in making reasonable adjustments for people with a learning disability or autism. The Oliver McGowen Mandatory training will ensure staff working in health and social care receive learning disability and autism training, at the right level for their role. They will have a better understanding of people's needs, resulting in better services and improved health and wellbeing outcomes. Once The Oliver McGowan Mandatory Training trial is complete the Department for Health and Social Care will use the evaluation to inform a wider rollout of the training.
The full report can be found at:
NHS England » Independent Review into Thomas Oliver McGowan's LeDeR Process: phase two

Shropshire Telford and Wrekin response to the Clive Treacey life and death review

A portrait of Clive

Clive Treacey was only 47 years old, at the time he died at Cedar Vale in Nottinghamshire, a specialist unit for men with complex needs. Clive died on 31 January 2017 following a seizure and cardiac arrest from which he did not recover. His family have fought hard for the answers to their many questions about why he died, how it was that he spent so many years detained in specialist hospitals, why he was not kept safe from harm and why he did not get to live the life he and his family hoped for. His family have raised many questions about the events that led up to his death,

remaining dissatisfied with the outcome of the investigations and the inquest that followed. In July 2020, NHSE/I commissioned an independent review in line with the principles of the Learning Disability Mortality Review (LeDeR) programme methodology, into the serious matters raised by Clive's family about his experience of care and the circumstances leading up to his death. The review found that Clive's death was 'potentially avoidable'. There were multiple, system-wide failures in delivering his care and treatment that together placed him at a higher risk of sudden death as set out in the report. Clive should not have spent so many years of his life detained in specialist hospitals. There were extensive periods when he experienced an unacceptably poor quality of life and where he was not always kept safe from harm. Following the Clive Treacey report, a national initiative was launched to ensure people with learning disabilities received a safe and well review, this included a number of elements that had not previously been considered or questioned as part of a patient review. Each CCG held a number of scrutiny panels consisting of Clinicians, Medical, experts by experience, non-clinical and social care colleagues to discuss in detail the finding of the reviews, many of which prompted additional actions for the case managers to go back and further investigate, but also a number of themes were identified which will be discussed as part of the STW LD&A Board and where required escalated to the ICS MH LD&A Programme Board. Learning events and provider collaborative planning meetings had been scheduled during May 2022 to review the learning and plan future action. There were more than 30 people invited to the events, however, at the time of writing this report they were postponed by NHSE until early June. The full review can be found at: www.england.nhs.uk

Local provider progress 2021/22

Midlands Partnership Foundation Trust (MPFT)

Over the last year, MPFT have continued to work proactively alongside system partners to deliver on key health focussed targets in the local LeDeR action plan. MPFT have continued to champion the health needs of people with learning disabilities in Shropshire Telford and Wrekin with a focus on reducing health inequalities and improving health outcomes. Key areas of focus for adult learning disability services in MPFT have included:

- Improved LD&A training within the Acute Trust including ReSPECT documentation and Mental Capacity Act (MCA)
- Ensuring Acute Liaison Nurses (ALN) are based on the acute sites, with access to all relevant clinical systems and are visible on wards
- Annual Health Checks (AHC) – ongoing cleansing of GP registers; GP training, MPFT following up with face-to-face home visits when AHC appointments have not been attended. GPs are sharing lists of all patients who are overdue AHCs for face to face follow ups; supporting with pre-health check questionnaires; MPFT are flagging areas of concern back to GPs for follow up and prioritisation.
- Developed bespoke training for Shared Lives and social care providers to outline what carers should expect from the AHC
- Covid Vaccinations – support provided regarding reasonable adjustments, clinical holds, and Mental Capacity Act (MCA) and best interest (BI) decisions.

MPFT has robust governance systems in place to ensure the learning from national and local LeDeR and internal Trust mortality reviews are used to both celebrate and promote best practice, and to take action to improve service delivery where needed. Key actions taken forward this year have included:

- Initial assessment paperwork now includes a question on both Covid Vaccination and AHC status.

- Information regarding covid risk provided to all highest risk groups (including people with Down's Syndrome and/or from ethnic minority communities).
- Review and development of the Physical Health Pathway for service users with learning disabilities prescribed antipsychotic medication (in line with Stopping over medication of people with a learning disability and/or autism, (STOMP) agenda
- Provision of Aspiration Pneumonia Training to the STW system via Joint Training.
- Epilepsy Care Pathway updated (includes Sudden Death in Epilepsy (SUDEP) risk assessment), all staff received epilepsy awareness training and there is audit underway to review compliance with the epilepsy care pathway.
- Constipation – provision of staff training on the soft signs of deterioration and promotion of "Stop and Watch" resources and MPFT on-line training.

Shropshire County Council

Working collaboratively with parents, carers experts by experience, advocacy, and other partners Shropshire Council's People's direct are planning the consultation for their Autism and Learning Disability strategy updates. We are also working closely with our colleagues in Public Health to address health inequalities and they link in with our partnerships board and ongoing work. Our Learning Disability Partnership Board members are going to be working with Healthwatch and colleagues in the CCG to look at accessibility of health services along with our provider colleagues who are leading on the Treat Me Well campaign Shropshire Council runs internal learning reviews following adverse incidents from which we are aware that there are opportunities to learn and develop our service. These are run on a case-by-case basis following a referral through to the Principal Social Worker. Action plans are developed and reviewed as a result of the learning from the learning reviews. Recently we have also been running some workshops looking into the life and death of Clive Treacey. Staff have been encouraged to reflect on the independent report and to consider the learning for Adult Social Care. Findings and reflections from this exercise will inform a report to managers and an action plan for improvement.

Telford and Wrekin Council

Telford and Wrekin Council continue to see the benefits of a dedicated Learning Disability and Autism front line Social Work team supporting people residing and placed by Telford and Wrekin Council, supported by a Specialist Autism lead to improve practice and commissioning of services for Autistic people. Completion of the Learning Disability strategy and pre-consultation of the Autism Strategy reinforced the importance of embedding healthy lifestyles within social care settings and care provision. Working with agencies such a Leisure Service, Public Health and specialist Learning Disability and Autism health services systems continue to push services to work together in reducing health inequalities and improving outcomes for people. Learning from national and local LeDeR reviews also continues to drive improvements and enhance the quality of support provided. Activities to improve quality of provisions, working in partnership with experts by their experience, parent carers and specialist organisations that champion the views of people who use services and identify improvements and drive positive change is at the heart of our co-production commitments.

Support for Care Homes across Shropshire Telford and Wrekin

The Community Learning Disability Team (CLDT) from MPFT have visited care homes to improve the understanding of the 'softer signs of illnesses and the need to raise early concerns about subtle changes in a person's condition. Individuals with LD and autism can often deteriorate slowly

however, if those caring for people with LD and autism can flag simple changes sooner, appropriate action can be taken to avoid unnecessary, and often distressing, transfers to hospital. Early changes can be noted in sleeping patterns; feeding; toilet habits; an increased lack of interest, more fatigue than usual or an increase in behaviour issues. People with learning disabilities may become distressed with having their blood pressure, or temperature, taken using medical equipment. Therefore, increased use of a 'soft-signs' could earlier action. Care home provider organisations have also undertaken work to highlight softer signs of deterioration.

- The Community Learning Disability Team (CLDT) commenced a risk assessment of each person registered with the service – physical and mental health needs were assessed, and support given to the level of risk and reviewed regularly. (Green stable -monthly visits, Amber could possibly deteriorate- reviewed individually, Red -deteriorating patient weekly contact)
- The Community Learning Disability Team continue to provide face to face visits throughout the pandemic, where a person was considered vulnerable.
- A targeted approach with all LD providers promoting and raising awareness of annual health checks. Currently, MPFT are supporting practices in some care homes MPFT nurse led team are completing face to face visits for base line observations and support in completing the health check questionnaires which follow the AHC template
- Covid-19 passports were completed, online training i.e., awareness training for care staff
- Information is shared and priority patients flagged to GPs for them to see face to face where there are areas of concern.
- For those people seen by the team it is requested that health action plans are completed/reviewed and sent to the person.

Easy read documents shared with the local community and partners A video was developed by local young service users to encourage attendance at Annual health checks https://www.shropshiretelfordandwrekinccg.nhs.uk/your-health/local-services/learning-disabilities-and-special-educational-needs/annual-health-checks/

Learning Disability Annual Health Checks (LDAHCs) 2021-22

Although GP practices were asked to prioritise the COVID-19 vaccination programme throughout the year alongside their usual pressured primary care work, practices continued to complete LDAHCs recognising the importance of this work in addressing health inequalities. The Omicron booster campaign during quarter 3 and 4 2021/22 and the high local incidence of COVID-19 during March and April impacted on the local delivery of LDAHCs with the completion rate being lower than anticipated in the original plan.
In 2021-22 Shropshire Telford and Wrekin completed LDAHCs for 65% of those patients on the practice Learning Disability (LD) register (1577 patients) with 18 practices achieving over the national target of 75%. This is below the national average of 71.8% and a local decrease from the 77% achieved for STW in 2020-21. GP Practice LD register list sizes have continued to grow as lists and coding are reviewed. There has been an increase of 138 people registered with LD in the year rising to 2436 in March 2022 from 2298 in April 2021.STWCCG have worked with practices and partners to continue work to improve the offer and uptake of quality of Annual Health Checks for people with a Learning Disability throughout the year. As a system we are committed to offering 100% of people with a learning disability an annual health check.

Some of the key progress made during 2021/2022 is listed below.

- A local webinar was held to focus on the importance of reviewing coding at practice level and to examine processes and good practice. Stirchley Medical Practice shared their practical experience of growing their practice LD register and the learning was shared with all practices.
- A new local LDAHC quality audit tool was developed and then piloted in autumn/winter 2021. The learning has been shared with all practices. A programme of scheduled visits will start in 2022/23.
- Regular data collection and close monitoring against STW targets.
- Regular communications to practices with links to updates and resources to use.
- The MPFT Community Learning Disability Team continue to offer support to practices in terms of extra resource to complete base line observations, carrying out home visits and offer advice and support on improving quality.
- Primary Care Networks (PCN) are encouraged to identify a LD lead and to share good practice across practices.
- Training is offered to practice staff.
- Engagement with advocacy groups, carers, and families.
- LDAHCs included in LA training for Social Work teams.
- LDAHCs included in LA tender process on provider framework.
- Continued links with local special schools and colleges.

Plans for Learning Disability Annual Health Checks 2022/2023

- Recovery Plan: This year the initial focus for quarter 1 (April-June) is to reach those who are overdue with their LDAHC and to complete these as soon as possible.
- For 2022/23 the focus will pick up the work to engage the 14–18-year age group, working jointly with Special Educational Needs and Disability (SEND) Teams, specialist schools, the Local Authority and Parent & Carer groups to ensure LDAHC's are embedded within services i.e., Education Health and Care Plan (EHCP) and that young people are captured on the GP LD register and offered a LDAHC.
- Work will also take place to identify and understand local variation, continue to review, and improve quality, and increase the accuracy of LD registers. A schedule of LD quality practice visits will be undertaken by the CCG and practices will be encouraged to use the audit tool annually to support this work.
- During quarter 4, 2021/22 we also saw increased numbers of 'did not attend' (DNA's) to appointments locally from 5 in Q3 to 40 in Q4. Although this is understandable due to high local rates of COVID-19, this will be further investigated and discussed as part of the quality audit review.
- A pilot audit of annual health checks was carried out last year and will be completed again this year to look at the quality aspect.

LeDeR Structure and Governance

The Senior Responsible officer (SRO) for the programme is STW CCG Executive Director of Nursing and Quality. The day-to-day management of the LeDeR Programme has been undertaken by the Local Area Contact (LAC). The STW Steering Group provides bi-monthly updates to STW Learning Disability and Autism Delivery Group who provide updates to the Learning Disability and Autism Board. During Covid, representatives have attended Steering group via Microsoft teams. The Steering Group is chaired by STW LAC, and the group takes strategic level oversight of the reviews of deaths of people with learning disabilities and autism and drives transformation to improve care.

The role of the LeDeR Steering group is to have clear Terms of Reference, agreed by membership, which reflect:

- The scope and purpose of the forum
- Representative membership
- Governance arrangements including responsibility, accountability, and reporting arrangements.

The newly formed Shropshire Telford & Wrekin LeDeR Governance Panel has been established in accordance with the NHS England directive of the Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy of March 2021. The purpose of the panel is to receive a summary of anonymised review case reports of the life and death of people with learning disabilities or autistic people to contribute to a collective understanding of learning points and recommendations. The Governance panel will advise the LeDeR steering group of the findings from the reviews and in turn the Steering group will take priority actions. The terms of reference can be found in appendix 2

Performance of Shropshire Telford and Wrekin LeDeR programme

About the people who died- Pen portrait

All the reviews include a pen portrait of the person who died. This gives a real sense of the person; their likes and dislikes, their favourite things, what they liked to do, their friends and family, what kind of character and personality they had.
The reviewers have found out some amazing things about individuals by talking to friends, family and carers however have also found out about a few people who had sad lives; some who may have spent time in institutional care which may have had an impact on them during their life. These portraits help the reviewer connect to the person and remind us to consider whether the care and treatment they received has been of a high enough standard.
Undertaking a review can often result in exposure to distressing details of the circumstances leading up to a person's death. Contact with bereaved relatives and care staff can also be emotionally demanding. It is therefore important that reviewers are supported appropriately in order that they can carry out their role effectively and with compassion. The requirement for remote working and the impact of the pandemic (both emotionally and in terms of the volume of notifications requiring timely completion) has meant that the LeDeR LAC role has been as vital as ever in supporting reviewer wellbeing and an outstanding level of timely and consistently high standard completed reviews.
The process for the quality assurance and approval of all completed reviews has been maintained throughout this year. The process of quality assurance does however mean that the friends and families of people with a learning disability who lose a loved one can feel confident that relevant aspects of learning are drawn from each LeDeR review with the aim of influencing improvements in the healthy future lives of others. Where the potential for care gaps or failings are apparent within the detail of an individual LeDeR review the LeDeR programme will work alongside colleagues and families to ensure alignment or escalation to appropriate statutory processes including NHS provider Serious Incident reporting, Safeguarding Reviews and Coroner's Office proceedings.
Notifications continue to be predominantly made by Community Learning Disability Nurses or Learning Disability Acute Liaison Nurses.

The pattern of notifications received by STW is detailed in table below

Table 1
Summary of deaths notifications in 2021/22

Total notifications 1st April 2021- 31st March 2022	28
Total notifications not yet assigned to a reviewer (31st March 22)	8
Number of initial reviews	20
Number of focussed reviews	0
Number of reviews on hold (as above undergoing statutory investigations)	2 (2020 & 2018)
CDOP (included in outstanding reviews)	1
Completed reviews in 2021/22	20

As discussed in the introduction, due to resource implications there are eight reviews that will be required to be carried over into 2022/23, At the point of notifying a death there is an option to advise of any initial concerns with the death, this ensures priority is given to reviews where concerns with the death have been identified. Of the eight reviews carried into 2022/23, one is a CDOP case, which is currently under the CDOP process, two further reviews remain on hold due to statutory investigations.

Demographic data and equality impact

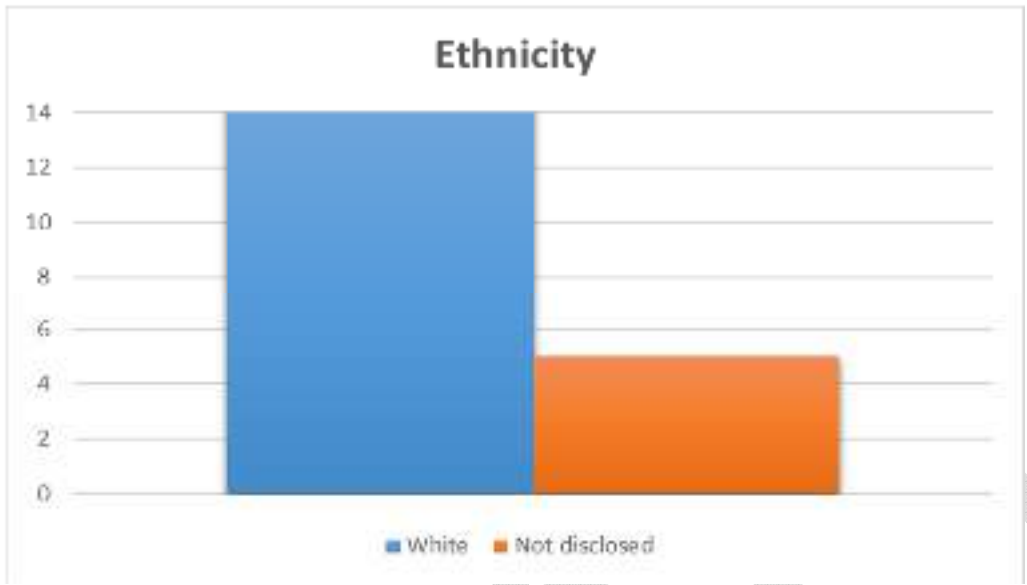
As at 31.01.2022 the population of Shropshire Telford and Wrekin is 518, 272. The Quality and Outcomes Framework (QoF) data indicates as of 31st January 2022 there are 2359 people across Shropshire Telford and Wrekin registered with a Learning Disability (0.48% of STW population). Nationally the QoF data prevalence of learning disability is 0.5% of the population. At the time of authoring the report local data for Autism is being corroborated however both the Autism society and Local Authorities calculate the population with autism to be based on 1% of the total population. This would equate to 5183 people with autism across STW. The age and gender breakdown for LD as of 31.1.22 is in table 2

Table 2

Age	Female	Male	Total
0-9	44	84	128
10-13	21	56	77
14-17	55	76	131
18-24	145	260	405
25-34	187	323	510
35-44	116	192	308
45-49	68	89	157
50-54	69	109	178
55-69	63	86	149
60-64	47	68	115
65-69	39	44	83
70-74	34	32	66
75 and over	32	20	52
Total	**920**	**1439**	**2359**

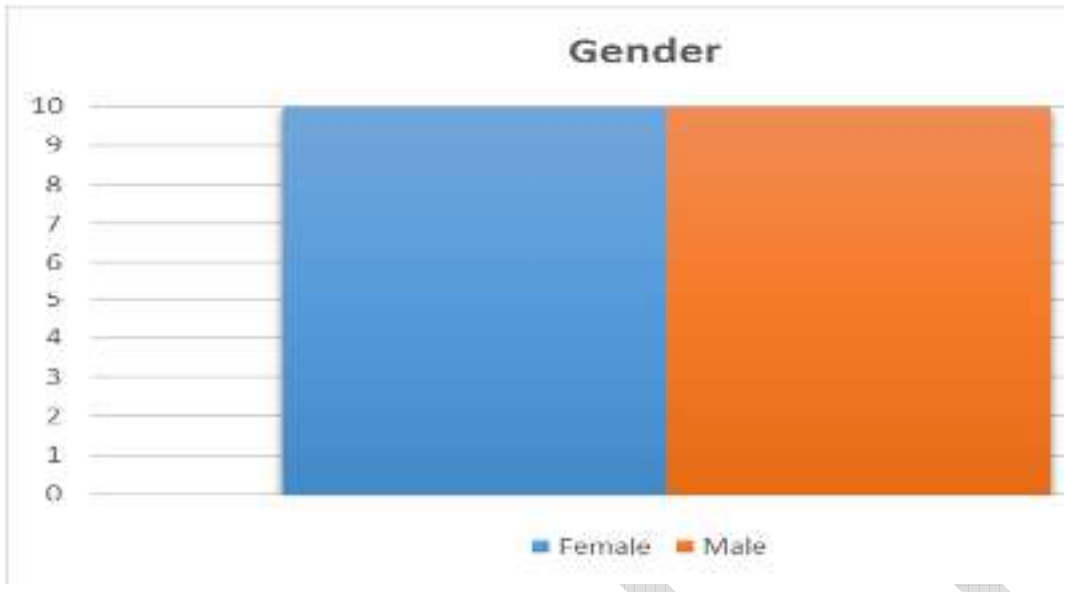
Ethnicity

Table 3



At the point of notification 5 of the reviews did not state what the ethnicity of the person was who had died. It could be that this information was not available, however a recommendation to the steering group is that there is an improvement in data capture, specifically but not exclusively for ethnicity for notifications in 2022/23.
Every LeDeR steering group has been asked to identify a named lead for their area who will ensure that the challenges faced by people from minority ethnic communities are considered and addressed as part of local LeDeR work. For all minority ethnic service users on our Community Learning Disability Team caseloads, we have ensured that throughout the pandemic all wellbeing calls (and clinical contacts) have included consideration of heightened risks and we have used these contacts to promote and proactively support covid vaccination for this group.

Gender
Table 4



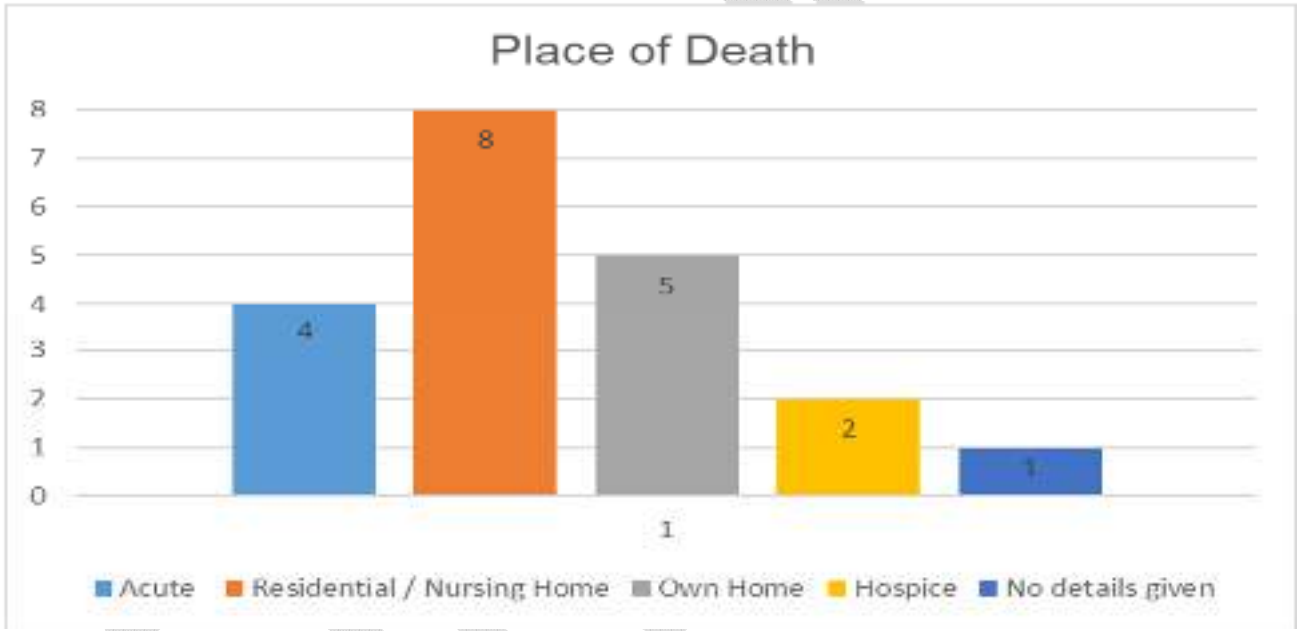
Nationally there are more deaths of males than females. Across STW there is an equal divide between males and female deaths

Age at death
Table 5

Table 5 shows the age at death for all 20 reviews that were completed. Nationally the average age of death for a person with learning disability is sixty-one. People with a learning disability and/or autism often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. People with a learning disability are dying earlier than they should, many from things that could have been treated or prevented. In STW the average age of death for 2021/22 is age 60 years, compared to 55 years in 2020/21 and 50 years in 2019/20.

Place of death

Table 6



As per table 6, thirteen people (65%) died in their usual place of residence, i.e., either their own home or a care home.

Cause of Death

(Taken from part 1a on the death certificate)

Table 7

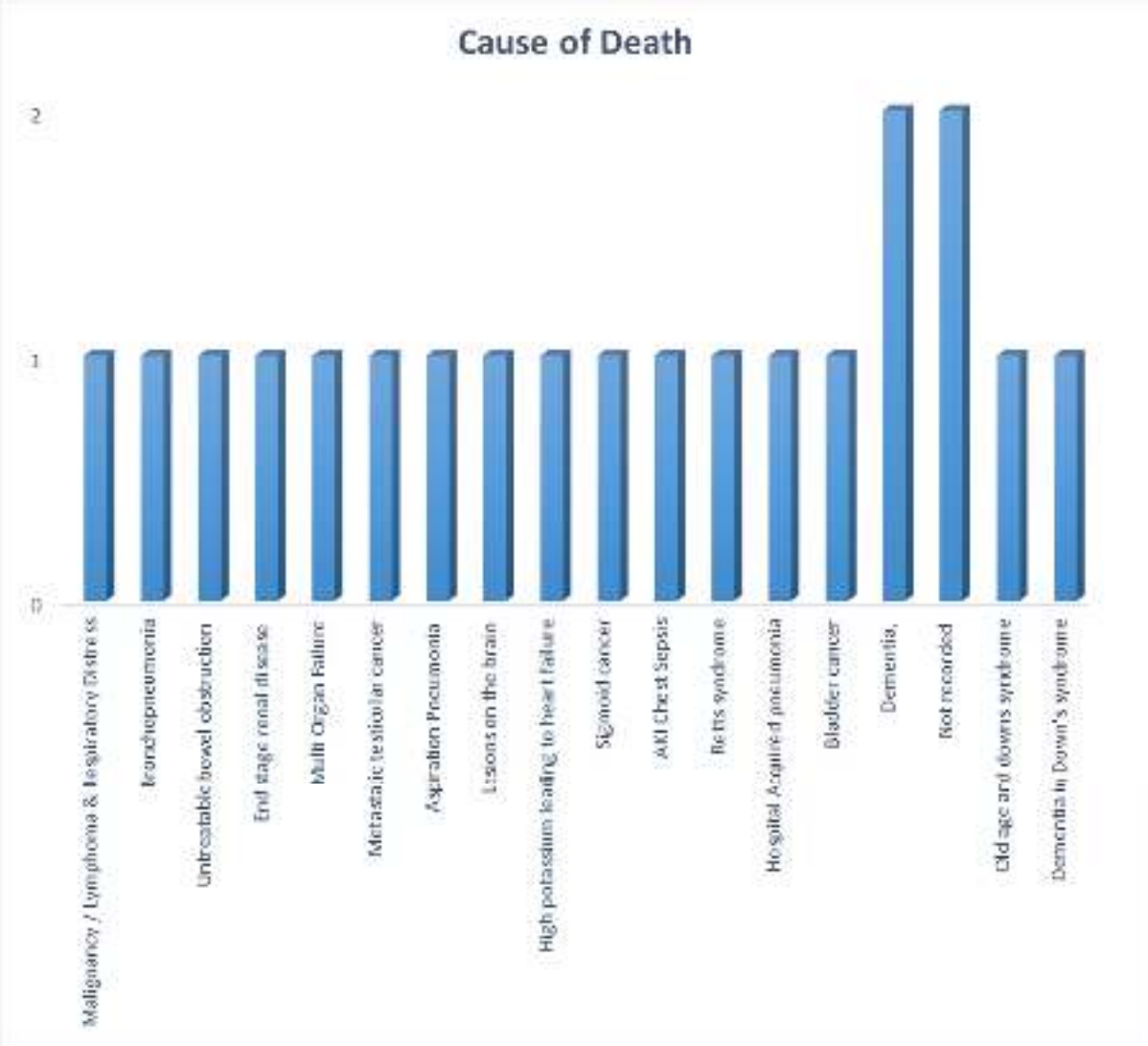
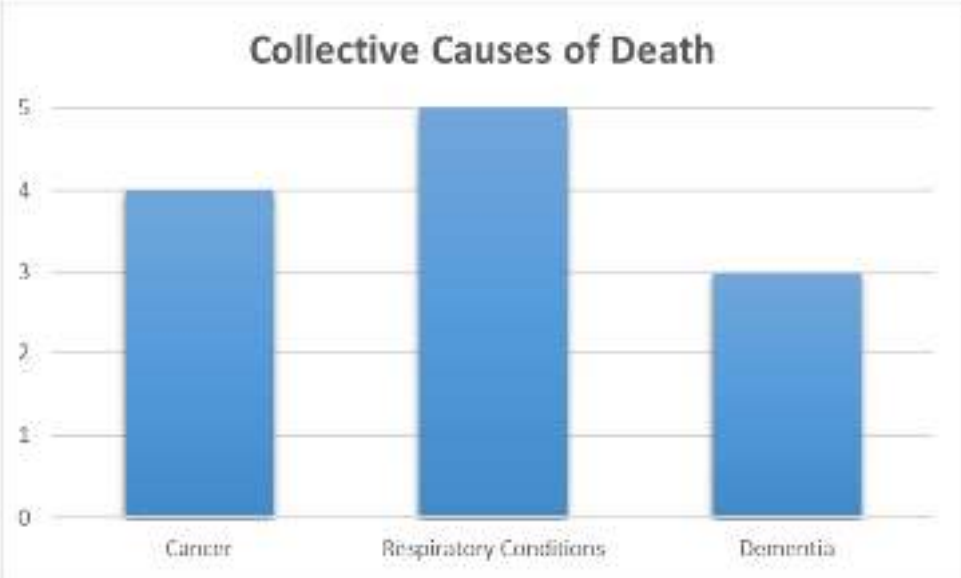


Table 8



As per table 7 the causes of death for the twenty reviewed were varied during this reporting period

As per table 8 the top three themed causes of death are:

- Respiratory conditions, which counted for the highest cause of death with five (25%) people having this documented as the primary cause
- This was followed by four (20%) cancer related deaths
- Three (15%) patients had dementia as a primary cause

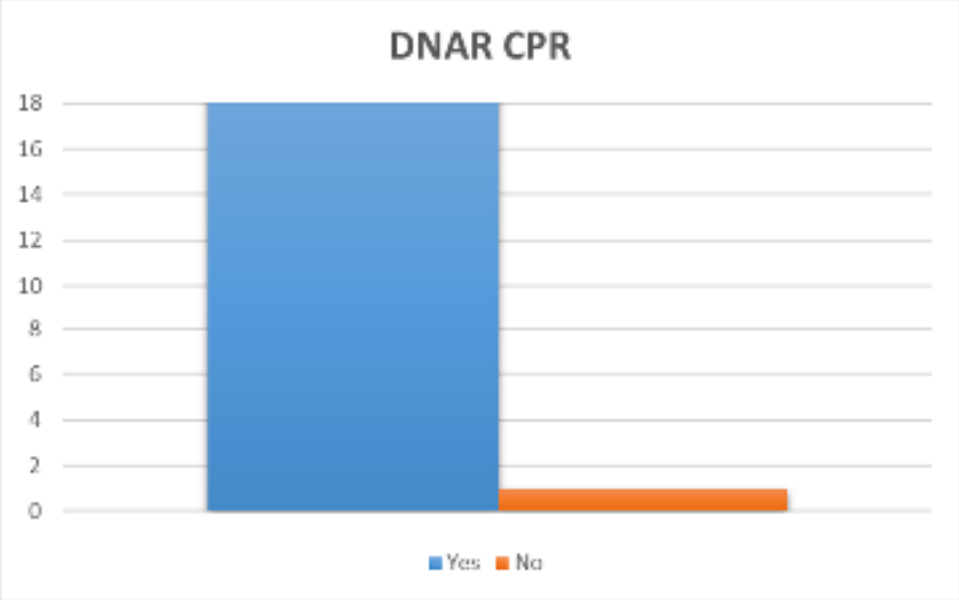
Nationally it has been acknowledged that a considerable number of deaths of people with Learning disabilities are because of respiratory conditions. Two national pieces of work commissioned last year by the LeDeR team and delayed by COVID-19 are now back on track to be delivered in 2022: NHS England and NHS Improvement commissioned guidance on pneumonia and aspiration pneumonia from the British Thoracic Society – whose members include doctors, nurses and respiratory physiotherapists and which champions 'Better lung health for all'. This guidance is being co-produced with people with lived experience. Secondly the NHS Right Care programme, which makes recommendations to improve healthcare, is developing guides to improve the outcome for patients with respiratory conditions. As part of this it is working with the learning disability and autism programme to develop a Right Care pathway scenario for pneumonia care. National LeDeR reviews tell us that people with a learning disability who have cancer can be diagnosed late; diagnostic overshadowing is sometimes an issue; access to investigations can be poor due to lack of reasonable adjustments and assumptions about ability or willingness to tolerate tests. Improving access to screening for people with a learning disability and autism is vital learning from national LeDeR reviews. NHSE continue to work to reduce inequalities in screening, including by informing people of their choices, making services easier to access and supporting people who are diagnosed with cancer, and in partnership with the screening and immunisation team and Public Health England increase participation in national screening programmes.

Covid-19

There were no covid deaths reported from 1st April 2021- 31st March 2022. Despite the challenges encountered because of the Covid-19 pandemic, the past year has seen some positive work and continued drive by local Learning Disability specialists in our hospitals and community providers. The local teams have had a focus on ensuring all those with a learning disability are offered Covid-19 vaccinations The impact of Covid 19 may still to be evaluated fully on the LD and A population. The programme will continue to review all deaths where individuals have contracted Covid-19. Improvements in the national vaccination programme and learning from looking at individual deaths should enable LeDeR to progress some of the key themes from these deaths throughout the coming years.

End of life

Table 9



As per table 9 the (DNAR) which stands for cardiopulmonary resuscitation, a treatment that can be given when a person stops breathing or their heart stops beating. Completion of DNAR for 2021/22 is 95% showing an improvement from 75% in 2020/21. DNAR is captured on the LeDeR platform however the completion of ReSPECT documentation (Recommended Summary Plan for Emergency Care and Treatment) is not. ReSPECT is a national patient held document, completed following an Advance Care Planning conversation between a patient and a healthcare professional. It is an important aspect of a person's wishes during their life and any plan for during episodes of illness. Going forward into 2022/23 STW will capture this information on a local LeDeR dashboard and completion of this will be reviewed and discussed at both Steering Group and Governance Panel.

Learning from reviews

What we did well

Many areas of good practice were identified in the twenty reviews completed in 2021/22. These will be shared to maintain these areas of good practice and promote consistency across the system for all people with a learning disability and Autism/Autistic.

- Consistent contact, ensuring the same clinician saw the individual at all their hospital appointments
- Pro-active Intensive Health Outreach team (IHOT) - providing good support for care homes
- A number of care homes were noted as 'exceptional' by family members for the care shown to individuals
- Very good care from Hospice, GP and District Nurses was cited in a number of reviews.
- Clear evidence of MDT working across all services

Examples of good practice taken from discussions with family, friends, and carers during reviews

- "The care home delivered end of life care, in a compassionate and professional manner"
- "Once diagnosed things were put in place very quickly regarding medication and a referral and acceptance at the hospice was quick, our son was transferred, and family and carers were allowed to support him whilst there."
- "Our son was well known to community Learning Disability team and had good support from both the nursing team and the dietician, who were involved up until the time of his death"
- "The Palliative care nurses were supporting the care home staff and the district nurses were visiting on a regular basis to support and manage the syringe driver".
- "We had good support from our GP for both our daughter and the family"

What we have learnt

- The importance an Annual Health Check can make to an individual with Learning Disability and/or Autism/Autistic
- Increase staff awareness of reasonable adjustments
- Increase staff awareness of healthy lifestyle advice
- Increased focus on improving activity levels within LD/A community
- Work as a system to address inequalities

Measuring success

STW ICS are committed to extracting learning from LeDeR, implementing actions, and demonstrating change with ongoing commitment to sustainability of change, Achievements will be monitored by LeDeR Steering group and measured by:

- A reduction in the early deaths of people with a learning disability and/or autism
- Positive feedback from reviews of the quality and standards of care
- Achievements and progress of identified actions from our local LeDeR action plan

- Local dashboard data from completed LeDeR reviews evidencing increase in annual health checks, use of MCA framework, ReSPECT documentation, demographic data capture.
- Audit of action plan to ensure we are capturing all the learning and recommendations from the completed LeDeR reviews
- Benchmark local performance against national standards

Recommendations and next steps

It is proposed that while the key recommendations for 2022/23 are supported by the CCG we should also seek support our Integrated Care Board (ICB) and system partners enabling us to:

- Strengthen links with and reduce inequalities for people from minority ethnic communities. Every LeDeR steering group has been asked to identify a named lead for their area who will ensure that the challenges faced by people from minority ethnic communities are considered and addressed as part of local LeDeR work. Their role includes ensuring that reviewers understand the challenges faced by people with learning disability and autism in accessing services, establishing links with organisations that represent minority ethnic groups, raising the profile of LeDeR and increasing the notification of deaths from minority ethnic communities, proportionate to the local communities. This will be done in conjunction with the CCG/ICB Equality and Diversity lead and system organisations. The new LeDeR policy outlines the requirement to carry out a focused review for every person from a minority ethnic community to learn how to address any additional inequalities relating to race and ethnicity.
- Undertake further work to make improvements in all key areas we have identified this year, Health action plans, respiratory management, and cancer screening.
- Strive for better performance of Learning Disability Annual Health Checks (LDAHC) with an initial focus in quarter one (April- June) to reach those who are overdue with their LDAHC and to complete these as soon as possible. For 2022/23 the focus will be to engage the 14–18-year age group, working jointly with Special Educational Needs and Disability (SEND) Teams, specialist schools, The Local Authority and Parent & Carer groups to ensure LDAHC's are embedded within services i.e., Education Health and Care Plan (EHCP) and that young people are captured on the GP LD register and offered a LDAHC. Work will also take place to identify and understand local variation, continue to review, and improve quality, and increase the accuracy of LD registers. A schedule of LD quality practice visits will be undertaken by the CCG and practices will be encouraged to use the audit tool annually to support this work. An audit of annual health checks was carried out last year and will be completed again this year to look at quality assuring the reviews.
- Undertake a system review to ensure End of Life Pathways are appropriately used and fully involve people with learning disabilities and autism and their families, including the use of accessible information and ReSPECT plans.
- Work with system partners to embed sustained learning and improvement of care for people with learning disabilities and autism, ensuring learning identified from reviews informs day to day practice across our providers in health and social care.
- Continue to promote and share action learning with the aim of ensuring all people with a learning disability and/or autism experience good and excellent care.

- Widen the membership of the Steering Group and Governance Panel to include people lived experience, valuing their contribution in making a difference to people with Learning disabilities and Autism.
- Deliver on the recommendations in the Oliver's McGowan's report, in particular the commitment to improve staff knowledge and confidence in making reasonable adjustments for people with a learning disability or autism.
- Deliver on the recommendations from Clive Treacey life and death review, themes were identified and will be discussed as part of the STW LD&A Board and where applicable will be escalated to the ICB Mental Health LD&A Programme Board. Learning events and provider collaborative planning meetings have been scheduled by NHSE during June 22
- Deliver local service improvement, learning from LeDeR reviews about good quality care and areas requiring improvement at both regional and national level.
- Undertake a thorough review of the Steering Group action plan, setting clear priorities and agreement of those priorities across the whole economy for 2022/23
- Influence national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews.
- Work with NHSE/I regional and national LeDeR teams to quality assure our reviews.
- Work with SCW CSU on outcomes and findings from LeDeR reviews, ensuring all reviews are quality assured and share findings from the reviews from the newly formed Governance panel.
- Undertake a system review to ensure End of Life Pathways are appropriately used and fully involve people with learning disabilities and autism and their families, including the use of accessible information and ReSPECT plans.
- Greater emphasis on thematic review of LeDeR findings, aligning with national work
- Continue to promote and share action learning with the aim of ensuring all people with a learning disability and/or autism experience good and excellent care.
- We have a detailed local/system wide LeDeR action plan to take forward priority actions within set timeframes and named individuals responsible.
- We will work with NHSe/I regional and national LeDeR teams to quality assure our reviews. As per the policy requirements the Quality Assurance aims to ensure there are systems in place to assure quality of reviews and check that ICSs are producing stretching and challenging actions to reduce variation, ensuring consistent quality. Work within regional quality oversight arrangements to address any system quality and safety issues impacting on the performance of the regional LeDeR programme. Call in a random sample of reviews to quality assure reviews including both initial and focused reviews (LeDeR policy 2021). Monitor the percentage of reviews that translate from initial too focused reviews, co-ordinating with NHS England and NHS Improvement national team and colleagues across the country to ensure equity and parity.
- Consider resource implications for the LeDeR programme across STW ICS
- This report once signed off by the Governing Body will be published on CCG websites as per NHSEI request.
- It will also be shared with the CCGs Quality and Performance Committees in Common, System Quality Group and LD & A Board

Conclusion

The LeDeR programme in Shropshire Telford and Wrekin has seen engagement with stakeholders across the system who are committed to reducing premature mortality and improving services. We have seen several examples of good practice within our reviews, but we know that we need to continue to strive to achieve improved uptake with Annual Health Checks, improve our links with ethnic minority groups and continue to learn from local reviews.
As the LeDeR programme moves forward under the new policy framework and as responsibilities for programme delivery transfer to the local ICB we are confident that there is a solid foundation on which to build and on which to deliver better heath outcomes for people with Learning Disability and Autism living in Shropshire Telford and Wrekin

More information on the LeDeR policy can be found at: B0428-LeDeR-policy-2021.pdf (england.nhs.uk)
Any person can make a notification by accessing (leder.nhs.uk)
The national LeDeR report for 2020/21 can be found at: LeDeR-Action-from-learning-report-202021.pdf (england.nhs.uk)

Appendix 1

Shropshire Telford & Wrekin CCG/ICB LeDeR Steering Group
Terms of Reference

Background

The Learning from Lives and deaths- people with a learning disability and autistic people (LeDeR) Programme was established as one of the key recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPoLD) (2013). During 2021 the programme will expand to include the lives and deaths of autistic people. The aim of the Programme is to drive sustainable improvement in the quality of health and social care service delivery for people with learning disabilities or autistic people, to help reduce premature mortality and health inequalities in this population, Reviews will be undertaken to help clarify contributory factors for the cause of death that contribute to the overall burden of excess premature and avoidable mortality for people with learning disabilities or autistic people; identify variation and best practice; and identify key recommendations where there is opportunity to influence improved outcomes.Progress made through the STW LeDeR Programme will be overseen by the Learning Disabilities and Autism (LD&A) Programme Board. The Steering Group will ensure that learning extracted from each completed review results in agreed system action to affect meaningful improvements in health equality outcomes.

Aim

- To extend the average lifespan of those with a LD/Autism in Shropshire and T&W
- To ensure that those with LD&A are kept as healthy as they can be during their lifespan.

Core shared values

As members of the LeDeR Steering Group we commit to ensuring that local LeDeR Programme delivery:

- Keeps the experience of people with a learning disability or autistic people, whose life and death we will become aware of through the course of the Group, firmly at the center of the review and learning process and the forefront of our mind.
- Work within our respective organisations to stopping early deaths of people with a learning disability and autistic people due to health inequalities.
- Remain focused on celebrating where end of life experience is managed well, capturing examples of ‘reasonable adjustments’ and considering how lessons can be learnt following deaths considered to be premature or amenable to improvements in health and social care.
- Support an evolving process that will become sustainable and embedded in local culture.
- Uphold the key principles of cooperation and partnership to ensure that the programme of work affects meaningful change on reducing health inequality and increasing the opportunities for the experience of a ‘good’ death for people with a learning disability.

Purpose / role of the Steering Group and its members:

- Receive regular updates from the Governance Group about the progress and findings of reviews.
- Analyse the data & smart actions presented by the Governance Group
- Monitor SMART actions resulting from the outcome of reviews
- To agree priority actions based on the recommendations and themes of reviews and contributory factors that have the potential to make the greatest impact
- Support system partners to ensure all providers are working to prioritise learning from local and national LeDeR reviews
- To track the progress of agreed measurable outcomes
- To work in partnership with the regional leads for NHS Midlands LeDeR / Learning Disability and Autism Programme to incorporate learning from other areas
- To consider areas of additional learning or good practice identified by the LD & A Programme Board
- Influence partners to improve the local offers that support healthy living for people with a learning disability and autistic people.
- To agree the key benchmarks or indicators from which progress and impact of the local LeDeR programme will be evaluated.
- To review and re-prioritise or modify a Priority Action Plan in response to emerging local themes
- To ensure each identified partner agency is accountable for the delivery of action required from the organisation that they represent.
- To gain assurance from system partners that quality monitoring and improvements with providers around health inequalities are a part of their organisations 'business as usual' duties.

Membership

Membership for the LeDeR Steering Group will include broad representation including health and social care; provider and commissioning organisations; people with a learning disability and those who support them, including family carers and advocacy organisations. Where a key representative is unable to attend and where a suitable deputy should attend.

Core Membership

- Family members who are carers or a family member who are experts by experience. (No requirement for deputising in absence)
- People who have a learning disability and/or autism (appropriately supported, no requirement for deputising in absence)
- Local Area Contact (LAC)

Representatives from:

- Each of the main acute NHS providers; SATH, SCHT, RJAH
- Mental health and community learning disability team providers; MPFT
- Ambulance service; WMAS – to be agreed
- Autism service provider; MPFT currently.
- PCN representatives – to be agreed.
- Social care representative.
- Public Health

- Shropshire Local Authority
- Telford & Wrekin LA
- Nurse Specialist Child Death Reviews SCHT
- Nurse Specialist Safeguarding Adults SCHT

Governance

- Learning into Action Group meetings will be held bi- monthly
- Meetings will be quorate when at least one representative or nominated deputy of each of the following is present- expert by experience, family carer, acute hospital, specialist Community Learning Disability services, CCG, commissioning, Public Health
- Meetings will be organised by the STW ICS LeDeR Local Area Coordinator.
- The Chair will be the Integrated care System (ICS) LeDeR LAC.
- The Group will provide a monthly update to the LD & A Programme Board
- Papers will be circulated at least 5 working days before each meeting.
- High risks identified that cannot be mitigated will be escalated to the CCG System Quality Group via the STWICS Risk Register and to each relevant partner agency

Appendix 2

Shropshire Telford & Wrekin CCG/ICS LeDeR Governance Panel Terms of Reference

Background

Learning from lives and deaths of people with a learning disability (LD) and autistic people (LeDeR) formerly known as the Learning from Deaths Review is a programme which started in April 2017 as a result of the Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD). The Shropshire Telford & Wrekin (STW) LeDeR Governance Panel is established in accordance with the NHS England directives of the Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy of March 2021. These terms of reference set out the membership, remit, responsibilities, and reporting arrangements of the Governance Panel.

Aim

- To extend the average lifespan of those with a LD/Autism in Shropshire Telford and Wrekin
- To ensure that those with LD&A are kept as healthy as they can be during their lifespan.

Core shared values

As members of the STW LeDeR Governance Panel we commit to ensuring that local LeDeR programme delivery:

- Keeps the experience of people with a learning disability or autistic people, whose life and death we will become aware of through the course of the Group, firmly at the center of the review and learning process and the forefront of our mind.
- Work within our respective organisations to stopping early deaths of people with a learning disability and autistic people due to health inequalities.
- Remain focused on celebrating where end of life experience is managed well, capturing examples of 'reasonable adjustments' and considering how lessons can be learnt following deaths considered to be premature or amenable to improvements in health and social care.
- Remain open minded and agree not to pre-judge outcomes or contributory factors, giving fair consideration to all available information.
- Support an evolving process that will become sustainable and embedded in local culture.
- Uphold the key principles of cooperation and partnership to ensure that the programme of work affects meaningful change on reducing health inequality and increasing the opportunities for the experience of a 'good' death for people with a learning disability.

Purpose and Expected Outcomes.

It is expected that LeDeR reviews will deliver the following outcomes for the local population:

- Positive experience of the LeDeR process for bereaved families.
- Decreasing numbers of preventable deaths. Greater use of reasonable adjustments in health and care services for people with a learning disability and autistic people.

- Better outcomes for people as a result of local service improvement projects.
- Increased awareness of the main causes of death for people with a learning disability and autistic people among health and social care professionals, both locally and nationally.
- Improved data about the lives and deaths for people with a learning disability and autistic people.

Role of the STW LeDeR Governance Panel

- Receive a summary of anonymised 'Focused Review' case reports pertaining to deaths relating to people with learning disabilities or autistic people in order to contribute to a collective understanding of learning points and recommendations.
- To help interpret and analyse information submitted from local reviews, including areas of good practice in preventing premature mortality, and areas where improvements in practice could be made.
- To consider the recommendations made within completed Focused reviews, to agree the report quality and completeness and agree system or partner agency actions to be taken to ensure improvements in health outcomes and experience
- To agree priority actions based on the recommendations and themes of reviews and contributory factors that have the potential to make the greatest impact
- To require STW LeDeR Steering Group to focus on finding solutions and reporting progress with specific emerging priorities and issues.
- To gain assurance that action plans are being implemented and progressing

The responsibilities of the Panel include, but are not limited, to:

- Ensuring LeDeR governance is an integral part of ICS governance and quality reporting arrangements and is not stand-alone.
- The Panel will have final sign-off on reviews completed for the ICS and determine the actions to be taken as a result of reviews
- Helping interpret and analyse the data obtained from local reviews, including areas of good practice in preventing premature mortality, and areas where improvements in practice could be made.
- Identifying good practice locally and share this nationally via NHS England and NHS Improvement regional teams.
- Ensuring that LeDeR actions are reported on as part of routine quality assurance of the ICS and to the NHS England and NHS Improvement regional team.
- Identifying matters for escalation to STW System Quality Group (SQG)
- Ensuring agreed protocols are in place for information sharing, accessing case records and keeping content confidential and secure.

Panel members will review programme direction and make decisions to ensure that:

- They champion LeDeR's cause within and outside of their respective work areas.
- They work in partnership to support the success of the project and make sure that no single interest undermines the programme.
- Recording of programme information is accurate and coherent and shared with Panel members.
- The progress of the overall programme is monitored, and any necessary remedial action is timely undertaken so as to not hold up the project.
- All risks are assessed and managed well, putting in place actions and contingency plans for all high impact risks.

- Sufficient resources are available to complete LeDeR reviews for the ICS in line with the LeDeR policy.
- Members of the group are notified, as soon as practical, if any matter arises which may be deemed to affect development and delivery.
- They report to STW ICB LeDeR Steering Group

Membership

The LeDeR Governance Panel consists of a core membership which is representative of our LDA community as well as all health and social care partners in the Shropshire Telford & Wrekin system. Nominated delegates will be expected to attend all meetings, or, where not possible, send an appropriate deputy, and have decision making powers for the organisation they are representing.

Core Membership

- Family members who are carers or a family member who are experts by experience.
- People who have a learning disability and/or autism (appropriately supported).
- Local Area Contact (LAC) – who will have a key role in administering the panel.
- Senior Reviewers and respective reviewers as per the listed reviews on the agenda – service currently provided by NHS South, Central and West Commissioning Support Unit.

Representatives from:

- Each of the main acute NHS providers; SATH, SCHT, RJAH
- Mental health and community learning disability team providers; MPFT
- Ambulance service; WMAS – as required
- PCN representatives – as required
- Social care representative.
- Screening services – as required

Quorum

A minimum of the following representatives must be in attendance for a meeting of the Governance Panel to be considered quorate:

- Local Area Contact (LAC) or designated Deputy - Chair
- Expert by experience; patient, family, or carers
- Senior Reviewer and/or a relevant case reviewer
- Representatives from acute providers
- Representative from social care commissioning
- Representative from a community healthcare provider
- Representative from Telford & Wrekin Council
- Representative from Shropshire Council

If a meeting is not quorate, decisions may be taken however these will not be considered final until the absent core members have been made aware of these decisions and have approved them, in person or by email.

Panel Meetings

All meetings will be chaired by LeDeR LAC

Decisions will be made by consensus, i.e., members are satisfied with the decision even though it may not be their first choice.

Panel agenda minutes will be provided through administrative support within the ICS. This will include:

- Preparing agendas and supporting papers.
- Preparing meeting notes and information.

Frequency of Panel Meetings

Panel meetings shall be bi-monthly in the first instance with frequency reviewed at regular intervals to ensure meeting intervals is aligned with the number of reviews that require sign off. Where possible, meetings will be arranged at a time convenient to the majority of members and continue to maximise the benefits of agile working.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.051	Month 12 Financial Position

Executive Lead (s):	Author(s):
Claire Skidmore Director of Finance claire.skidmore@nhs.net	Laura Clare Deputy Director of Finance Laura.clare@nhs.net Angus Hughes Associate Director of Finance- Decision Support Angus.hughes1@nhs.net

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
N/A		

Executive Summary (key points in the report):

The CCG control total for 21/22 was a £9.984m deficit, the final actual position (subject to audit) against this plan is a deficit of £4.327m and therefore a favourable variance of £5.657m. In the main this is due to the receipt of significant non recurrent funding in year which the CCG and system have been unable to fully consume.

There has been a small overall deterioration in the overall variance to plan since M11 of £69k.

Recommendations/Actions Required:

The Governing Body is asked to :

- Note the M12 financial position against plan of £4.327m deficit. This value is subject to audit.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication?	Yes

1

	(If yes, please provide details of additional resources required). *Yes, financial cost pressures to the CCG are described throughout the report. Overall financial risk is highlighted in the Governing Body Assurance Framework. Sufficient staff resources to identify and deliver the required efficiency plan is crucial to the achievement of the required financial position.*	
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).* *Yes, implications to the financial position and longer term financial sustainability of the CCG are described throughout the report*	Yes
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).* *The CCG financial position contributes to the System wide performance discussions to ensure that the System sustainability financial plan is monitored. Key variances and risks to the System position are highlighted.*	Yes

Tables included in this report:

Introduction

1. The financial performance reported in this paper is for Month 12 – March 2022.

21/22 Financial Plan

2. Table 1 shows the CCG summary of both the H1 actual position against plan, the H2 plan submitted and the combined full year position.

Table 1: 21/22 Financial Plan

	H1			H2			TOTAL		
Plan	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Surplus/(Deficit)	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
CCG ledger position	(4,754)	(4,569)	185	(5,230)	496	(5,726)	(9,984)	(4,073)	5,911
NHSEI centralised adj - clawback HDP								(254)	(254)
System adj shown in CCG	6,005	0	(6,005)	0	0	0	6,005	0	(6,005)
CCG Total with System Adjustment	**1,251**	**(4,569)**	**(5,820)**	**(5,230)**	**496**	**(5,726)**	**(3,979)**	**(4,327)**	(348)

3. In H1 the system submitted a break even plan which required a £6m 'high risk adjustment' held with the CCG. After discussions with NHSEI the system submitted a deficit plan for H2 and therefore the risk adjustment is no longer required.

4. The CCG only control total for 21/22 is therefore a £9.984m deficit, the final 21/22 actual position against this plan is a deficit of £4.327m and therefore there is a significant favourable variance of £5.657m. In the main this is due to the receipt of significant non recurrent funding in year which the CCG and system have been unable to fully consume. This position also includes a post year end centralised adjustment from NHSEI for the net total clawback of HDP (Hospital Discharge Programme), COVID and WAF (Winter Access Fund) funding.

5. When taking into account the £6m system adjustment in H1, the overall CCG control total for the year including the system adjustment is a £3.979m deficit, our actual position including the system adjustment is therefore a deficit of £4.327m which is a £0.348m adverse variance to plan.

Summary Financial Performance

Financial Performance Dashboard

6. The CCG financial performance dashboard against its key targets is shown in Table 2.

Table 2: Financial Performance Dashboard - Key Indicators

Target/Duty	Target	Actual FOT	RAG
Statutory duty to break-even	Break-Even	£4.327m deficit	
Control Total (exc System adjs)	£9.984m deficit	£4.327m deficit	
Cash	<=1.25% of monthly drawdown	0.46%	G
Better Payment Practice within 30 days (Number of invoices)	>=95%	99.1%	G

7. The CCG did deliver its element of the full year system plan but still breached the statutory duty to break even.

8. The cash target is to have a cash balance at the end of the month which is below 1.25% of the monthly drawdown or £250k, whichever is greater. This was met for the CCG in Month 12.

9. The Better Payment Practice targets were also met in Month 12 as over 95% of invoices were paid within 30 days.

M12 Position

Table 3: M12 Financial Position

Category	M12 Budget	M12 Actual	M12 Variance
	£'000	£'000	£'000
Allocation			
Programme	867,089	867,089	-
Running Costs	9,685	9,685	-
Co Commissioning	79,228	79,228	-
HDP/ERF	25,720	25,720	-
Planned Deficit	3,979	3,979	-
TOTAL Allocation	**985,701**	**985,701**	-
Expenditure			
In System			
SATH	373,940	373,936	4
RJAH	53,605	53,606	- 1
SCHT	75,728	74,928	800
In System Total	**503,273**	**502,470**	**803**
Out of System			
Acute	78,296	78,486	- 190
Community	16,989	12,462	4,527
Individual Commissioning/Mental Health	160,070	167,905	- 7,835
Primary Care (ind delegated)	186,230	178,928	7,302
Other	37,165	35,889	1,276
Running Costs	9,683	9,656	27
Out of System Total	**488,433**	**483,326**	**5,107**
NHSEI centralised adjustment	- 254		- 254
TOTAL Expenditure	**991,452**	**985,796**	**5,656**
System affordability gap	- 6,005	-	- 6,005
TOTAL Expenditure post system gap	**985,447**	**985,796**	- **349**
DEFICIT	- **254**	**95**	- **349**

10. The final (subject to audit) 2021/22 financial performance is an overspend of £0.348m against the planned deficit of £3.979m, i.e. an overall £4.327m deficit. However, this includes the H1 system

affordability gap of £6.005m meaning that CCG performance reflects a favourable position against plan of £5.657m (£4.9m in non system spend and £0.8m SCHT).

11. There has been a small deterioration in the variance to plan since the M11 forecast of £69k.
12. The previously reported underspends on non recurrent allocations and non recurrent prior year benefits are offsetting the individual commissioning overspend which was flagged as a risk in both the H1 and H2 plan submissions.

13. After closing the financial ledger position, NHSEI notified the CCG that they would be actioning a final centralised adjustment in relation to HDP (Hospital Discharge Programme), COVID and WAF (Winter Access Fund) funding. For the CCG the net position on these three funding streams would be a £254k clawback. This has been factored into the position presented in this report.

14. Acute expenditure shows a small overspend of £0.2m. An overspend in the acute NCA position is partially offset with an underspend due to the delay in the start date of the neurology transfer and prior year benefits.

15. Community expenditure shows a £5.3m (£4.5m non system, £0.8m system) underspend mostly due to the underspend on non recurrent allocations from NHSEI reported in Months 10 and 11 and the Shropshire Community Trust contract underspend.

16. Across Individual Commissioning and Mental Health expenditure there is a total forecast overspend for the year of £7.8m. The overall cost pressure has been offset partially with prior year benefits. In M12 the CCG received a last minute allocation from NHSEI of £1.168m with a notification that this is to cover a backdated Funded Nursing Care (FNC) price increase from 1st April 2021 to cover covid pressures. Local information suggests the cost for the CCG will be £1.254m and this has been accrued into the position against this allocation. This is a non recurrent change for 2021/22. The Department of Health and Social Care have also recently announced an increase in the FNC rate for 2022/23 and that an additional allocation will be issued to CCGs to cover this cost. We are currently awaiting the details of the allocation and value.

17. The over spend in Individual Commissioning/Mental Health has increased by £2.8m since Month 11. £1.2m is a movement between categories of reporting due to £1.2m of coding corrections in Mental Health which has moved credit notes to the 'other' category of spend. The £1.6m actual increase in spend in Individual Commissioning since last month is due to the review of open appeals and retrospective decisions for open backlog assessments.

18. Primary care expenditure overall is underspent by £7.3m. The majority of this underspend is non recurrent and relates to the release of prior year benefits previously reported (£0.6m – QOF, £1.2m – Prescribing, £1.4m – PCN ARRS, £3.1m – GPFV, Covid expansion, Enhanced Services and premises), as well as an in year (£1m) underspend on ARRS (Additional Roles Reimbursement) in PCNs due to delays in recruitment. The overall improvement from M11 forecast is due to additional release of prior year benefits for Enhanced Services Locum costs and Premises.

19. Other expenditure shows a forecast £1.3m underspend. Underspends in the COVID budget (used to offset some of the COVID pressure in Individual Commissioning) and programme pay lines (due to vacancies) are partially offset with pressures around funding COVID related services through the Local Authority which are now forecast to be above the Hospital Discharge Programme (HDP) allocation for the system.

20. The ring fenced running costs spend is broadly in line with the allocation. In Month 12 some costs associated with the ICS have been re-coded to programme pay. Although the running costs expenditure for this year is contained within the envelope, this is due to a number of non recurrent benefits in 2021/22

including prior year redundancy provision reversals and vacancies in the early part of the year. There remains a significant underlying pressure on this budget moving into 22/23.

21. In year efficiency plans have delivered above the plan with savings of £7.165m. This is shown in Table 4.

Table 4: 2021/22 Efficiency Delivery

	£000's		
Programme Area	**Year Plan**	**M12 Actual**	**Variance**
Individual Commissioning	3136	4005	869
Primary Care	1759	2229	470
Running Costs	156	82	-74
Estates	131	197	66
Contracts	419	537	118
Other	139	115	-24
Total	5740	7165	1425

Sustainability and Underlying Position

22. The CCG continues to work with system partners and NHSEI on the development of the system sustainability plan and a full review of the CCG underlying expenditure has been undertaken to ensure that this is in line with the latest guidance and assumptions.

Conclusion

23. For 2021/22 the CCG has ended the year (subject to audit) with a deficit of £4.327m which is £5.657m better than the CCG plan of £9.984m deficit. In the main this is due to the receipt of significant non recurrent funding in year which the CCG and system have been unable to fully consume.

24. The CCG is working with the system on the 22/23 finance plan submission and a full review of the underlying expenditure presented within that plan in line with the latest guidance and assumptions.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.052	2022/23 Financial Plan Update

Executive Lead (s):	Author(s):
Claire Skidmore Director of Finance claire.skidmore@nhs.net	Laura Clare Deputy Director of Finance Laura.clare@nhs.net

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
N/A		

Executive Summary (key points in the report):

On 28th April 2022 the STW system made its 22/23 operational planning submission. The system submitted a planned 22/23 deficit of £38.1m, this is against a national target of break even. The CCG/ICB element of that plan is an £18.8m deficit but the CCG is also currently holding the system additional efficiency target of £7.9m, taking the overall CCG/ICB planned deficit with this adjustment held for the system to a total planned deficit of £10.9m.

CCG/ICB budgets have now been issued to budget holders on the basis of the 28th April plan submission.

NHSEI discussions continue and we have been informed that a resubmission of plans is required by 20th June 2022. There are therefore a number of key steps being worked through in the system finance action plan to continue to refine our assumptions/modelling and efficiency identification.

There is significant financial risk built into the plan and the system is also currently working through operational risks from schemes/pressures that have not been funded. The system investment panel is due to meet at the end of May/beginning of June (date to be confirmed) to consider prioritisation of the system list of pressures though at this time no funding is available to proceed.

Financial risks and mitigations for the CCG/ICB are highlighted in this paper as well as the best and worst case scenarios for the financial position if these were to materialise.

22/23 is also the first year that the system will move away from contracting under the 'payment by results' regime and will operate under the Intelligent Fixed Payment methodology. The first IFP management group meeting took place in April.

Recommendations/Actions Required:
The Governing Body is asked to : - **Note** the 22/23 planned CCG/ICB deficit of £18.8m - **Note** that budgets have been issued based on the submitted plan - **Note** that a further plan submission is required by 20th June

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).* *Yes, financial cost pressures to the CCG are described throughout the report. Overall financial risk is highlighted in the Governing Body Assurance Framework. Sufficient staff resources to identify and deliver the required efficiency plan is crucial to the achievement of the required financial position.*	Yes
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).* *Yes, implications to the financial position and longer term financial sustainability of the CCG are described throughout the report*	Yes
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *Reducing health inequalities is a key factor in the prioritisation process for system investments and cost pressures*	Yes
2.	To identify and improve **health outcomes** for our local population. *Improving health outcomes is a key factor in the prioritisation process for system investments and cost pressures*	Yes

3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *Quality, Safety and Sustainability are all key factors in the development of the system financial plan and prioritisation process*	Yes
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *Yes the system financial plan has been developed in full partnership with system providers as well as input from both local authorities and MPFT.*	Yes
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).* *The CCG financial position contributes to the System wide performance discussions to ensure that the System sustainability financial plan is monitored and delivered*	Yes

Tables included in this report:

Introduction

1. On 28th April 2022 the STW system made its 22/23 operational planning submission, this included a system financial plan. The STW healthcare system as a whole submitted a planned 22/23 deficit of £38.1m, this is against a national target of break even. The CCG/ICB element of that plan is an £18.8m deficit, but the CCG/ICB is also currently holding the system additional efficiency target of £7.9m, taking the overall CCG/ICB planned deficit with this adjustment held for the system to a total planned deficit of £10.9m.

Table 1: 22/23 System financial plan

Organisation	Recurrent 22/23 £m	Non Recurrent 22/23 £m	Planned 22/23 Deficit £m
SATH	(34.0)	10.7	(23.3)
RJAH	(3.8)	2.2	(1.6)
SCHT	(5.7)	3.4	(2.3)
CCG	(28.8)	9.9	(18.8)
Additional system efficiency	2.9	5.0	7.9
TOTAL	**(69.3)**	**31.2**	**38.1**

Final April plan submission and budgets

2. Budgets have now been issued to budget holders on the basis of the April plan submission. Budgets and phasing at a category level are shown in Table 2.

Table 2: CCG/ICB 22/23 Budgets

	As per plan submission			Phasing	
	Recurrent	Non Recurrent	Total	M1-3 CCG	M4-12 ICB
	£m	£m	£m	£m	£m
Allocations					
Programme	825.6	-	825.6	206.4	619.2
Primary Care Delegated	83.0	-	83.0	20.7	62.2
Running Costs	9.2	-	9.2	2.3	6.9
Health Inequalities	-	1.5	1.5	0.4	1.1
COVID	-	15.2	15.2	3.8	11.4
ERF	-	16.3	16.3	4.1	12.3
SDF	-	15.2	15.2	3.8	11.4
TOTAL	**917.8**	**48.2**	**966.0**	**241.5**	**724.5**
Expenditure					
System Providers					
SATH	- 348.8	- 12.5	- 361.3	- 90.3	- 271.0
RJAH	- 41.8	- 6.5	- 48.3	- 12.1	- 36.3
SCHT	- 71.2	- 4.3	- 75.6	- 18.9	- 56.7
TOTAL	- **461.9**	- **23.3**	- **485.2**	- **121.3**	- **363.9**
Non System Providers					
Acute	- 80.4	- 3.4	- 83.8	- 20.6	- 63.2
Community	- 13.2	- 1.2	- 14.4	- 3.6	- 10.8
Individual Commissioning/Mental health	- 167.7	- 5.7	- 173.4	- 42.6	- 130.8
Primary Care Non Delegated	- 100.4	- 3.3	- 103.7	- 25.9	- 77.8
Primary Care Delegated	- 83.0	- 0.9	- 83.9	- 21.0	- 62.9
Other	- 30.8	- 0.4	- 31.2	- 8.0	- 23.1
Running Costs	- 9.2	-	- 9.2	- 2.3	- 6.9
TOTAL	- **484.6**	- **14.9**	- **499.6**	- **124.1**	- **375.5**
TOTAL Expenditure	- **946.5**	- **38.3**	- **984.8**	- **245.4**	- **739.4**
CCG Deficit	- **28.7**	**9.9**	- **18.8**	- **3.9**	- **14.9**
System held adjustments	2.9	5.0	7.9	2.5	5.4
CCG deficit including system adjustments	- **25.8**	**14.9**	- **10.9**	- **1.4**	- **9.5**

3. The budgets include the CCG/ICB 1.6% efficiency programme savings of £7.3m and system transformation savings of £1.4m. £1m currently remains unidentified and £0.8m is deemed to be high risk in relation to running costs. The ICB AO is aware of the running cost pressure and is reviewing team requirements with the incoming ICB directors in order to develop an action plan with regards to managing running costs over time.

Table 3: 22/23 CCG/ICB Efficiency Plans

	Efficiency Value	Confidence in Delivery		
CCG Programme Area	**£000's**	£000's	£000's	£000's
CHC	3000		720	2280
Medicines Management	1781			1781
Out of Area Providers	150		150	
Corporate	2			2
Contracts	26		26	
Individual Commissioning	200			200
Running Costs	778	778		
Primary Care	315			315
Unidentified	1002	1002		
Total	**7254**	**1780**	**896**	**4578**
System Programme Area				
BTI PBJC	1079		1079	
BTI MSK	282		282	
Total	**1361**		**1361**	
Total Efficiencies	8615	**1780**	**2257**	**4578**

Risks and Mitigations

4. The plan submitted carries significant risk and at a system level additional financial risk of £40.5m was reported. For the CCG the total risk submitted and potential mitigation was a net risk of £11.9m. Since submitting the plan there have been some updates to the level of risk taking it to total of £14.9m and this is also shown in Table 4.

Table 4: CCG Risk and Mitigation

	Risk	Mitigation	Net Risk
	£m	£m	£m
Individual Commissioning- worst case scenario based on modelling options, potential to increase efficiency by a further £1m to offset	6.4	1.0	5.4
Potential contract risk	0.6		0.6
Vaccination team and assumed income	0.3	0.3	0.0
Current unidentified efficiency	1.0	0.0	1.0
Transport cost fuel increases	0.3	0.0	0.3
Funded nursing care price uplift	1.1	0.0	1.1
	9.6	**1.3**	**8.4**
COVID expenditure risk	3.5	0.0	3.5
Plan submisson risk	**13.1**	**1.3**	**11.9**
Updates since plan			
FNC risk removed - allocation announced	-1.1		**-1.1**
Risk added for community beds/discharge	2.8		**2.8**
Elective recovery funding risk	1.3		**1.3**
TOTAL Risk	**16.1**	**1.3**	**14.9**

5. Best and worst case scenarios using the extreme positions between risks and mitigations above show a range in the potential deficit position for the CCG shown in Table 5.

Table 5: Deficit Scenarios

Best Case Deficit	Most Likely Deficit	Worst Case Deficit
£17.5m	£18.8m	£34.9m

Intelligent Fixed Payment

6. As previously noted, the system will move to the 'Intelligent Fixed Payment' (IFP) arrangements in 2022/23 so that contracts within the system are no longer based on a traditional payment by results basis (PbR). Activity information will continue to be captured as it is important to monitor what our funding is buying. The distribution of funding allocated to system providers will be based on sharing the overall core system allocation split on an underlying cost basis. This means that the system deficit is shared across all system partners. The principles of IFP have been applied in the April plan submission to allocate an overall position to each organisation. The first IFP management group met at the end of April and all final documentation will be signed off at its May meeting. This documentation has been shared with the Finance Committee.

7. The IFP arrangements aim to move away from lengthy discussions around funding flows to focus efforts and incentivise behaviours to ensure that care is delivered in the right place (through changes in pathways) and that the use of system financial resources is maximised. The IFP will be deemed successful if the system is able to deliver on the agreed financial plan and that capacity has been created in teams to focus on pathway changes and cost reduction

Next Steps

8. Discussions are ongoing with NHSEI and we have recently been notified that there will be a further plan resubmission on 20th June 2022. There will also be some additional funding given to systems to cover inflationary pressures in terms of the tariff cost uplift factor, Funded Nursing Care, Better Care Fund and additional funding for ambulance trusts. We are awaiting details of the value of additional funding for STW but the funding will come with conditions to be met in the plan submission in June and is provided on the basis that the rest of the planning gap is closed and the system submits a break even plan. In the meantime a number of next steps have been agreed across the system which include:

- Working through 4 areas of review (action plan held by System CFO)
    - Plan build (ie testing the run rate, understanding the cost and income base)
    - Assumptions (ie testing assumptions for income, Elective Recovery Fund (ERF) earnings/clawback, impact of IPC guidance etc)
    - Investments (ie clarity about what level of cost pressure/investment we accept in our plan up front)
    - Efficiency and Productivity (ie have we maximised our opportunities here and are we confident in delivery plans?)
- Establishment of in-year monitoring to closely track performance against plan and allow early identification of any deviation. Areas of focus to include (but not limited to):
    - Covid costs
    - ERF/UEC impact on system
    - Efficiency and
    - Transformation programme delivery
- Rapid identification of SROs and programmes of work to concentrate on the £7.9m unallocated savings target.

Conclusion

9. Focus is now required on delivery of the plan that has been set and the efficiency and transformation programmes that have been included. We await guidance from the NHSEI national team regarding the plan resubmission in June but we are already carrying significant financial risk in the existing financial plan and attention needs to be given to delivering the existing system planning gap of £7.9m (£2.9m gap on system transformation savings and additional ask of £5m reduced costs).

10. For the CCG there also remains an unidentified efficiency of £1m and a high risk efficiency programme of £0.7m in relation to running costs which urgently need to be addressed.

Recommendations

11. Governing Body are asked to:

- **Note** the 22/23 planned CCG/ICB deficit of £18.8m
- **Note** that budgets have been issued based on the submitted plan
- **Note** that a further plan submission is required by 20th June

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.053	Annual Accounts 2021/22

Executive Lead (s):	Author(s):
Claire Skidmore Director of Finance claire.skidmore@nhs.net	Maria Tongue Associate Director of Finance – Financial Accounting, Planning & Reporting maria.tongue@nhs.net

Action Required (please select):									
A=Approval	X	R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
N/A		

Executive Summary (key points in the report):

- The audit of the 2021-22 annual accounts is underway and no material issues have been identified to date;
- A revised approval process is required this year for the approval of the final audited accounts prior to their submission on the 22nd June. Audit work will not be complete until the week of the Governing Body meeting leaving insufficient time for CCG Governing Body meeting review and sign off;
- Governing Body members are therefore asked to formally delegate this final approval to the Audit Committee who will meet on the 15th June to consider the final report from the CCG's external auditors.

Recommendations/Actions Required:

The Governing Body is asked to :

- Agree the delegation of the approval of the CCG's 2021/22 accounts to the CCG's Audit Committee at a meeting to be held on the: 15th June 2022.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No

2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).* *The CCG financial position contributes to the System wide performance discussions to ensure that the System sustainability financial plan is monitored. Key variances and risks to the System position are highlighted.*	No

Annual Accounts 2021-22

Introduction

1. The CCG's 2021-22 draft annual accounts were submitted to NHSEI on the 25th April. The audit process is now well underway, with the final audited accounts and annual report to be submitted by 9am on Tuesday 22nd June. The timing of Governing Body meetings this month has meant that the scheduled meeting falls outside of the window between audit closure and submission deadline and therefore alternative arrangements need to be made for the formal approval of the documents prior to the submission date.

The 2021-22 Accounts

2. The draft accounts were reviewed in detail by audit committee members at its meeting on the 20th April and no issues were raised regarding the content.

3. The audit of the accounts by the external auditors, Grant Thornton, is now well underway and is estimated to be completed by the 7th June. No material issues or concerns have been raised at the point of writing this report and a verbal update on progress will be given at the meeting.

4. Some minor presentational issues have been highlighted to date by Grant Thornton and agreed by management. These include the removal of some prior year figures in the Statement of Comprehensive Net Expenditure and the associated notes, and an amendment to the Going Concern statement in Note 1 of the accounts to include the issue of a Section 30 report by the auditors to the Secretary of State for Health in respect of the financial deficit.

Approval Process

5. The auditor's report in respect of its opinion on the financial statements and annual report (AFR), is not likely to be finalised until on or around the 9th June. These dates are in line with the agreed plan, given that the submission date is the 22nd June;

6. As the June meeting of the Governing Body is after the finalisation of the AFR, (i.e. week commencing the 13th June), members are asked to delegate full approval of the accounts to the Audit Committee;

7. An extraordinary meeting of the Audit Committee has been arranged to carry this out on the 15th June.

Conclusion

8. The audit of the annual accounts is underway and no material issues have been identified to date;

9. A revised approval process is required this year for the approval of the final audited accounts, prior to the submission on the 22nd June;

10. Governing Body members are asked to formally delegate this approval to the Audit Committee, who will meet on the 15th June.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held on 8th June 2021**

Item Number:	Agenda Item:
GB22-06.053	NHS Shropshire, Telford and Wrekin CCG Annual Report 2021/22

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Alison Smith Director of Corporate Affairs alison.smith112@nhs.net

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion	X	I=Information	

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
The Draft Annual Governance Statement 2021/22 was presented to the Audit Committee meeting in March 2022 for comment.	16th March 2022	D
The Draft Annual Report 2021/22 was presented to the Audit Committee meeting in April 2022 prior to submission to the External Auditor and NHS E/I	20th April 2021	D,A

Executive Summary (key points in the report):

Section 14Z15 of the NHS Act 2006 (as amended) requires clinical commissioning groups to prepare an annual report and annual accounts.

This report seeks to provide an update to the Governing Body on the development of the Annual Report 2021/22.

Annual Report 2021/22

The Annual Report, which includes the Annual Governance Statement is attached for consideration and comment by the Governing Body. There are some parts of

the content that are awaiting further information, and these have been highlighted in yellow.

A revised approval process is required this year for the approval of the final audited accounts and annual report, prior to their submission to NHSE/I on the 22nd June as audit work will not be complete until the week of the Governing Body meeting leaving insufficient time for CCG review and sign off any changes required to the content.

Governing Body members are therefore asked to note the content of the annual report and formally delegate final approval of the Annual Report to the Audit Committee who will meet on the 15th June to consider the final report from the CCG's external auditors.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation? Legal requirements are outlined above.	Yes
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:

NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to:

- To note the content of the Annual Report 2021/22 which includes the Annual Governance Statement 2020/21 and assure itself that the content of the Annual Report 2021/22, including the Annual Governance Statement 2021/22, is accurate and sufficiently reflects the position of NHS Shropshire, Telford and Wrekin CCG.

- To delegate to Audit Committee final approval of the Annual Report 2021/22 which includes the Annual Governance Statement 2021/22.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Annual Report and Accounts

2021-2022

Contents

Performance overview

Statement from Mark Brandreth

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

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

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

We have continued to try and be guided by our mission to ensure that everyone in Shropshire, Telford and Wrekin has the best possible health and healthcare through our planning, buying and monitoring of services. To do this, we have been led by our five key priorities: to reduce health inequalities, improve health outcomes, improve joint working with our local partners, to achieve financial balance, and to ensure that the health services we commission are high quality, sustainable and value for money.

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

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

This year we have further cemented our relationship with the voluntary sector. They play a huge role in ensuring our residents across Shropshire, Telford and Wrekin are able to

access the support that they need whether it's supporting them through long-term illness or helping them stay well at home for longer. Importantly though, they do so much more than this in terms of connecting residents and providing support. We are very grateful for their hard work.

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

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

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

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

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

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

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

Statement of purpose and activities of the CCG

This section of the Annual Report provides summary information on NHS Shropshire, Telford and Wrekin CCG – its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed over 2021/22.

About us

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

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

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

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

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

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

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

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

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

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

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

A governance structure chart is included on page 112 of this report for information.

Our mission statement and priorities

Mission statement

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

Strategic priorities

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

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

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

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

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

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

Population challenges

We serve a total population of around 487,000 people across Shropshire, Telford and Wrekin, who live in a large and diverse landscape of urban and rural areas.

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

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

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

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

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

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

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

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

Working with partners

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

leading on a number of initiatives with partners that are key to the delivery of ICS objectives. This has continued to be a key focus for us in 2021/22.

COVID-19

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

Locally, this has continued to solidify strong partnership working on a vast scale to ensure we had capacity to treat COVID-19 positive patients and also non-positive patients in the safest way possible.

All providers, commissioners, local authority and third sector partners have been working together to support those suffering from COVID-19, and also to prevent the spread of the virus by encouraging everyone eligible to be vaccinated. This meant ensuring local people were given accurate and up-to-date advice on how to keep themselves and their families safe.

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

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

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

Both HWBBs have a Health and Wellbeing Strategy in place.

Telford and Wrekin Health and Wellbeing Strategy

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

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

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

Shropshire Health and Wellbeing Strategy

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

- reduce health inequalities
- increase healthy life expectancy.

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

Shropshire Council and Telford and Wrekin Council

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

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

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

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

NHS Midlands and Lancashire Commissioning Support Unit

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

2021/22 financial position

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

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

All organisations agreed to:

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

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

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

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

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

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

COVID-19 expenditure

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

The breakdown of this is as follows:

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

The majority of the CCG's 'general' COVID-19 allocation for the first half of the year (H1) and second half of the year (H2) was transferred to the three system providers: The Shrewsbury and Telford Hospital NHS Trust, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and Shropshire Community Health NHS Trust.

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

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

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

Community health services

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

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

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

EU exit funding

The CCG received no funding in 2021/22 in respect of EU exit costs and incurred no expenditure.

Adoption of going concern basis

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

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

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs. Should the Bill be passed the CCG functions, assets and liabilities will therefore transfer to an ICB, (NHS Shropshire, Telford and Wrekin Integrated ICB).

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

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

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

Although the financial position of the CCG and the issue of a Section 30 referral letter to the Secretary of State for Health in relation to the CCG for 2021/22 indicates some uncertainty over the CCG's ability to continue as a going concern, the Governing Body, having made appropriate enquiries, have reasonable expectations that the CCG will have adequate resources to continue in operational existence for the foreseeable future both as a CCG and as its successor organisation, the ICB .

Further, the CCG has submitted its 2022/23 financial plan covering the 3 months that the CCG will still be in operation and the 9 months once the ICB has been established. This plan is based on the allocations notified by NHSEI for the full financial year of 2022/23.

Performance dashboard

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

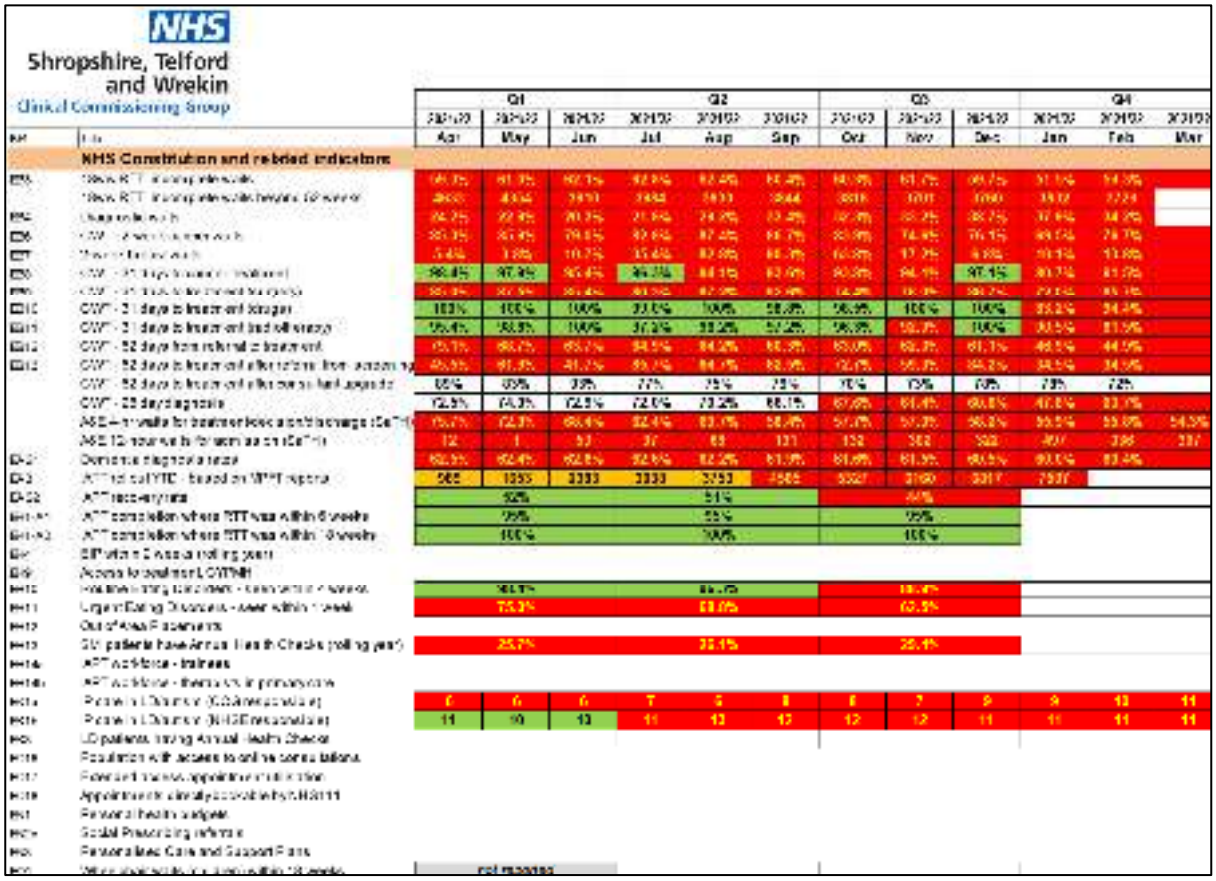
Operational performance for 2021/22 continues to be significantly impacted by the need to deal with the COVID-19 emergency. This has meant continued reductions in some areas of planned and emergency activity and the cessation of reporting on some key indicators. There are a number of key performance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

In unscheduled care the system has been very dynamic in managing patient flow to include early diagnostics for breast screening, right care first time with the single point of referral (access), the rapid implementation of the two-hour community response and advanced care planning for our patients with long term complex needs. A critical piece of work has also been implemented across the system with modelling different scenarios for reducing productivity, this modelling identifies opportunities and risks associated with the long-term management of our patient journeys.

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

COVID-19, the local health system has coped well with the COVID-19 emergency in 2021/22 and has endeavoured to maintain critical services as much as possible with dynamic deployment of capacity (workforce and workspace). The system is forever learning how it needs to respond to mitigate the risk to the wider healthcare environment.

The CCG year-end performance is as follows:



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

Standard	Performance
Referral to Treatment (RTT) for non-urgent consultant-led services: Incomplete patients to start treatment within a maximum of 18 weeks from referral	At the end of March 2022, we achieved 60% which has remained stable throughout 2021/22. Performance was impacted particularly at SaTH by the impact of COVID-19 and the loss of capacity for elective care and at RJAH by a pause in the elective admissions to allow staff to be seconded to SaTH to assist in critical care due to the COVID-19 surge. In addition, staff have been seconded to assist in the delivery of a successful local COVID-19 vaccination programme.
Number of 52-week RTT pathways (incompletes): Zero tolerance of over 52-week waits	At the end of March, published figures showed 4083 Shropshire patients had been waiting over 52 weeks for treatment. Waiting list backlogs will be addressed taking full account of clinical priority to recover the numbers waiting. The plan is to have zero patients waiting 104 weeks for elective care by July 2022 and zero patients waiting 78 week waits by April 2023. We have commissioned support with mutual aid from the independent sector and nationally the NHS.

	The system transformation work is expected to yield efficiencies that will help with recovery of long waits by preventing unnecessary face to face appointments for patients.
Diagnostic waiting times: Patients waiting for a diagnostic test should have been waiting fewer than six weeks from referral	Waiting times for diagnostic tests have not been achieved regularly throughout the year and were at 38.7% in March. We have responded to the recovery by holding clinics outside of the current operating model, and have received funding for a Community Diagnostic Hub that will come on line during 2022. Performance has increased in Q4 across the system as a result of targeted local actions.
A&E waits: Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	It's been a difficult year in managing the complexities of the COVID pandemic, the emergency departments have seen increased staff absences and a decreased flow through the hospital. There has also been a 58% year on year increase in the number of patients self-presenting with no contact to NHS 111 or other services prior to arrival. Despite the increase we have maintained the performance for patients being dealt with less than four hours. Improvement plans at SaTH are focused around increasing productivity throughout the hospital to achieve quicker progress through A&E and earlier discharge, to reduce ambulance conveyances by developing alternate options other than A&E and implementing national recommendations around "Same Day Emergency Care" (SDEC). Work continues with appropriate signposting of the public to NHS 111 to encourage patients to use other appropriate alternative services. Infection control measures, which were enhanced due to covid, have begun to return to pre covid standards This will contribute to increased throughput of patients which will help recover the position in overall performance.
Cancer waiting times: First outpatient appointment for patients referred urgently with suspected cancer by a GP	Performance remains challenged due to balancing resource and loss of treatment capacity arising from the impact of COVID-19. Challenges continue to exist across staffing capacity for all tumour types. There is a national shortage of radiographers which is having an impact locally. Recovery in breast screening continues to be of concern and we are working with NHS England to rapidly improve the position. There has been an increase in the number of patients being referred for breast pain. The system has responded by commissioning additional community-based services. The evidence would suggest that there is unknown demand that we are unable to quantify at this time as there are of patients that have not presented or presented late due to the pandemic. The

	CCG is actively reaching out to our local communities to encourage patients to contact their GP if at all concerned. The CCG is one of eight systems working with the West Midlands Cancer Alliance on a three year trial in early diagnostic and intervention with identifying cancer with a simple blood test.
Category 1 ambulance calls: Category 1 calls to have an average emergency response within seven minutes and reach90 per cent of calls within 15 minutes	The CCG has not achieved the targets locally during 2021/22 in category 1 responses. For calls in categories 2 the performance deteriorated in the second part of the year as seasonal activity combined with staffing absences relating to COVID-19 impacted on ambulance waiting times. We have restoration plans to help recover Category 1 and 2 performance in 2022/23 to improve waiting times.
Mental health and primary care indicators	The restoration of services in Primary Care has seen an in year increase of 24% in face to face appointments with the addition of maintaining virtual appointments where appropriate. The CCG has an improving performance in achieving annual health checks for people with a learning disability and dementia assessment rates over 2021/22. Numbers of people presenting to the improving access to psychological therapies (IAPT) services has now restored to 2019/20 levels. The system is now responding to the demand in recovery of the services following the pandemic. In 2021/22 we have invested in improving services for Children and Young people in mental health crisis.

Performance analysis

Primary care

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

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

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

Primary Care Networks

The CCG has 51 GP practices across four localities (North Shropshire, South Shropshire, Shrewsbury and Atcham, and Telford and Wrekin), which are all linked to one of eight PCNs:

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

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

These include:

- **extended access**
- **structured medication reviews** supported by the CCG Medicines Management team
- **Enhanced Health in Care Homes:** provide a lead GP for each care home, create a simple plan with local partners as to how the care home multidisciplinary team will operate, introduce a weekly home round, building on the work from 2020/21 to establish a Care Home Enhanced Support team; development work has continued on a system approach to support care homes with integration into the work on anticipatory care
- **early cancer diagnosis** including review of the referral practice for suspected cancers
- **social prescribing and care co-ordination**

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

We have continued to support PCNs to develop their workforce plans to progress recruitment into new roles that are part of the Additional Roles Reimbursement Scheme (ARRS). Clinical pharmacists, social prescribing link workers, first contact physiotherapists and mental health practitioners have been the main roles to be recruited to this year, with over 120 ARRS-funded staff now in post.

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

Access to general practice

There has been media coverage nationally and locally in 2021/22 about patient concerns about not being able to access their local GP surgery in a timely way, particularly regarding accessing face-to-face appointments.

Compared to pre-pandemic, general practice has seen an increase in the number of calls requesting appointments and the range and type of appointments offered. The levels of increased demand and the infection prevention and control restrictions resulting from the pandemic have created challenges for primary care locally and did impact detrimentally on some patients' experiences.

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

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

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

Our local schemes included:

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

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

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

Primary care workforce

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

- continued involvement in the system-wide vaccination workforce group, enabling over 300 practice staff, CCG staff and locums to join the STP workforce
- supporting 20 newly qualified GPs and one newly qualified general practice nurse on the NHSEI funded Fellowship Programme across the Shropshire, Telford and Wrekin footprint
- seven GP mentors supported to deliver mentoring sessions to colleagues
- continued funding for newly appointed GPs, providing support for GPs in the early part of their careers
- an enhanced Training Hub across the Shropshire, Telford and Wrekin footprint has enabled the delivery of a number of training programmes, including continuing professional development (CPD) for around 240 general practice nurses.

Primary care estate

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

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

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

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

Blood taking (phlebotomy) in primary care

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

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

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

Cancer care co-ordination

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

Home blood pressure monitoring

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

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

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

Veteran-friendly practices

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

Digital

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

These include:

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

Learning disability annual health checks

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

Despite the challenges of COVID-19, practices exceeded the annual target of at least 67 per cent of people on learning disability registers receiving an annual health check before the end of March 2021 by reaching a total of 77 per cent.

Transformation and commissioning

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

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

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

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

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

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

These areas, described in more detail below, include:

- Urgent and Emergency Care Transformation
- Mental Health Transformation, including mental health, dementia, learning disabilities and autism
- Children and Young People's Services Transformation
- Outpatient Transformation
- Elective Care Transformation and Recovery
- Cancer Transformation
- Eye Care Transformation
- Musculoskeletal and Pain Transformation
- Community and Local Care Transformation.

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

- Digital Transformation
- Workforce transformation
- Hospital Transformation
- Estate and Space Transformation.

Urgent and emergency care transformation

Integrated urgent and emergency care – NHS 111 First

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

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

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

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

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

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

Reducing Delayed Discharges

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

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

The outcome of these events included:

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

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

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

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

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

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

Shropshire Community Trust – Urgent Community Response Teams

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

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

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

People who receive this service tell the teams that they really valued being able to stay in their own with their loved ones around them whilst they were unwell.
We are currently in the process of rolling out the full urgent care response service across Shropshire. This will ensure that there is the ability to respond to a national set of clinical conditions from 8am to 10pm, 365 days a year.

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

Royal Shrewsbury and Princess Royal Hospital – Same Day Emergency Care

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

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

Mental health, learning disabilities and autism

Adult mental health

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

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

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

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

Increasing investment means that we now have:

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

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

Dementia

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

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

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

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

Children and young people (CYP)

CYP Mental Health Long Term Plan

The Shropshire, Telford and Wrekin Transformation Plan for Children and Young People's Mental Health and Wellbeing have been refreshed in 2021. This report details an update since 2020, areas where improvements have been made and where services and plans are being developed to meet the actions.

Areas of improvement include:

- Increase in early intervention mental health via programme such as Anna Freud across the county schools, the mental health trailblazer in school service
- Improved communications and understanding of what is available around mental health on both council websites
- No waits for mental health services over 18 weeks. Children and young people referred to BeeU Access are triaged within one week and contacted by service within four weeks, but usually within two weeks. The only pathways that have CYP waiting over 18 weeks is autism spectrum disorder (ASD) diagnosis
- Shropshire's recent Special Educational Needs and Disability (SEND) inspection concluded in a written statement of action. One of the areas of concern is 'Significant waiting times for large numbers of children and young people on the ASD and attention deficit hyperactivity disorder (ADHD) diagnostic pathways'. An ASD diagnostic team within Midlands Partnership NHS Foundation Trust (MPFT) has been in place since September 2020. When they started there were more than 300 on the waiting list across the county, they are now working through this list and all CYP will have started their assessment by the end of April 2021. It is then envisaged that all CYP will start their assessments within 12 weeks of referral – as per National Institute for Health and Care Excellence (NICE) guidance
- All children and young people in crisis are triaged within four hours and seen by the crisis homecare team within 72 hours. This meets the national target
- Since January 2021, a 24/7 crisis care for children and young people ran by MPFT has been in place with increased funding from mental health transition monies.

Areas still under development:

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

System Governance

During 2020/21, a children and young people workstream has been developed. The key elements include:

- The development of a recovery, restoration and 'new normal' governance structure within the health and care system has highlighted a need for a stronger CYP voice
- The foundations of a healthy and fulfilled adult life are laid in childhood and adolescence
- There are some excellent examples locally of partnership working to support improved outcomes for CYP
- There are many components and services that are interdependent and explicitly linked to each other underpinning successful outcomes for the CYP and their families
- An initial group met in June 2020 to discuss appetite, benefits and barriers. The group has met monthly since October 2020
- It is proposed a CYP pathway group will pull together and co-ordinate the elements of the CYP service across the health and care system
- Short, medium and long-term actions have been developed to demonstrate commitment to getting this right.

The aims of the group are to:

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

Future work for 2022/23

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

Community physical health

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

- CYP therapies
- Child Development Centres
- Wheelchair services
- Children community nursing service
- Paediatric psychology
- Community paediatricians

- 0-19 healthy child programme.

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

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

Personalised care

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

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

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

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

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

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

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

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

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

These projects have been complemented by a package of workforce training which has reached across our local healthcare system as well as our voluntary sector and health and wellbeing practitioners. All commissioned training was accredited by the Personalised Care Institute and promoted shared decision making, health coaching and motivational interviewing.

SEND (Special Educational Needs and Disability)

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

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

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

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

The full WSOA is available online.

Learning from COVID-19

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

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

The main elements which the group felt were invaluable were:

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

Learning disabilities and autism

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

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

Elective care transformation and recovery

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

These include:

- Addressing health inequalities
- Increased used of Advice and Guidance (and conversion to prevented face to face appointments)
- Virtual consultations (and conversion to prevented face to face appointments)
- Patient-initiated follow-ups (and conversion to prevented face-to-face appointments)
- Improved capturing and reporting of the above in system data.

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

Shropshire, Telford and Wrekin ICS was chosen as an early pilot for the first three specialties (ear, nose and throat (ENT), orthopaedics and ophthalmology) including the use of elective hubs (where possible) and innovation around surgical areas of 'High Volume, Low Complexity' activity, theatre utilisation and efficiencies, and improved and streamlined pathways.

A second phase has recently commenced with the expansion to urology, gynaecology and general surgery. The whole programme is clinically-led and the local system has had to select clinical leads for each specialty.

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

- Clinical outcomes
- Equity of access (clinical priority and waiting times)
- Theatre and Outpatient productivity
- Improved patient and staff experience.

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

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

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

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

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

- MSK
- ENT
- Ophthalmology
- Gynaecology
- General Surgery
- Urology.

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

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

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

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

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

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

- Improved utilisation of secondary care resource – physical space and clinical time
- Optimised use of shared information and improved pathways
- Improved clinical outcomes through patients receiving expert advice more quickly and follow ups based on clinical need – rather than arbitrary schedules
- Improved co-ordinated care for patients with multiple conditions
- Improved patient experience through improved timely access to the right service, more informed and more empowered
- Better use of patients' time through preventing what may be unnecessary trips to hospital
- Improved environment through reduced journeys to hospital therefore reduced CO2 emissions – reduced environmental damage and risk of preventable deaths through air pollution
- Financial efficiency to patients through not having to travel, and to the system through improved efficiency and utilisation of existing resource.

Outpatients Transformation

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

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

The scoping, baseline data modelling and analysis, and preparatory work is complete with the aim of commencing this programme of work with engagement and involvement sessions from November 2021, although as a recovery requirement, Patient Initiated Follow Ups went live earlier in June 2021 for three specialties.

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

Cancer

Improving cancer pathways continues to be a priority and is at the heart of the ICS approach to recovery of cancer services. Key actions have been undertaken during the last 12 months include:

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

- Work continues with restoration of 62-day performance and the delivery of the faster diagnosis standard
- The rollout of a non-site specific pathway has been delayed whilst a Clinical Lead is appointed, and the deadline for this is now 2024 (previously 2022)
- Living Well sessions continue virtually and SaTH is developing a Health and Wellbeing App to help further support cancer patients in other ways
- Rollout of Faecal Immunochemical Testing (FIT) for all colorectal urgent suspected cancer patients from 1 April 2022
- A project in its early stages, to develop a pilot for the use of tele-dermatology as a first step towards having this provision across the county. This would help with the effective and efficient triaging of suspected skin cancer referrals and significantly reduce the need for face-to-face appointments in the hospital
- Community Breast Pain Clinic established in November 2021 to provide care closer to home in a non-acute setting whilst protecting capacity for more urgent suspected cancer patients.

Eye care transformation

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

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

The phases of the programme will cover:

- Rethinking referrals and Integrated Pathways (primary, community and secondary care)
- Outpatient transformation
- Multispecialty pathways (i.e. Giant Cell Arteritis and Hydroxychloroquine Monitoring).

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

- General outpatient eye care services
- Children's eye care services
- Urgent eye care services
- Glaucoma
- Cataract
- Medical retina
- Macular degeneration
- Sight loss access to services.

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

After the Shropshire, Telford and Wrekin system agreed to be an early adopter and one of the 11 ICSs in the Midlands, and with the NHSEI Midlands Procurement of software underway, we are moving ahead earlier with one aspect of eye care transformation which is the rollout of electronic eye care referrals. The project plan is currently being developed with NHSEI colleagues and will involve stakeholders, GPs, patients and public. The project will see an improved flow of direct referrals between optometrists, RAS and TRAQs, GPs and secondary care with the ability to transfer high resolution digital images directly from optometrists to secondary care consultants, and enabling effective virtual consultations to take place without the need for the individual having to visit hospital.

Musculoskeletal (MSK) transformation

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

The services currently in scope of this work are:

- Referral and triage (SOOS/TEMs)
- Therapies
- Orthotics
- Pain Services
- Rheumatology
- Surgical services
- Delivering recovery of the COVID-19 backlog of patient care without additional resource
- Workforce planning.

The objectives of the programme are:

- Delivering good outcomes and patient experience
- Achieving outstanding patient safety
- Providing timely access to patient care
- Spending our money wisely
- Patients are cared for by the right person, at the right location at the right time
- Improve citizens' MSK and pain health.

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

The MSK transformation programme is phased as follows:

- Phase 1 (Year 1) – Strengthening of rheumatology

  - Consolidation and standardisation of Community MSK Provision)
- Phase 2 (Years 2 and 3) – Optimisation of Orthopaedics
  - Outpatients improvement project (aligned to the transformation programme)
  - Pain services
  - Maturing of system provision to support primary care
  - Falls, fractures and osteoporosis (dependent on decision on trauma scope)
  - A decision to be made by quarter 4 2021/22 whether trauma will be in scope for the programme
- Phase 3 (Years 4 and 5) – Supporting those with long-term MSK conditions
  - Development of self-management models.

Local care and community transformation

System changes

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

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

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

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

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

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

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

As the structure of the ICS developed over 2021, the National Ageing Well Programme which included the previous model of the Care Closer to Home Programme was realigned under the umbrella of the Local Care Transformation Programme. This programme of work is linked to two place-based programme boards the Shropshire Integrated Care Partnership Programme (SHIPP) and Telford and Wrekin Integrated Care Partnership Programme (TWIPP).

Telford and Wrekin Integrated Place Partnership (TWIPP)

Telford and Wrekin Integrated Place Partnership (TWIPP) was established in 2019 as a partnership board between the Clinical Commissioning Group, Telford and Wrekin Council, local health care service providers and representatives from the Primary Care networks.

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

1. Integrated care and support pathways
2. Integrated advice, information and access to support
3. Building community capacity and resilience
4. Integrated response to tackling health inequalities
5. Prevention and healthy lifestyles
6. Maintaining the identity of Telford and Wrekin whilst supporting the system.

Key achievements against our shared priorities

- Delivery of the COVID-19 vaccination programme as a combined health and social care programme using real-time data from primary care to assist in directing vaccination activities to areas of lower uptake, including using outreach methods to more fully engage with our communities
- In regard to prevention and healthy lifestyles, the local authority has launched the ‘Year of Wellbeing’. The CCG has launched an NHSEI digital weight management offer via primary care for those with hypertension and diabetes as part of a system-wide approach. This is connected into the wider pathways and assistance available from local authority healthy lifestyle advisors and as part of our strength-based assets approach within communities for adopting healthier lifestyles. In addition, during 2021/22 there has been a programme of work to introduce NHS-funded tobacco prevention in acute inpatient settings and further development of the tobacco prevention model in maternity. Shrewsbury and Telford Hospital NHS Trust have also been successful in securing funds for an alcohol care team to deliver inpatient services at the Princess Royal Hospital. Shropshire Community Health NHS Trust have commenced the implementation work for the community diagnostic hub in Telford

- Telford and Wrekin Council have opened the independent living smart house to showcase technology that supports people at home as well as support skills and means of digital access
- COVID-19 has impacted on the scale of the transformation planned within respiratory and diabetes services as clinicians' input has been reduced due to operational pressures, however during 2021/22 the respiratory services have developed and refined their models of in reach and duty nurse role to assist more individuals receive care in their own homes
- The Integrated Health and Social care team have continued to provide a valued service over 2021/22 and the care home team element of our community services have continued to develop advanced care planning documentation and processes to support individuals in receiving care in their own environment
- TWIPP have also contributed to the development of the system-wide Dementia Strategy and reviewed how mental health can connect more closely into the TWIPP work as we develop our governance structure as part of the transition to an integrated care system
- As part of our integrated response to health inequalities, we have established joint working groups to look at addressing inequalities around cancer access and outcomes and in the detection and management of hypertension. This will build on the learning from the vaccination programme and will be in partnership with our primary care colleagues
- Working with our partners in the voluntary and community organisations, a programme of work has commenced to co-produce the development of the Telford Ageing Well Strategy which will seek to address at place level the particular challenges of the rapidly ageing population in Telford.

Find out more about TWIPP.

Shropshire Integrated Care Partnership Programme (SHIPP)

Shropshire Integrated Place Partnership (SHIPP) is a Partnership Board of commissioners, providers of health and social care, the voluntary and community sector and involvement leads, in Shropshire.

The Board focusses on objectives and outcomes, not organisations. It is a partnership of equals with shared collaborative leadership and responsibility, enabled by the ICS governance and decision-making processes.

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

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

SHIPP has six key priorities:

7. Health and Wellbeing – including Children and Young People's Strategy, encouraging healthy lifestyles and mental health

8. Community capacity and resilience with the voluntary sector
9. Local care and personalisation
10. Supporting the Primary Care Networks
11. Integration and One Public Estate
12. Tackling health inequalities.

Key achievements against our shared priorities

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

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

We provided grant funding to bolster the voluntary and community sector infrastructure, including volunteer brokerage, VCSE development, community development, mental health and data and evaluation.

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

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

For local care, we have expanded rapid response across Shropshire and implemented a new Case Management and Community Respiratory pathway.

To help tackle health inequalities, we developed a Shropshire Inequalities Plan, secured NHSE funding to launch a Shropshire, Telford and Wrekin system Cancer Champion project, which will be delivered by the voluntary and community sector. We also supported Primary Care Networks to deliver further inequalities projects.

Local Care Transformation Programme

Working in collaboration with the CCG and local providers, the Local Care Transformation Programme is led by the Shropshire Community Health NHS Trust.

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

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

The programme also completed phase one of the Respiratory Transformation Programme which sees the Community Services team working more closely with the hospital team to support early hospital discharge and to avoid unnecessary admission to hospital.

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

- Ageing well
- Anticipatory care
- Integrated therapies
- Virtual Wards.

Palliative and end of life care

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

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

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

Shrewsbury Admission Avoidance / Rapid Response Team

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

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

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

The funding enabled:

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

The project taking what was the pilot of an Admission Avoidance service until whole county rollout of a community-based Rapid Response service is now being implemented. Governance is managed at a local level within Shropshire Community Health NHS Trust, Telford and Wrekin Council, Shropshire Council, and feeds into the Local Care Programme and system structures.

Other

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

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

Work is also underway to commence a review and redesign of audiology services in the county, including ear irrigation.

Future plans not yet developed include the need to review and redesign cardiology, dermatology and irritable bowel services.

Medicines optimisation

Medicines optimisation looks at the value that medicines offer, making sure they are clinically- effective (that they improve outcomes for the person taking them) and cost-

effective (that they represent good use of NHS resources). It is about ensuring that people get the right choice of medicines, at the right time and are engaged in the process by their clinical team (shared decision-making).

The goal of medicines optimisation is to help patients:

- Improve their outcomes
- Take their medicines correctly
- Avoid taking unnecessary medicines
- Reduce waste of medicines
- Improve medicine safety.

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

COVID-19 response

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

Medicines optimisation clinical projects

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

- **Wound care**. A wound care management formulary was finalised for use across the local health economy in Q3 21/22 and formally launched in April 22, following a short delay in the launch event due to redeployment and the COVID-19 vaccination booster programme. The medicines management team supported the implementation and roll out of this formulary along with the development of a wide range of supporting clinical pathways to ensure appropriate use of wound care products, including use of antimicrobial pathways and negative wound pressure therapy (NWPT).

- **Respiratory.** Working with clinicians in SaTH and Shropshire Community Health NHS Trust, the COPD treatment guideline was updated to reflect the latest evidence-based guidance for the treatment of COPD (NICE). Inhaler choices for this

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

A clinical focus project for COPD was conducted across all practices in STW to level-up previous work undertaken across most Shropshire practices, providing opportunity for a clinical catch-up programme across Primary Care. The project involved optimising inhaler therapy in COPD patients, reducing inhaled corticosteroid prescribing where appropriate/optimising triple therapy. This movement has been reflected by changes in prescribing data, with reduced inhaled steroid prescribing and increased uptake of triple therapy. Optimisation of treatment was to reduce harm from inappropriate steroid use and prevent further decline of patients with poorly controlled COPD, which may lead to hospital admission. This was particularly important during COVID-19 to keep patients out of hospital and reduce the need for GP practice visits.

- **Cardiovascular disease (lipid management and atrial fibrillation)**
  Work to support the NHSE long-term plan in reducing cardiovascular deaths:
  A cardiovascular focus project was conducted across Primary Care, focusing on AF and the optimisation of anticoagulation management in these patients to reduce stroke risk. Patients' therapy was reviewed by practices across Primary Care and optimised in line with the new NICE AF management guidance. A lipid management project has also been running alongside this, ensuring patients with high risk of cardiovascular events are appropriately treated and optimised to reduce the risk of further CVD events.

  Guidance and searches were developed by the team (alongside secondary care) to support these projects, along with a training programme run in conjunction with local clinicians and the WMAHSN.

  The medicines management team have also established a working group with specialist cardiologist and lipidologist leadership, to focus on lipid management and develop a system approach to support the implementation of inclisiran and reduce health inequalities.

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

  - Vitamin D
  - Dry eyes
  - Vitamin B

Medicines optimisation in care homes

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

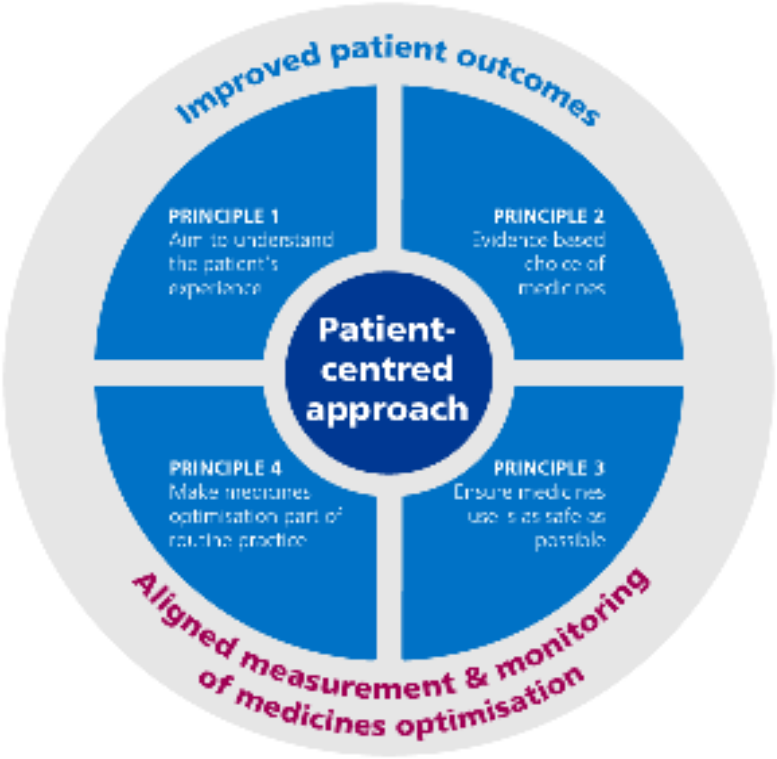
The rolling training programme for care homes has been progressed to an online learning resource offering a blended learning approach throughout Covid-19. Nine modules have been added to the Learning Management System available to all care settings, including Antimicrobial Resistance and Medicines Management in Care and a task group has been developed to create STOMP, medicines reconciliation and error training. Throughout a very challenging time for care homes training attendance was still high, with five Medicines Management in Care training sessions delivered in collaboration with local authorities and Shropshire Partners in Care, covering 20 organisations with 80 delegates attending, plus the organisation of a medicines assessor's workshop with 20 delegates attending.

Medicines formulary

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

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

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



Prescribing support systems (Scriptswitch in Shropshire and Optimise Rx in Telford)

Scriptswitch, since its inception in Shropshire in 2015 and Optimise Rx in Telford since 2019, have been continually developing to ensure that safety and savings messages remain current, strengthening engagement with practices. This year has been no exception, with savings of £424,000 for Scriptswitch and £274,000 for Optimise Rx exceeding both the planned target figures. Information and safety messages have been updated, which has been key to respond to COVID-19 developments.

This year a procurement process following the SBS framework, has taken place to move to one prescribing support system. An evaluation panel assessed the two current systems used across STWCCG and have made the decision that Scriptswitch will continue their contract and cover all practices from the 1st June 2022. Scriptswitch already has more than 9,000 messages on the system with weekly updates which will be rolled out to all practices. Additional improvements include the integration and roll out of the Eclipse system support tool within Scriptswitch to alert practices to high-risk prescribing. This has had positive feedback and will, moving forward, become an integral safety system within GP practices

ECLIPSE – Patient safety

Eclipse Live provides a suite of Radar Admission Avoidance Alerts which identifies patients that fall within a prescribing safety risk category. These risk categories capture the

latest 'UKMI Drug Monitoring in Adults in Primary Care' suggestions and NICE current best practice. The suite of alerts is a risk stratification system which can be utilised to help identify patients who may be at an increased risk of harm from medicines.

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

At the 20/21 National Eclipse awards ceremony, STWCCG achieved national recognition winning 3 awards for High-Risk Drug monitoring (Azathioprine, Methotrexate & Warfarin).

Formulary and medication switches/ cost-effective prescribing

Cost-effective medication switches across Shropshire, Telford and Wrekin were impacted by redeployment due to COVID-19, however still exceeded planned target QIPP figures. To further support our cost-effective prescribing programme and realisation of efficiencies in prescribing across the system, we implemented the Accelerate cost effective prescribing programme, working with Optum. This programme allowed medication switches to be performed quickly to realise efficiency savings over a short time period, maximising in-year savings opportunity whilst team capacity was low.

Antimicrobial resistance

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

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

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

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

Improving patient safety

The medicines management team works with all local providers in order to promote the

safe use of medicines. This includes conducting audits of the prescribing and monitoring of potentially High-Risk Drugs, providing advice and guidance on appropriate use of medicines, cascading drug warnings and safety information to providers and promoting and sharing learning from reported medication incidents.

System oversight is provided by the Medicines Safety Group which is made up of the Medicines Safety Officers from the provider organisations and representatives from primary care; Local Authority Social Service Dept and the care home sector. The MSG receives summary reports from all the providers and considers whether medicines safety themes are emerging from routine medicines incident reporting. The following three medicine classes warrant a more proactive planned approach to safety monitoring – the anticoagulants: valproate in pregnancy prevention programme and high dose opioids, a collaborative approach across all our NHS providers is underway.

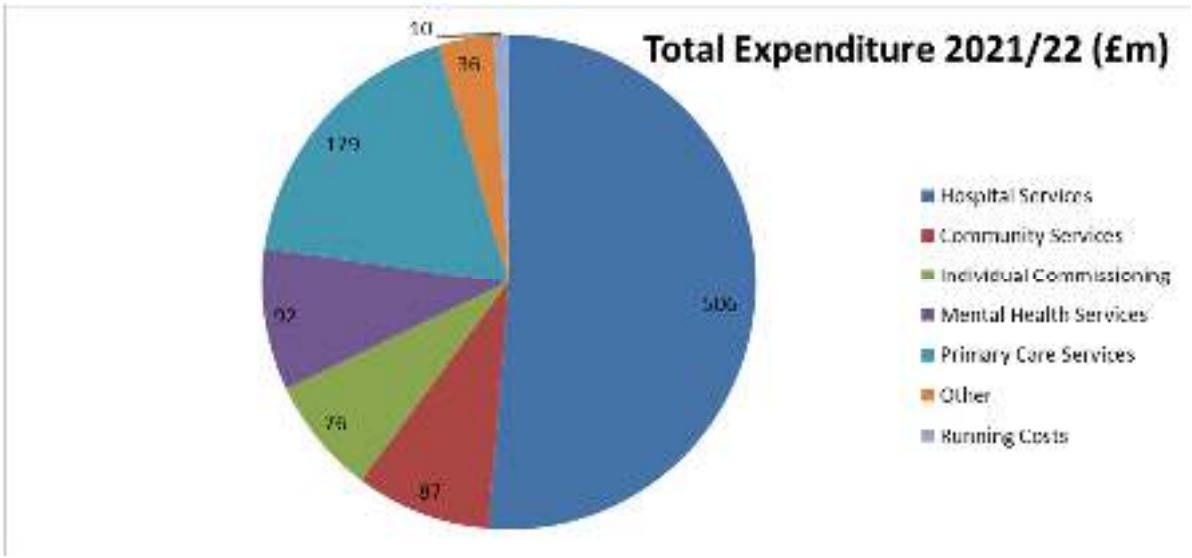
Working collaboratively with our local hospitals and community provider

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

Finance

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

CCG Expenditure 2021/22 (£986 million)



Further analysis of expenditure, by type, can be found within the Annual Accounts on page X of this report.

An analysis of the Statement of Financial Position, detailing movements in assets and liability balances, can be found within the Annual Accounts on pages X and X of this report.

Sustainable development

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

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

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

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

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

More information on these measures is available on the Greener NHS website.

Energy

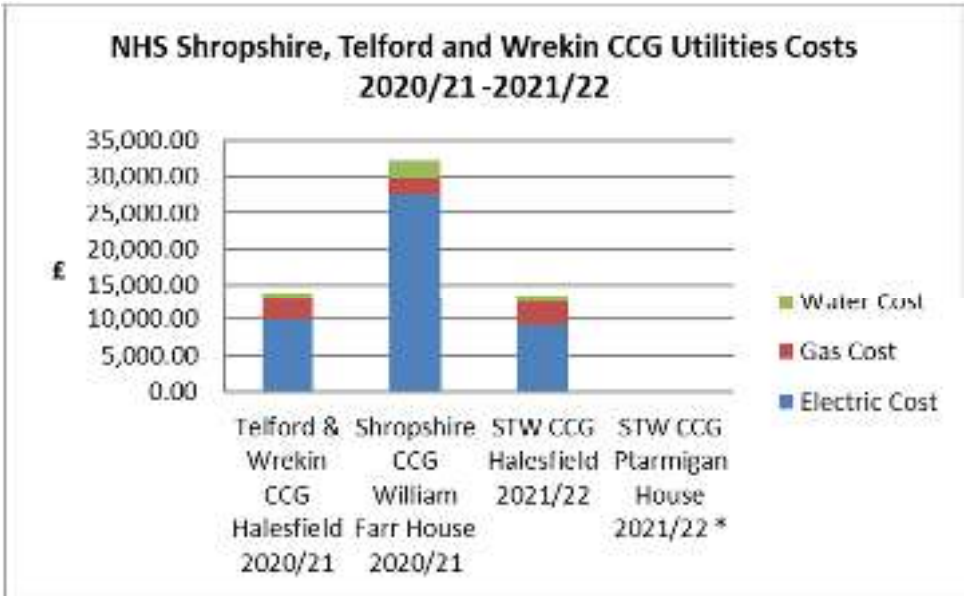
NHS Shropshire, Telford and Wrekin CCG – Utilities costs 2020/21 – 2021/22

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

The graph below shows the position for 2020/21 across the two sites occupied by the then separate CCGs, Shropshire CCG at William Farr House and Telford and Wrekin CCG at

Halesfield. In May 2021 following the two CCGs being dissolved, a single CCG was created and staff based at William Farr House were moved to a new site at Ptarmigan House.

The graph below shows there has been the same level of usage of energy at the Halesfield site in water costs, gas and electricity costs during 2021/22, which is partly due to the CCG staff working from their homes for significant periods during 2020/21 whilst the country was subject to restrictions to combat COVID-19 pandemic, although the impact is less on energy costs as some staff still had to base themselves at the CCG's headquarters during these periods and so the buildings continued to require heat/ light and water. The landlord of Ptarmigan has been unable to provide the CCG with energy usage data for the building, so we are unable to make any direct comparisons with last years figures and also evaluate positive and negative impact from the relocation from William Farr House to Ptarmigan House and as this was the first year of occupation, we are unable to provide estimates based on previous energy consumption at this site.



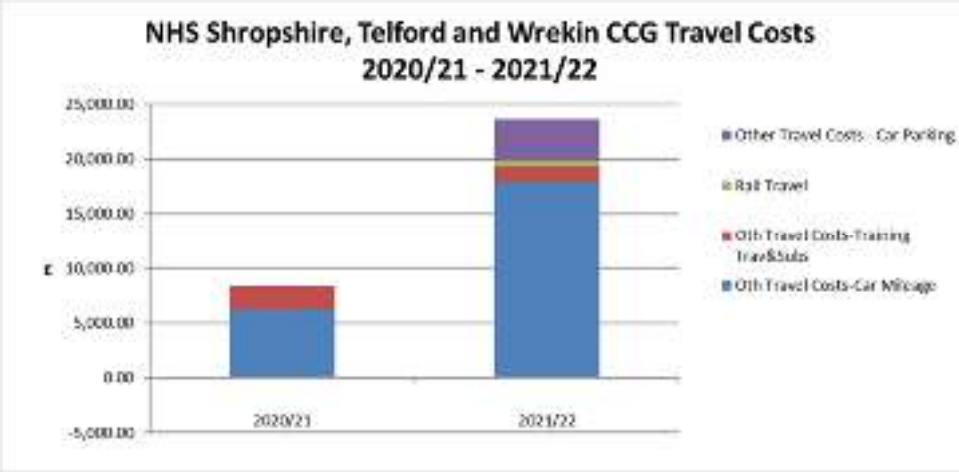
* Data energy usage is not available for the Ptarmigan House site to calculate our position against our benchmark.

Travel

NHS Shropshire, Telford and Wrekin CCG – Travel costs 2020/21 – 2021/22

The graph below shows an increase of travel costs from 20/21 which reflects the relaxing of COVID 19 restrictions nationally, but is significantly less than the accumulated travel costs reported in the annual reports of Shropshire CCG and Telford and Wrekin CCG for the year 2019/20. To support staff, the CCG has developed an agile working policy, which has enabled staff to continue to work from home wherever possible, to reduce staff travelling and enable them to have an improved work life balance.

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



Consumables and Waste Management

The CCG used in total during 2021/22 a total of 217 reams of paper, but we are unable to provide a comparison to last years consumption as this was not reported.

Contracts for waste are overseen by landlords of each of the properties CCG staff are based at and so the CCG does not have access to waste management information for reporting purposes.

Procurement

The CCG through its procurement processes, ensures that all tenders issued have a sustainability clause included and that since the beginning of the year all authorities have to include social value (which encompasses sustainability) in their tender evaluations (minimum weighting of 10%). Clause SC18 Green NHS and Sustainability is in the NHS Standard Contract 22-23 Service Conditions which the CCG uses to contract for its services.

Efficiency programme

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

During 2021/22, delivery of these plans was challenging due to the impact of the pandemic. Block contracts remained in place with our main providers and some efficiency programmes were suspended as staff were redeployed to other departments. However, the CCG was still

able to deliver £7.2 million of savings which were predominantly within the medicines management and individual commissioning teams.

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

Monitoring the quality of services

Quality assurance principles and processes

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

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

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

We commission services from independent providers and all the main NHS trusts in the area:

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

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

Patient safety and quality

Quality is only achieved when three key elements are met:

- clinical effectiveness
- patient safety
- patient experience.

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

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

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

Alongside the CQC we support providers to celebrate areas of strength and improvement and target areas of challenge. Over the past 12 months, we have worked with providers to identify several quality areas which required further in-depth analysis and understanding. CCGs hold the responsibility for the performance management of the Serious Incidents (SIs) reported by commissioned services. We ensure that all incidents are investigated, and we develop action plans which we then monitor to completion. Any changes in practice are tested through quality assurance visits.

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

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

Key issues and risks

The most significant quality risk during 2021/22 continues to be with SaTH, which has a history of challenges, including quality. SaTH is placed in NHSEI System Oversight Framework (SOF) 4 (Recovery Support Programme). In November 2021, a CQC inspection was undertaken at the trust with a focus on:

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

In addition, a well-led inspection took place.

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

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

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

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

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

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

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

Our pathways and facilities for children and young people in need of a mental health assessment needed reconsideration to meet national standards. We are undertaking a range of improvement work and developing different models of care delivery. We are also providing safeguarding assurance visits to inpatient settings to offer a good level of assurance that care delivery is centred around children and young people.

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

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

Emergency Preparedness Resilience and Response (EPRR)

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

Further to the challenges presented by the COVID-19 pandemic in 2020/21, the 2021/22 year has been no less challenging. COVID-19 has continued to be present and has dominated service planning and delivery. We have continued to apply the principles of EPRR to manage our response and to ensure the continued collaboration and support of all partners in our system. To this end, we have retained our Incident Management infrastructure throughout the year.

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

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

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

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

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

Further details regarding our vaccination programme can be found in section XX.

EPRR self-assessment

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

During the year, we have maintained our Director on call rota 24 hours a day, 365 days of the year – not only to support the incident response but to ensure other critical or major incidents and business continuity matters could be addressed in tandem.

Risks of fraud and error in COVID-19 support schemes

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

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

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

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

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

Safeguarding

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

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

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

Our key safeguarding activities during 2021/22 included:

- working closely with local authority partners to assess levels of risk and prioritise and respond to changing needs
- maintaining our quality monitoring of and improvement approach to all our providers
- working directly with hospital trusts to review and advise on best practice approaches to ensure safeguarding practice is robust and resilient
- ensuring a child-centred approach in services for children and young people in crisis
- maintaining a strong focus on attending to the health requirements for looked-after children
- developing and implementing the training and support we offer to GP practices
- investing in additional Multi-Agency Safeguarding Hub safeguarding capacity regarding the prevention of harm to children and young people, more health representation at key statutory child protection agency meetings and promoting the improvements in information sharing across agencies in the risk assessment process
- completing Child Safeguarding Practice Reviews within tight timescales to identify learning across agencies and improve safeguarding provision.

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

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

Learning from deaths (LeDeR programme)

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

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

- implementing our LeDeR policy and the three-year LeDeR strategy that will build on our successes
- further strengthening partnership working to actively improve the lives and deaths for those with learning disabilities or autism.

Achievements will be evidenced and monitored by:

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

View the Shropshire, Telford and Wrekin CCG LeDeR Annual Report 2020/21.

ICS quality developments

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

In line with the national direction, our key quality priorities for 2022/23 will focus on 'making quality everybody's business' and ensuring the delivery of consistently high-quality care. We will develop an integrated and collaborative approach to quality governance and assurance across the Shropshire, Telford and Wrekin system that minimises duplication, reduces variation and delivers tangible improvements for our local population. We will work to develop a shared definition, vision and understanding of quality to establish a single view of quality across health and social care, including the voluntary and third sector.

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

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

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

- **infection prevention and control:** preventing avoidable healthcare-associated infections and building on the good work undertaken as part of the COVID-19 pandemic across our county
- **maternity transformation** and improvement priorities

- **learning from deaths:** including the new requirements of the LeDeR programme
- **patient experience:** with a focus on co-production as a principle of shared working
- **quality improvement** approaches.

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

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

Engaging people and communities

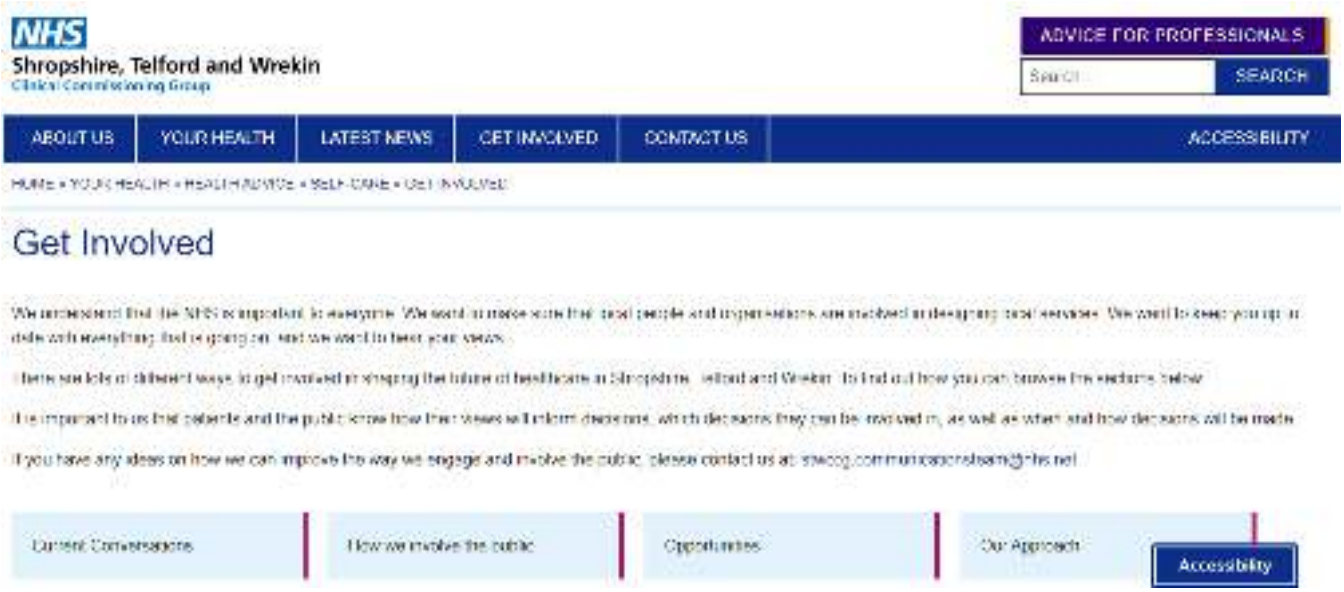
As a commissioning organisation, we have a legal duty under the National Health Service Act 2006 (as amended) to involve the public in the commissioning of services for NHS patients ('the public involvement duty'). For NHS Shropshire, Telford and Wrekin CCG, this duty is outlined in Section 14Z2 of the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

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

- the planning of services
- the development and consideration of proposals for changes, which if implemented, would have an impact on services
- decisions which, when implemented, would have an impact on services.

In meeting our statutory duty to involve, we recognise the importance and value of patient and public engagement to develop and deliver whole-scale system change through new models of service provision. The success of these models of care will depend on the way we interact with and empower patients and the public to be involved in their own healthcare.

We are always keen to hear the views of and provide opportunities for local people to be involved in the work of the CCG. There are numerous ways for people to share their views on local health services and discover ways to be involved. Below is a screenshot of the CCG website to show the range of ways that people can do so.



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

We use all available routes, including:

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

Governance and assurance

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

Our commitment

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

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

Engagement assurance

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

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

The Assuring Involvement Committee

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

The AIC comprises 10 volunteers from across Shropshire, Telford and Wrekin, along with the two lay members for patient and public involvement of the CCG's Governing Body. Its role is to provide assurance and oversight to the CCG Governing Body and its committees, and to ensure that meaningful patient and public engagement is embedded in the commissioning process. The AIC also ensures that equality and diversity activity is undertaken in the most effective way and meets the CCG's statutory and legal duties to involve patients, carers and the public, and the NHS mandatory guidance relating to public involvement.

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

Examples of the work of the AIC include:

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

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

Impact of involving people

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

Some examples are highlighted on the next page.

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

Engagement activities

Community Diagnostic Centres

The CCG communications team provided support with engagement work following the successful bid for more than £6 million to run a pilot Community Diagnostic Centre in Telford.

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

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

Musculoskeletal Transformation Programme

The Musculoskeletal Transformation Programme is about strengthening community provision over the next five years to improve care.

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

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

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

High Intensity Users Service

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

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

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

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

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

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

Voluntary, community and social enterprise sector Memorandum of Understanding

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

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

The MoU was co-produced between the ICS and the chairs of Shropshire and Telford and Wrekin VCSE, and co-signed at the Annual General Meeting.

Encouraging uptake of the COVID-19 vaccine

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

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

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

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

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

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

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

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

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

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

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

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

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

Engaging people by working with others

Place engagement

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

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

This way of working will inform and support the system leadership as it develops a new architecture and culture for system working which integrates good health and wellbeing support for those who live and work in Shropshire, Telford and Wrekin.
Place relies on organisations working better together to enable improved health outcomes for our population. Each Place alliance holds regular meetings, with a wide range of representation from principal system organisations and other relevant local organisations/groups.

Voluntary sector

The CCG has a history of strong links with the voluntary sector in Shropshire, Telford and Wrekin. We continue to work closely with them in relation to our plans, particularly with regard to Place. We use their networks as well as our own direct contacts to reach out to more voluntary sector organisations and into diverse communities across the patch.

Patient participation group networks

We work closely with our patient participation group (PPG) networks, which bring together PPGs from across the county. The meetings provide a forum to share good practice, keep informed and engaged with national and local NHS developments and provide opportunities to get involved. PPG networks are also key in helping shape our engagement techniques.

Shropshire, Telford and Wrekin Maternity Voices Partnership

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

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

Healthwatch

Healthwatch continues to be an important partner for the CCG. They are regularly involved in formal and informal meetings including Governing Body and service transformation programmes. They attend the QPC and are invited to input into the Patient Experience Report tabled there.

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

Patient Advice and Liaison Service

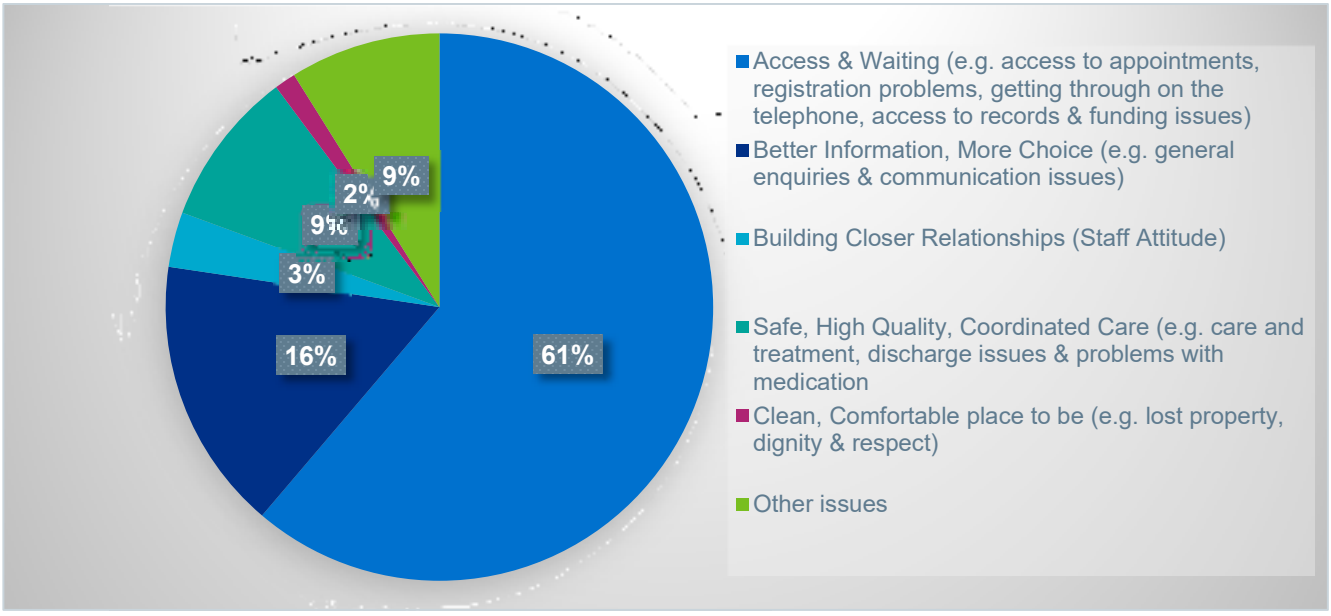
PALS is integral to the commitment of NHS Shropshire, Telford and Wrekin CCG to working closely with patients and staff to improve services. It is an informal and impartial way to resolve the concerns of patients, relatives, carers and members of the public.

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

During 2021/22, 876 PALS enquiries were received via NHS Shropshire, Telford and Wrekin CCG Patient Services team. This is a decrease on the 1060 enquiries received during 2020/21.

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

Subject area of PALS concerns



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

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

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

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

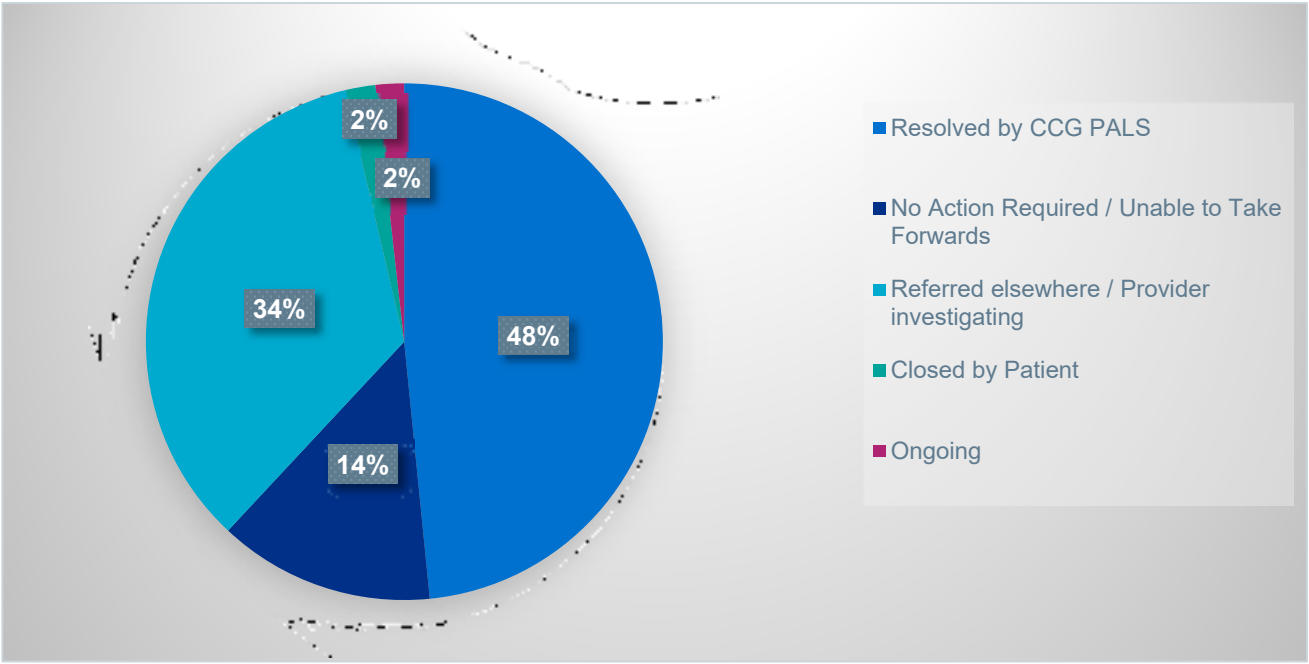
24 enquiries related to the Prescription Ordering Department and were around access or problems with prescriptions once they had been ordered.

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

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

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

PALS enquiries outcomes



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

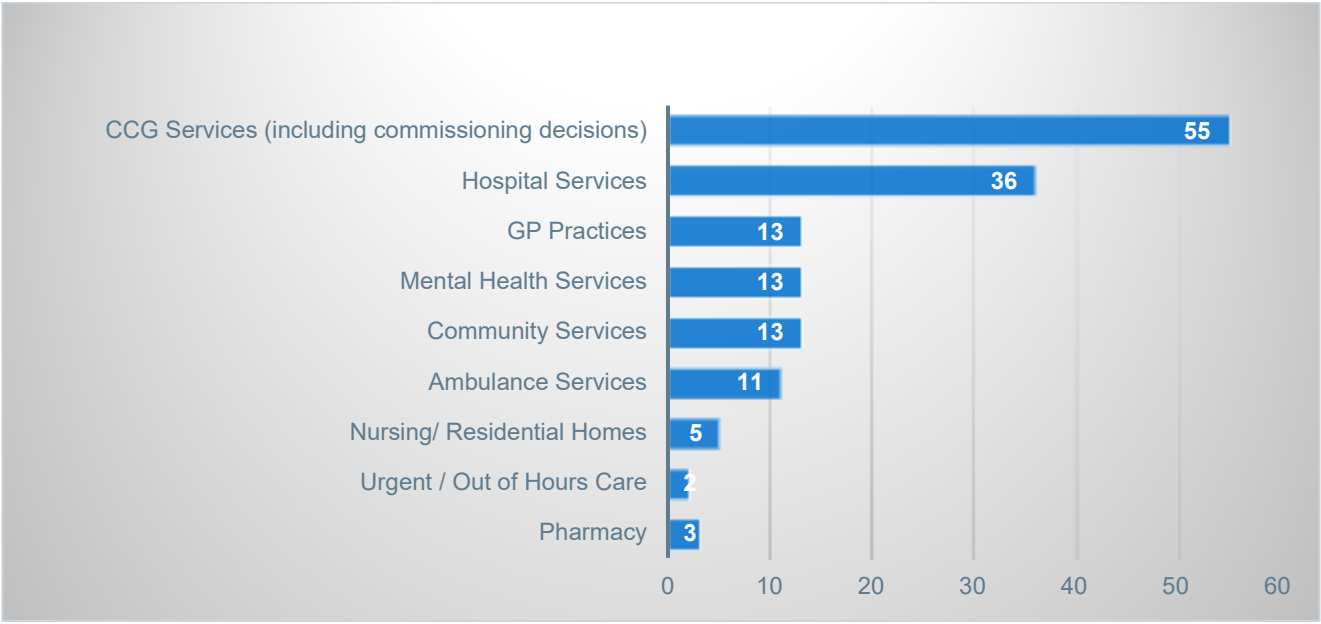
Complaints

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

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

During 2021/22, the CCG received 135 complaints, which is a slight increase on the number received in 2020/21. As shown in the graph below, in addition to complaints about the CCG itself, many of the complaints relate to providers of services commissioned by the CCG.

Services complaints related to

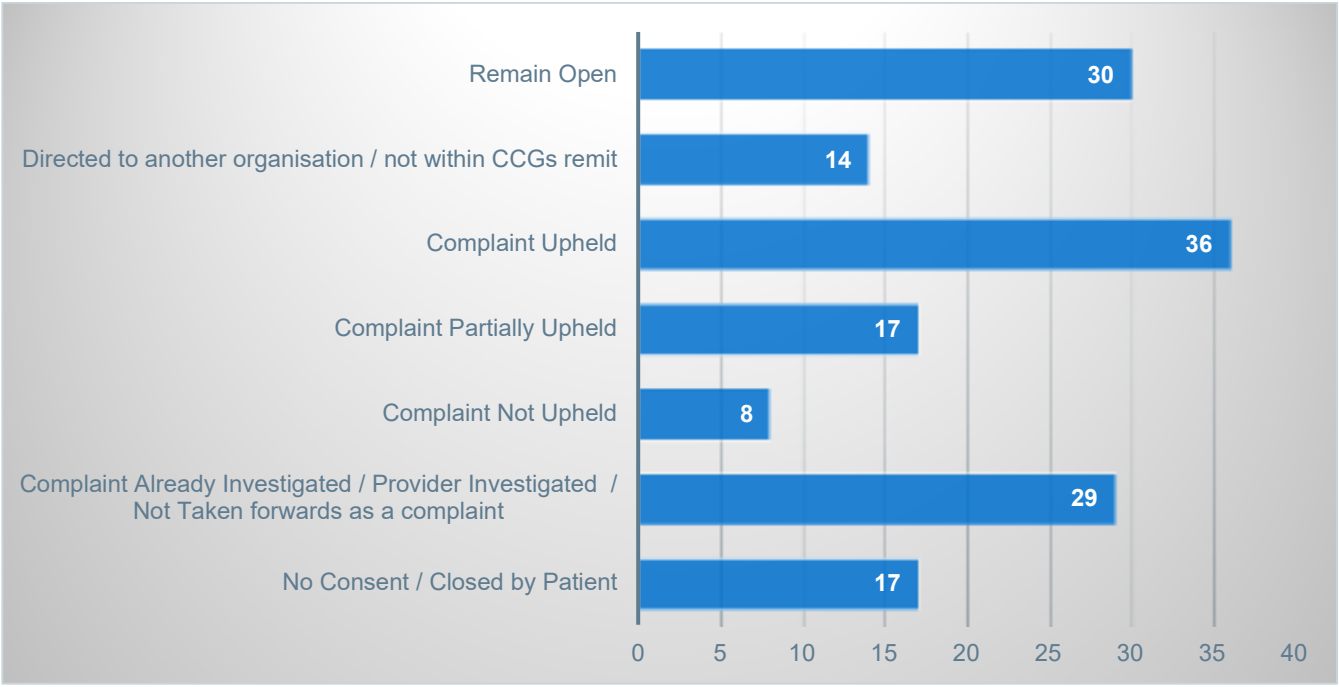


Of the complaints received, 52 related to CCG services. 17 of these related to the Individual Commissioning team and were around delays with the Continuing Healthcare assessment process and poor communication from the team around these delays.

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

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

Complaint outcomes



Ombudsman

The public have the right to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for review if they are not satisfied with the CCG's response.

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

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

Member of Parliament letters

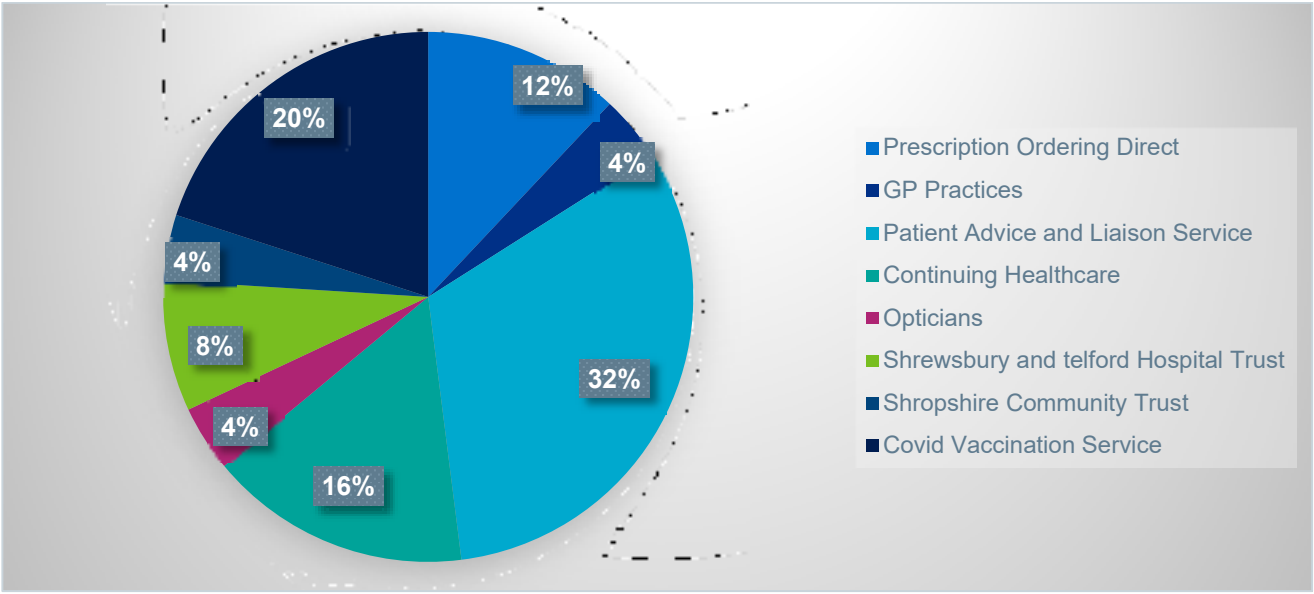
During 2021/22, the CCG received 88 letters or emails from local Members of Parliament relating to the healthcare of their constituents. 70 of these enquiries related to access to services, 22 related to COVID-19 and were mainly around accessing the vaccine, and 20 enquiries related to GP services and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

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

Compliments

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

Services compliments related to



Learning from feedback received

An important part of the complaints and PALS process is that lessons are learned and improvements made to services based on feedback received from individuals.

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

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

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

Equality, Diversity and Human Rights Report

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

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

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

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

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

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

The nine protected characteristics are as follows:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership (ICB)

- Pregnancy and maternity
- Race including nationality and ethnic origin
- Religion or belief
- Sex
- Sexual orientation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Assuring Involvement Committee (AIC) for NHS Shropshire, Telford and Wrekin CCG was set up in 2021 to ensure the CCG is effectively engaging its local population to support service redesign. The Committee is made up of 10 members of the public and is tasked with looking in-depth at communications and engagement strategies produced as part of service redesign projects.

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

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

Over the course of 2021, the AIC reviewed the following communications and engagement strategies:

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

Find more information about the AIC on our website.

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

The EQIA is then considered at Executive Level as part of the agreement to proceed with projects and commissioning decisions. All papers presented to the CCG's Governing Body have a mandatory section with regard to the impact of the report on equality and diversity. The EQIAs have a risk scoring system for any negative impact identified. A Stage 2, fuller EQIA will be required for risks of 9 and above.

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

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

The CCG has also encouraged senior managers to apply for the locally run Inclusive Leadership Programme which seeks to address managers awareness of inequalities in the workplace. Along with partners, the CCG has created the ICS System BAME Network for staff to come together from across various system partner organisations and raise awareness of key issues.

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

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

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

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

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

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

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

The Workplace Race Equality Standard (WRES) requires us to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

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

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

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

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

The CCG recognises that unfair discrimination is unacceptable and, in this respect, has made a statement of policy on equal opportunities in employment through its Equality and Diversity Policy. This ensures that no potential or actual employee receives less favourable treatment on the grounds of age, disability, sex, sexual orientation, race, nationality, religion or belief, national or ethnic origins, gender reassignment, pregnancy or maternity, marriage or civil partnership or trade union membership.

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

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

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

Health and Wellbeing Strategy

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

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

There are two local health and wellbeing Boards as Shropshire, Telford and Wrekin CCG covers the boundaries of the two separate local authorities. Each of these Boards are in place to reflect the areas they serve, and they have different priorities and schemes of work. Throughout 21/22 Shropshire, Telford and Wrekin CCG have fulfilled their commitment for senior leadership attendance as members of the two HWBBs through the Accountable Officer and /or a director level representative.

Telford and Wrekin Health and Wellbeing Strategy

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

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

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

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

Shropshire Joint Health and Wellbeing Strategy

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

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

The CCG has supported these priorities through joint appointments with the local authority including a post with a focus on prevention. The CCG has continued to support the

development of the local care programme and the introduction of an integrated rapid response service to assist individuals to remain in their own homes over 2021/22.

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

Joint Health and Wellbeing Strategy

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

Between September and November 2021, feedback was gathered through an online survey and attendance at Shropshire Integrated Place Partnership board (ShIPP) committee meetings and groups. View the report of findings.

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

Strategic priorities for 2022-27 are:

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

Key areas of focus are:

- mental health
- children and young people
- healthy weight and physical activity
- workforce.

Other areas of focus are:

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

Shropshire, Telford and Wrekin CCG are active members of the ShIPP and have contributed to both its further development as well as to delivery of programmes of work associated with it.

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

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

Reducing health inequalities

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

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

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

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

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

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

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

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

Addressing inequalities in COVID-19 vaccine uptake

The Communications and Engagement Plan specifically included activity and approaches to increase uptake and reduce hesitancy amongst groups experiencing the greatest health inequalities.

Shropshire, Telford and Wrekin Vaccination team has come up with a novel and highly effective solution to help address low vaccination uptake in some of its most vulnerable

communities, tackling health inequalities with three vaccination buses, and targeted community engagement.

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

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

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

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

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

Accountability Report

Corporate Governance Report
Members' Report

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

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

The member practices are outlined below:

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

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

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

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

CCG Governing Body composition during 2021/22 is as follows:

Names of Governing Body members up to 31 March 2022	Board Role
Dr John Pepper (voting)	GP Chair
Dr Mike Matthee (voting)	GP/Healthcare Professional Member
Mrs Rachael Bryceland (voting)	GP/Healthcare Professional Member
Mrs Fiona Smith (voting) to 1 August 2021	GP/Healthcare Professional Member
Dr Mary Ilesanmi (voting)	GP/Healthcare Professional Member
Dr Adam Pringle (voting)	GP/Healthcare Professional Member
Dr Martin Allen (voting)	Secondary Doctor Member
Mrs Audrey Warren (voting)	Independent Nurse Member
Mr Geoff Braden (voting)	Lay Member – Governance
Mr Meredith Vivian (voting)	Lay Member – Patient Public Involvement (PPI)
Mrs Donna McArthur (voting)	Lay Member – Primary Care
Mr Ash Ahmed	Lay Member – Patient Public Involvement (PPI) – Equality, Diversity and Inclusion (EDI)
Mrs Claire Skidmore (voting) from 1 April 2021 and to 31 August 2021	Interim Accountable Officer
Mr Mark Brandreth (voting) from 1 September 2021	Interim Accountable Officer
Mrs Claire Skidmore (voting) from 1 September to 31 March 2021	Executive Director of Finance
Mrs Laura Clare (voting) from 1 April 2021 to 31 August 2021	Interim Executive Director of Finance
Mrs Zena Young (voting)	Executive Director of Nursing and Quality
Professor Steven Trenchard (voting) to 30 November 2021	Interim Executive Director of Transformation
Dr Julie Garside (voting) from 1 December 2021	Director of Performance responsible for the Executive Director of Transformation portfolio
Ms Claire Parker (non-voting)	Director of Partnerships
Miss Alison Smith (non-voting)	Director of Corporate Affairs
Dr Julie Garside (non-voting) from 1 April to 30 November 2021	Director of Performance
Mrs Sam Tilley (non-voting)	Director of Planning
Dr Deborah Shepherd (non-voting)	Medical Director
Dr Stephen James (non-voting)	Interim Chief Clinical Information Officer

Rachel Robinson (non-voting)	Director of Public Health for Shropshire Council
Liz Noakes (non-voting)	Director of Public Health for Telford and Wrekin Council
Lynn Cawley (non-voting)	Chief Officer – Healthwatch Shropshire
Marion Kelly (non-voting) to 31 July 2021	General Manager – Healthwatch Telford and Wrekin
Barry Parnaby (non-voting) from 1 November 2021	Chair – Healthwatch Telford and Wrekin

Committee(s) including Audit Committee

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

The Composition of the Audit Committee is as follows:

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

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

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

Information Governance incidents

NHS Shropshire, Telford and Wrekin CCG has reported a total of 10 incidents during 2021/22. All of these incidents were graded as non-reportable – very low risk and therefore not reportable to the Information Commissioner's Office (ICO).

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery

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

Statement of Accountable Officer's Responsibilities

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- Keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the Accounts comply with the requirements of the Accounts Direction)
- Safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my CCG Accountable Officer Appointment Letter.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information
- The Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

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

Governance Statement 2021/22

Introduction and context

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

The general function of the CCG is to arrange the provision of services for people for the purposes of the health service in England. Specifically, it is required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

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

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG is a clinically-led membership organisation comprising GP practices within the geographical area of Shropshire, which is coterminous with Shropshire Council, and Telford and Wrekin, which is coterminous with Telford and Wrekin Council. The members of the CCG are responsible for determining the governing arrangements of the organisation, which they are required to set out in the CCG's Constitution, found on our website.

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

with national guidance, also needed to change temporarily to fit this emergency situation. Some committees of the Governing Body and membership have stood down or are meeting less frequently, agendas have been streamlined and risk management processes have focused on the CCG Board Assurance Framework (BAF) and system Gold Command emergency response. The CCG undertook these changes to ensure that its focus and resources continued to be reserved to meet the challenges from COVID-19 during 2021/22.

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

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

Membership Forum

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

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

The Membership Forum did not meet during the year. The full list of the Membership Forum can be found in the Accountability section of this Annual Report.

Locality Forums

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

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

Locality Forum members and attendance are listed below:

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

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

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

- New maternity IT system
- Respiratory service
- Macmillan project
- Proxy ordering in care homes (Medicines Management)
- Low risk diabetic foot screening
- NHS 111 and winter
- End of life care pathway
- New Breast Pain Community service
- Cancer Strategy, pulse oximetry, outpatient transformation, two-week brain tumour pathway
- Connect Pain Management Solutions – review of service provision
- Phlebotomy
- Mental health
- Integrated care record update

- Musculo-skeletal (MSK) transformation
- Community services
- Community pharmacist consultation service
- Lantum staff bank
- End of Life Care Business Case
- Pathology 'Getting it right first time' initiative for blood test requests
- SaTH referrals – learning.

Telford and Wrekin Locality Forum

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

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

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

- Update on CCG matters
- GP Practice Forum Chair's update
- Practice managers' update
- Mental Health service update
- COVID-19 and vaccinations update
- Sexual health services
- Locality meetings – ICR
- West Midlands upper GI EAG recommended two-week wait form
- MSK transformation
- Macmillan project
- Diabetic foot screening
- Phlebotomy
- Primary care breast pain clinic
- Community diagnostic hubs
- Utilisation of NHS 111 direct booking slots
- Summary care records update
- Primary care blood test requests
- New sexual health service contract
- Maternity mental health
- Breast pain community clinic and Cancer Strategy update
- Primary care role in the ICS
- CCG/ICS/ICB update
- Primary care representation at ICS/ICB
- Agreement on two-week wait proforma
- New pathway for referrals into urology
- Agreement on the future of locality meetings
- Asthma – personalised care for children and young people
- Community service update.

The Shrewsbury and Atcham Locality Forum

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

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

- Chair update
- Partnerships update
- Mental health update
- Respiratory update
- Integrated care records
- Phlebotomy
- End of life care pathway
- Macmillan project
- Outpatient transformation programme
- Diabetic foot screening and phlebotomy

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

The South Shropshire Locality Forum

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

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

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

- CCG Chair report
- Locality Chair update
- Partnership update
- Breast Pain Community Service
- MSK update
- Integrated Cancer Strategy 2021-26
- Low-risk diabetic foot screening
- Medicines Management.

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

Governing Body

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

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

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

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

Audit Committee

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

The Committee has met a total of eight times during 2021/22, which is included in the attendance table below.

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

The major areas of focus for the Committee have been:

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

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

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

Remuneration Committee

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

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

The major areas of focus for the Committee have been

- Implementation of national guidance in relation to pay awards. This included enacting the pay freeze in 2021/22 for CCG staff engaged as Very Senior Managers as notified to the CCG by the Cabinet Office
- Consideration and ratification of National Guidance in relation to ICS Transition Management of Change Process for CCG staff
- Review and support for two retire and return applications presented to the committee which recognised the recruitment challenges and the need to retain specialist skills and corporate memory.

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

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

Quality and Performance Committee

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

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

The major areas of focus for the Committee have been:

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

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

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

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

Finance Committee

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

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

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

The major areas of focus for the Committee have been:

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

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

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

The Strategic Commissioning Committee

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

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

The major areas of focus for the Committee have been:

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

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

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

- IVF Policy
- Enhanced health in care homes and community support
- Elective care
- Board Assurance Framework and Directorate Risk Register
- Local care transformation
- Medicines Management
- ADHD
- Dementia care
- Flash glucose monitoring
- Integrated urgent care out of hours.

Primary Care Commissioning Committee

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

The Primary Care Commissioning Committee has met bi-monthly as scheduled during 2021/22 and some additional extraordinary meetings have been convened mainly to consider time-critical estates issues.

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

The major areas of focus for the Committee have been:

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

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

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

Individual Funding Committee

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

The IFR stage one screening panel considers IFR requests for funding for individual exceptional patients on behalf of the CCG. The Individual Funding Request Stage one screening panel met five times during the year 2021/22.

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

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

Names of Individual Funding Committee members (stage two)	Meetings attended during 2021/22
Barrie Reis-Seymour – Head of Transformation and System Commissioning – Elective Care	0
Tracey Jones – Deputy Director of Partnerships	0
Deborah Shepherd – GP	0
Kay Holland – Deputy Director Contracting	0
Meryl Flaherty – Contracts Business Partner	0
Gordon Kochane – Public Health Consultant	0
Francis Sutherland – Head of Transformation and Commissioning – Mental Health, Learning Disabilities and Autism	0
Liz Walker – Deputy Director Quality	0
Julie Garside – Director Transformation, Partnership and Commissioning	0
Angus Hughes – Associate Director of Finance – Decision Support	0
Angharad Jones – Finance Business Partner	0
Dr Adam Pringle – GP	0

Between 1 April 2021 and 31 March 2022, zero cases were taken to the IFR stage three (appeal) Review panel for consideration.

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

Assuring Involvement Committee

The Assuring Involvement Committee is composed of a number of volunteer members of the public who submitted expressions of interest via an advertisement to become committee members. The role of the committee is to ensure that the CCG involves patients and the public in its decision-making and strategic service design. The Assuring Involvement Committee has met six times during the year.

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

The major areas of focus for the Committee have been:

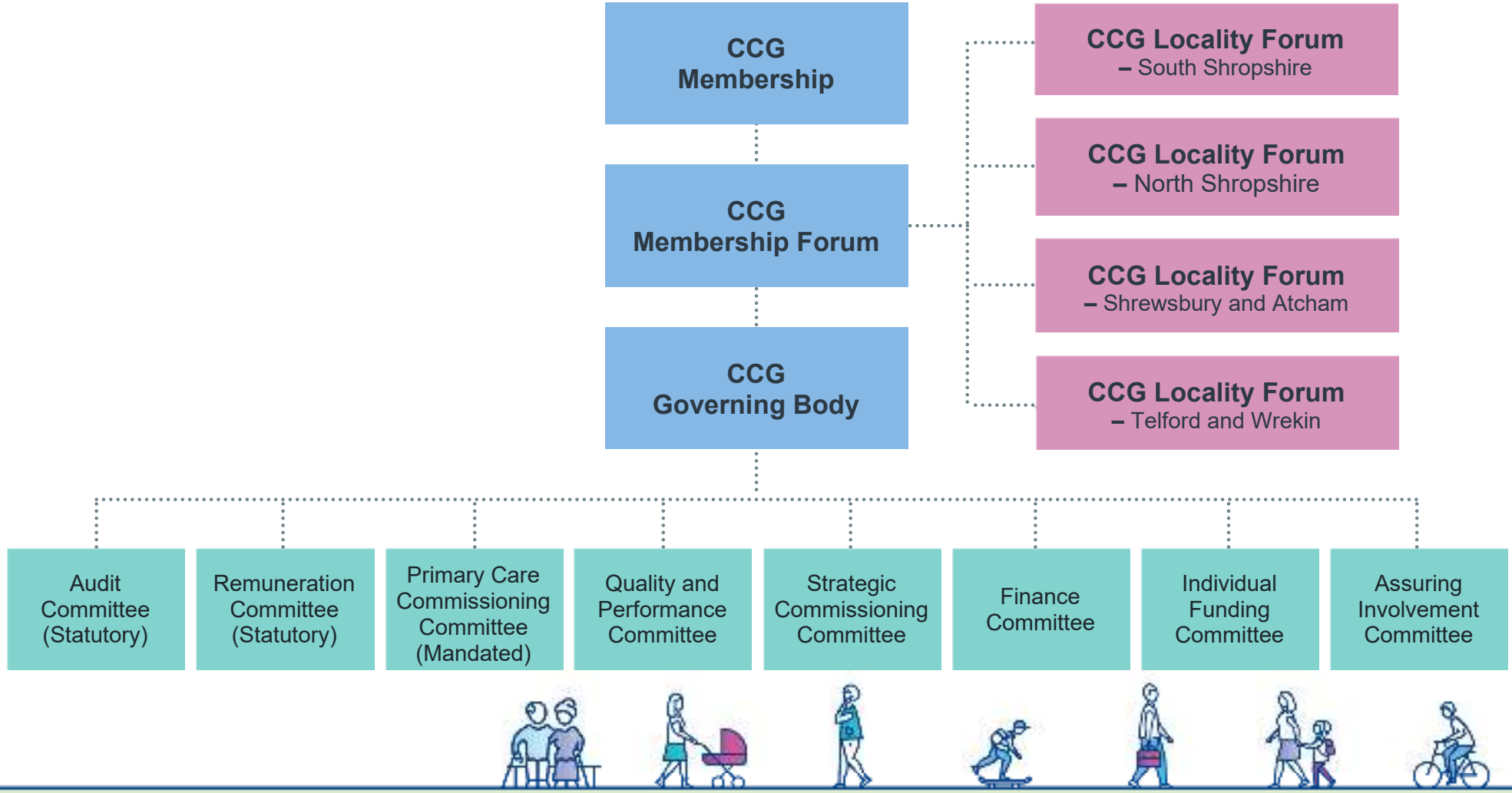
- Focus on the planned communications and engagement supporting the development of the Shrewsbury Health and wellbeing Hub has been significant over the year as this is a key primary care development which will affect a number of practices and patients in Shrewsbury
- Communications and engagement plan for the forthcoming five-year transformation of MSK services is also a key strategic development for the Shropshire, Telford and Wrekin system and which has attracted significant amount of public interest.

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

- Communications and engagement related to the planned development of the Shrewsbury Health and Wellbeing Hub
- Recruitment of patient representatives to steering and project groups
- Communications and engagement related to the refresh of the Integrated Cancer Strategy for 2021-26
- Communications and engagement related to the revision of the Dementia Vision (recommenced in 2021 following delays due to COVID-19) and three-year model for delivery
- Communications and engagement plan for the forthcoming five-year transformation of MSK services which had been paused during the pandemic.
- Involvement in the review and redesign of the High Intensity Users Service planned for implementation in spring 2022
- Engagement to date in the review of end of life care
- Engagement plan for proposed changes to Shrewsbury and Telford Hospital Trust Renal Dialysis services provided at Princess Royal Hospital
- Engagement to date re temporary changes to Shrewsbury and Telford Hospital Trust cardiology inpatient services in early 2022
- Development of the new ICS Involvement Strategy for People and Communities
- Communications and engagement plan for the Eye-Care Transformation programme launched in February 2022

- Plans for a Healthier Minds engagement event in Telford in May 2022 focussed on local BAME communities and intended to raise awareness of mental health services and broader community-based support.

Membership of the committees and sub-committees of the CCG Governing Body is outlined in respective terms of reference which are included in the CCG's Constitution and Governance Handbook. Attendance at these meetings is recorded in the minutes of each meeting. The governance structure for the CCG as described in the CCG's Constitution is shown in the diagram below:



The CCG has reflected on its own effectiveness and performance as part the quarterly assurance checkpoints undertaken by NHS England for all ICS systems during 2021/22. The outcomes of these are reported to the CCG Governing Body and ICS Board.

UK Corporate Governance Code

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

Discharge of statutory functions

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

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

Risk management arrangements and effectiveness

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

The following information outlines the normal risk management practice the CCG follows. However, due to the COVID-19 pandemic, the CCG Governing Body agreed to continue to focus its attention during 2021/22 on the Board Assurance Framework to assist it in navigating a very challenging environment and conserving valuable staff resources.

The CCG received a level 'A' assessment from its Internal Auditors which reflects that an Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement, and provides reasonable assurance that there is an effective system of internal control in place to manage the principal risks identified by the organisation. There were also some areas recommended for action which included the need to update some risks and actions and some inconsistency of detail and presentation of information. These recommendations are being action in quarter 1 of 2022/23 financial year.

The coordinating body for receiving assurance on these strands of governance is the Audit Committee, which oversees integrated governance on behalf of the CCG Governing Body. In addition, the other committees also oversee the risks within their specific remits, providing assurance to the Audit Committee where appropriate.

The CCG prevents risk arising wherever possible by:

- applying policies and procedures for staff and contractors to follow
- the CCG Constitution
- standing orders and prime financial policies
- the use of technical support external to the CCG (for example, legal, IG and human resources advice)
- internal audit.

The CCG also employs deterrents to risk arising (for example fraud and IT deterrents).

The system of risk control forms part of the CCG's system of internal control and is defined in the Integrated Risk Management Strategy, which is reviewed annually. The strategy defines the risk management responsibilities and common methodologies for the identification and assessment of risks for the whole organisation. It requires that risks are managed to a reasonable level, within the parameters of a defined risk appetite, rather than requiring the elimination of all risk of failure to achieve the CCG's objectives.

The risk control system facilitates the assessment of risk by:

- identifying and prioritising the risks to the achievement of the organisation's objectives
- evaluating the likelihood of those risks being realised and the impact should they be realised, and managing them efficiently, effectively and economically.

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

The risk appetite was determined and approved by the Governing Body and the strategy outlines the processes for maintaining and monitoring the Board Assurance Framework and the Directorate Risk Register with due regard to this appetite.

Our risk appetite can be summarised as follows:

- we expect to fulfil our statutory and regulatory duties to maintain and improve quality and safety in our activities and those of the organisations we commission healthcare from
- to achieve this, we will maintain a lean and flexible governance and staffing structure, populated by people who think in a holistic, patient-focused way and with a keen sense of inventiveness
- we will accept risks graded as 'very low', avoid expenditure and use of resources on those graded 'low', manage in a cost-effective manner those graded moderate and enthusiastically seek to reduce those graded 'high'
- conversely, we will actively seek to implement actions to take opportunities graded 'high' and proportionately respond to those graded below this
- whilst we will ensure cost-effectiveness and a balanced budget, we seek quality and innovation towards best practice in patient-centred care.

Risk management is embedded in the activity of the CCG and can be demonstrated through:

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

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

The following processes are used to identify risks:

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

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

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

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

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

Our capacity to handle risk

Leadership is given to the risk management process by the Accountable Officer whose role is to own the Board Assurance Framework (BAF). The BAF, which documents the principle risks to the CCG's objectives not being delivered, is underpinned by the Directorate Risk

Register. This outlines the lower-level risks to each executive lead not meeting their specific remit objectives and, specifically, risks to the CCG not fully discharging primary care commissioning under its delegation from NHS England effectively. Each executive lead, or members of their respective teams, will inform the Directorate Risk Register. Both the Accountable Officer and directors are supported by the Director for Corporate Affairs. CCG staff are provided with a risk assessment code of practice and receive support and training on risk management from the Director of Corporate Affairs where required.

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

Description of major risks added to the Board Assurance Framework during 2021/22	Existing controls	Further actions
1. Patient and Public Involvement There is a risk that the CCG fails to meet its statutory duty to involve patients and the public in planning commissioning arrangements, in development and consideration of proposals to change or cease existing services.	1. Interim Communications and Engagement Strategy for STW CCG approved by Governing Body. 2. Communications and Engagement teams working jointly across CCG, ICS and Providers providing more capacity and expertise in planning and delivery. 3. Reports to Governing bodies/Committees require section completing on Patient involvement. 4. Substantive ICS Director of Communications and Engagement now appointed and overseeing both ICS and CCG functions. 5. Presence of Healthwatch for both areas at Governing Body meetings and Quality and Performance Committee. 6. Lay Member for PPI and Lay Member for PPI – EDI in place on Governing Body to act as specific check and balance with regard to patient involvement. 7. Assuring Involvement Committee in place as part of CCG Governance.	1. The Interim Director and Assistant Director have established processes with their new-look team and are now developing a forward plan of activity. 2. Directors of Communications and Engagement and Corporate Governance will seek clarify where the AIC function will sit in ICB March 2022.

	8. Communications and Engagement teams are working jointly across the CCG, ICS and system partners providing more capacity and expertise in planning and delivery. 9. ICS Board meetings are now held in public and board papers published to the ICS website to increase transparency.	
2. Transition to a statutory Integrated Care Board (ICB) There is a risk that the CCG does not have sufficient capacity and capability to undertake the transition to the ICS satisfactorily, which results in the ICB being unable to discharge its new statutory duties.	1. Governing Body members taking lead roles in ICS governance and delivery functions. 2. CCG Directors have dual roles with CCG and ICS. 3. Joint CCG/ICS management team meetings. 4. Transition steering group meetings taking place ICS Director, ICS Workforce, CCG Director of Corporate Affairs. 5. ICS has been authorised by NHSEI. 6. Project lead identified by ICS. 7. National guidance has now been released. 8. ICS and CCG have now appointed an interim CEO for ICS. 9. Transition group overseeing transition plan and due diligence via fortnightly meetings. 10. Work is being shared between ICS/CCG and providers, with key leads being identified 11. CS Transition Group involves CCG Executive Director for Finance, Executive Director for Quality and Nursing, Director of Partnerships and Director of Corporate Affairs. 12. Transition Plan in place with PMO support. 13. Due Diligence plan approved and work is ongoing with identified PMO lead.	1. Guidance on model constitution and place and ICB structures has been released and ICB is leading more work on place-based arrangement for 1 July 2022.
3. CCG workforce capacity	1. Work has been done to ensure that there a no duplication	1. Capacity issues in directorates to be captured in DRR.

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

		and system plans ongoing – gaps identified and added to Directorate and system risk registers (JD November 2021). 5. CCG EDOF part of regional discussions regarding recurrent funding solutions for West Midlands Ambulance Service pressures. Assurance: 1. Business case documentation has been requested from all leads by the end of February. (Efficiency programme leads February 2022).
5. System failure to deliver overall long-term sustainability plan The underlying financial position of the CCG and the system as a whole is currently a significant deficit. The system is therefore in a recovery process and unable to make investment decisions without being through the 'triple lock' process of organisation, system and NHSEI approval. As well as delivering the CCG element of	1. Risk management framework in place across the system as part of development of system sustainability plan. 2. System governance arrangements in place through sustainability committee and investment panel to ensure that new investments are not made unless recurrent resource is available.	1. Significant work underway across system to model long term plan. Modelling task and finish group assembled and reviewing system wide financial model available from NHSEI. Future years of plan presented to the system in September – this included a ten year plan showing agreed high level assumptions. This was supported by system partners.

the sustainability plan, the CCG will also play a key part in the whole system delivering the longer term sustainability plan and the approximately £30 million transformational saving every year.		2022/23 plan now to be further refined following release of the planning guidance. ICS prioritisation session took place on 23 February to confirm system priorities and provide focus to financial, workforce and capacity modelling. Sustainability committee on 28 February to collectively review and agree the 2022/23 financial plan position, this will include delivery of Big 6 transformational projects. (CS February 2022) 2. System-wide development of Big 6 underway with SRO assigned to each, further work on modelling underway to align to system financial plan. Progress Review planned for February IDB meeting, focus on mobilisation plans. (Cherry West February 2022). 3. System risk management framework shared with sustainability committee and system CEOs in September 2021.

		Refinement ongoing to ensure non-financial risk is adequately captured. (CS February 2022).
6. Quality and Safety Without a robust quality governance framework in place, the system will not be able to monitor quality and safety and mitigate risks in a timely manner. Patients may experience poorer outcomes and experience.	1. Development of an ICS Quality and Safety Strategy, co-produced with system health and social care partners and patient representative groups. Approved by ICS Board June 2021. 2. Establishment of our ICS governance structure including Quality and Safety Committee (a sub-committee of the ICS Board) and System Quality Group (SQG) which provides quality surveillance and improvement. 3. STW LMNS function is developing to encompass the new responsibilities for PNQSG and Terms of Reference and risk register have been revised in light of this requirement. 4. SaTH Safety Oversight and Assurance Group (SOAG) in place, co-chaired by NHSE/ICS lead and with system membership. 5. Serious incident (SI) reporting in accordance with NHS SI Framework, monthly SI review meetings between commissioner and provider in place. 6. Patient Safety Group in place with remit to ensure the NHS Patient Safety strategy is delivered across system. 7. System-wide IPC forum in place providing oversight and peer support. 8. Vaccination quality governance forum in place to oversee COVID-19 delivery programme. 9. CCG/ICS quality and safety monitoring and reporting arrangements will run in parallel during 2021/22.	1. Further develop and embed the system-wide revised approach to quality governance during 2021/22, including quality governance at 'place'. Identify senior resource (DDoN) to lead this work. (quarter 3). 2. Continue to monitor quality risks and workforce plans at provider level through existing mechanisms including a presence at SaTH internal quality governance fora. (Note: Workforce reported to ICS People Board which has agreed key priority areas for action). (Ongoing). 3. Maintain a schedule of quality assurance visits, with triangulation of data from a variety of sources, including increased inclusion of patient experience elements. (Ongoing).

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

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

		15. Implement new statutory requirements for Liberty Protection Safeguards when national timelines and details are published. (Governing Body development event October 2021). 16. Review CCG Quality team staffing plans as part of budget setting. (quarter 4 2021/22).
7. Restoration of services post COVID-19 There is a risk that the restoration of health services following the COVID-19 pandemic will not keep pace with patient need resulting in patients suffering harm.	1. Demand and Capacity Modelling. 2. System Clinical prioritisation and approach to harm policy in place. 3. 6 Big Ticket Items. 4. Development of digital and virtual capabilities. 5. Developing system infrastructure. 6. H1 Plan. 7. People Plan and workforce planning.	1. Elective Recovery trajectories set out in H1 plan. Big 6 items addressing key elements of sustainability and transformation. 2. Demand and capacity and performance monitoring ongoing to track progress and allow for early mitigation if deviation from plan is evident. 3. Work ongoing on implementation of People Plan. 4. Ongoing dialogue with NHSE regarding equipment and estate.
8. Population Health Needs There is a risk that the CCG fails to understand its population health	1. Inequalities sits within the portfolio for Director of Planning and Partnerships. 2. Population Health Management sits within the portfolio of the Director of Planning. 3. JSNA work led by councils.	1. First phase review of capacity and capacity completed. Analyst network in place to support sharing skills and expertise

needs and how this contributes to health inequalities across the footprint resulting in widening health inequalities.		and supporting a system approach. 2 x PHM posts (joint with local authorities) recruited to. 2. Refresh of PH Strategy required to ensure system BI capacity is wrapping around the correct priorities. 3. PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. Need for appropriate data sharing arrangements to be finalised to support this work. 4. Further momentum needed in relation to digital developments. 5. Engagement strategies being developed with the SCCtH and TWIPP boards. Joint posts with local authority to develop partnership and place based working to deliver the needs of the population. 6. PHM SRO within ICS structure but reporting lines and working group arrangements to be developed.

		7. Funding requirement linked to output of the CSU Strategy Unit review.
9.Safeguarding / Looked After Child (LAC) There may be insufficient capacity to carry out statutory safeguarding responsibilities for adults and children within our system.	1. Robust safeguarding governance infrastructures for the two system local authorities, which is well attended by all statutory partners. 2. Regional safeguarding governance infrastructure which is well attended by CCG. 3. Experienced team members and good professional links between providers and commissioners of services across Shropshire, Telford and Wrekin.	1. Maintain attendance of designated and named professionals at safeguarding and LAC governance fora. 2. Continue to triangulate information and outcomes and address areas of concern. 3. Continue to undertake quality assurance visits. 4. Scope out development of a proactive/reactive support offer to CYP care homes with system partners. 5. Continue to support commissioners and providers in implementing new models of care.
10. Risk of sustained UEC pressure There is a risk that demand for urgent and emergency care consistently outstrips capacity and that this will result in patients suffering harm.	1. Daily Silver Call. 2. Weekly Gold Call. 3. UEC Improvement Plan in place.	1. Several improvement workstreams in place but capacity to deliver change has been limited due to the level of system pressure. There are signs that this is now beginning to ease. 2. Learning from our current UEC

		Improvement Plan and the approach to recent pressures needs to be consolidated and mapped into the current re-drafting of our UEC Plan from April 2022. 3. Significant collaboration between partners agencies, including our local authorities in addressing current pressures has shown benefits. 4. Winter Communications Plan in place, Winter Plan and specific winter schemes in place. 5. CCG UEC staffing resource structure developed and requires further discussion at Exec level regarding potential to implement. 6. Specific development in place regarding discharge and attendance avoidance.

Other sources of assurance

Internal Control Framework

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

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control has been in place and under review for the year 2021/22 and up to the date of approval of the Annual Report and accounts.

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

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

The following control mechanisms are in place:

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

Annual audit of conflicts of interest management

The CCG has a Conflicts of Interest Policy which governs the process for employees, Governing Body members, CCG Members, contractors and others undertaking functions on behalf of the CCG to declare their interests where these may conflict with those of the CCG. The Policy outlines a process for individuals both employed by the CCG or those not employed but acting on behalf of the CCG, to declare these interests to ensure that decisions made on behalf of the CCG are not compromised. The policy and registers can be found on the CCG website: www.shropshiretelfordandwrekinccg.nhs.uk/about-us/conflicts-of-interest/

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG has carried out its annual internal audit of conflicts of interest and the audit provided moderate assurance, with some recommendations for further action. The key areas that required management action were:

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

All recommendations have been fully accepted by the CCG and mandatory training is due to be up to date by 30 May 2022. Register of interests have been updated for Governing Body members and the senior management team and for practice members, with some of the latter still outstanding which have been escalated.

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

Data quality

The Board relies on the data quality elements in its contracts with providers that requires them to quality assure their data prior to submission. The CCG also uses NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) for provider information performance, quality and finance and therefore the CCG's contract with MLCSU outlines information reporting expectations. The data sources used by MLCSU is the national UNIFY system and Secondary Uses Service (SUS) data which is verified via the contracting process with providers.

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, particularly personal identifiable information. The framework is supported by a Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the CCG, other organisations and individuals that personal information is dealt with legally, securely, efficiently and effectively. The CCG has delivered a compliant DSPT for 2021/22 and submitted by the end of March 2022, ahead of the 30 June 2022 deadline.

The CCG places high importance on ensuring there are robust information governance (IG) systems and processes in place to help protect patient and corporate information. We have established an IG management framework and have developed processes and procedures in line with the DSPT. We have ensured all staff undertake annual IG training and provide a staff IG handbook to ensure everyone is aware of their roles and responsibilities.

There are processes in place for incident reporting and the investigation of serious incidents. We have reported a total of 10 incidents during 2021/22 and all these incidents were graded as non-reportable – very low risk and therefore not reported to the Information Commissioner's Office (ICO). We have developed an information asset register which enables the CCG to identify high-risk assets through data flow mapping, and the CCG ensures that an information risk culture is embedded throughout the organisation.

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

A work programme has been undertaken by MLCSU to ensure that the CCG is compliant against General Data Protection Regulations. As part of this, the CCG's information has been audited, staff training has been delivered and the CCG has a nominated Data Protection Officer.

Business-critical models

The CCG relies on centrally provided NHS business planning models to help it plan future strategy. The CCG has no business-critical models that it would be required to share with the Analytical Oversight Committee.

Third-party assurances

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

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

Raising concerns – freedom to speak up

The CCG has a policy in place to support staff to raise concerns (sometimes referred to as 'whistleblowing'). There have been no concerns raised by staff during the year 2021/22. The CCG has appointed a Speak Up Guardian at Board level to support staff to raise concerns under the policy moving forward.

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

Control issues

The significant control issues that have materialised during 2021/22 that would require reporting in this Annual Governance Statement are as follows:

1. Financial deficit

The Shropshire, Telford and Wrekin system is part of the Recovery Support Programme – Level 4 of the NHSEI System Oversight Framework. The system and CCG is therefore subject to significant scrutiny around finances and financial decisions. In 2021/22 the CCG (and the wider system) is reporting a deficit against the NHSEI requirement of break-even.

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

2. Quality issues at local providers

Shrewsbury and Telford Hospitals NHS Trust (SaTH) remains the most challenged provider and cause for concern within the Shropshire, Telford and Wrekin healthcare system. The CCG continues to work with SaTH to manage significant performance and quality issues in year in relation to its acute provider, which is in special measures for quality.

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

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

3. Urgent and emergency care

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

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

Multi-Agency Discharge Events (MADE) have proved valuable and system-level demand and capacity meetings have mitigated some of the risk with forecasting the bed model

required to achieve optimum flow. Outbreaks and staffing shortages due to COVID-19 have seen a number of system bed closures, which has severely impacted upon the ability to manage the back door and is reflected in this month's performance.

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

4. COVID-19 pandemic

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

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

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

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

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

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

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

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

Delegation of functions

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

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

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

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

Counter fraud arrangements

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

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

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

Head of Internal Audit (HOIA) Opinion

This opinion should be taken in its entirety for the Annual Governance Statement and any other purposes for which it is repeated. The purpose of my Head of Internal Audit Opinion (HOIAO) is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control.

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

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

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

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

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

The design and operation of the Assurance Framework and associated processes

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

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

It is my view that an Assurance Framework has been established which is designed and is broadly operating to meet the requirements of the 2022/23 Annual Governance Statement

and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. Updates for the BAF should be maintained.

The system of internal control based on internal audit work undertaken

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

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

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

**Draft at time of providing opinion*

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

Limited assurance review

Child safeguarding

The review noted positive feedback from system partners and we were provided with some good examples of system working despite the pressure that the service is under. A key

theme throughout the review had been the improvements required in terms of the reporting and assurances that need to be provided throughout the governance structure of the CCG.

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

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

Moderate assurance reviews

Adult safeguarding

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

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

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

Complaints

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

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

Conflicts of interest

The effective management of conflicts of interest within an organisation plays a pivotal role in providing assurances over governance arrangements and in particular transparency with key decision making. The CCG had a hard-working team, and despite a range of controls in operation, it was noted that declarations held for the majority of Governing Body members

and Senior Management Team had just lapsed the 12-month period at the time of our review. Mandatory training compliance for conflicts of interest required improvement.

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

Individual commissioning – funding nursing costs (FNC)

Review of FNC cases at three months is not routinely carried out (as based on best practice). This is due to current operational issues for the Individual Commissioning team – mainly team capacity and changed priorities in response to system escalation and patient flow.

In addition, as at February 2022 there was a significant number of FNC cases which have not been reviewed within 12 months. This backlog of outstanding referrals is in the process of being cleared by the CCG's dedicated interim team.

There still remains significant vacancies and sickness levels within the Clinical Staffing team which means that individual commissioning assessments and reviews (including FNC) are not carried out as quickly as planned. An active ongoing recruitment process is in place to help address establishment shortfalls.

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

Provider serious incidents

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

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

Sample testing identified some delays with providers reporting incidents within Strategic Executive Information Systems (StEIS) in line with the previous, but now suspended, two working day requirement. We also noted a lack of evidence to support compliance with Duty

of Candour (DoC) requirements (at providers) where it was not evident this had been identified through the CCG process.

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

Other

Transition to Integrated Care Board

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

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

Financial position

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

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

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

Following up of actions arising from our work

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

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

Reliance on third-party assurances

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

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

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

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

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

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

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

- There were concerns that at the time of review there were no plans to develop a prospective schedule of proactive safeguarding quality assurance visits
- The CCG was unable to identify a service-level agreement with the Designated Doctor
- Some enhancements were also found that could be made to policies
- Since the time of review, the CCG has been working through their action plan for this area.

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

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

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

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

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

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

The Head of Internal Audit Opinion contained within this report sets out an overview of the control issues we have faced which are also set against a number of external, ongoing challenges within the environment in which we commission services. These challenges continue to be evident in 2021/22 coupled with those posed by the continued need to respond to the COVID-19 pandemic.

However, during the year, progress has been made to address these challenges. This Annual Report highlights many of our achievements during this period and our Internal Audit opinion reflects the efforts by CCG staff to make the required improvements. Despite this

progress, significant issues still remain and Shropshire, Telford and Wrekin CCG will continue to build on the work we have commenced to address these ongoing challenges. In doing so we will continue to utilise the assurance methods available to us which are outlined above, but will strive to enhance and build on these foundations in order to ensure a robust transition of the CCG's internal system of control to the new Integrated Care Board (ICB) in 2022/23.

Conclusion

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

Mr Mark Brandreth
Interim Accountable Officer
xx June 2022

Remuneration Report

Remuneration Committee

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

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

Policy on the remuneration of senior managers

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

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

These tables are subject to audit by our external auditor.

A shadow ICB board has been in operation for the period 1 April 2021 to 31 March 2022. No remuneration or pension details have been disclosed in respect of these members since they have no voting rights or decision making powers.

Salary and pension benefits

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

Name	Title	Appointment details	Salary (bands of £5,000)	Expenses payments	Performance pay and bonuses	Long-term performance pay and bonuses	All pension related benefits	Total (bands of £5,000)
Astakhar Ahmed*	Assistant Lay Member, Patient and Public Involvement for Equality, Diversity and Inclusion	01/04/21 to 21/03/22	5 – 10	-	-	-	-	5 – 10
Martin Allen*	Secondary Care Clinician	01/04/21 to 21/03/22	10 – 15	-	-	-	-	10 – 15
Geoff Braden*	Lay member, Audit	01/04/21 to 21/03/22	100 – 105	-	-	-	-	200 – 205
Mark Brandreth	Interim Accountable Officer	01/04/21 to 21/03/22	15 – 20	-	-	-	95 – 97.5	15 – 20
Rachael Bryceland*	GP/Healthcare Professional	01/04/21 to 21/03/22	25 – 30	-	-	-	-	25 – 30
Laura Clare	Interim Director of Finance	01/04/21 to 21/03/22	50 – 55	-	-	-	60 – 62.5	110 – 115
Julie Davies	Director of Performance	01/04/21 to 21/03/22	105 – 110	-	-	-	42.5 - 45	150 – 155
Mary Ilesanmi*	GP/Healthcare Professional	01/04/21 to 21/03/22	25 – 30	-	-	-	-	25 – 30
Michael Matthee*	GP/Healthcare Professional	01/04/21 to 21/03/22	5 – 10	-	-	-	-	5 – 10
Donna McArthur	Lay member, Primary Care	01/04/21 to 21/03/22	25 – 30	-	-	-	-	25 – 30

Claire Parker	Director of Partnerships	01/04/21 to 21/03/22	105 – 110	-	-	-	42.5 - 45	150 – 155
John Pepper*	Chair and GP/Healthcare Professional	01/04/21 to 21/03/22	100 – 105	-	-	-	-	100 – 105
Adam Pringle*	GP/Healthcare Professional	01/04/21 to 21/03/22	25 – 30	-	-	-	-	25 – 30
Deborah Shepherd	Medical Director	01/04/21 to 21/03/22	85 – 90	-	-	-	35 – 37.5	120 – 125
Claire Skidmore	Interim Accountable Officer	01/04/21 to 21/03/22	45 – 50	-	-	-	37.5 – 40	85 – 90
Claire Skidmore	Executive Director of Finance	01/04/21 to 21/03/22	85 – 90	-	-	-	52.5 – 55	140 – 145
Alison Smith	Director of Corporate Affairs	01/04/21 to 21/03/22	105 – 110	-	-	-	45 – 47.5	150 – 155
Fiona Smith*	GP/Healthcare Professional	01/04/21 to 21/03/22	40 – 45	-	-	-	-	40 – 45
Samantha Tilley	Director of Planning	01/04/21 to 21/03/22	105 – 110	-	-	-	45 – 47.5	150 – 155
Stephen Trenchard	Executive Director of Transformation	01/04/21 to 21/03/22	80 – 85	-	-	-	30 – 32.5	110 – 115
Meredith Vivian*	Deputy Chair, Lay member for Patient and Public Involvement	01/04/21 to 21/03/22	15 – 20	-	-	-	-	15 – 20
Audrey Warren*	Independent Nurse	01/04/21 to 21/03/22	5 – 10	-	-	-	-	5 – 10
Zena Young	Executive Director of Nursing and Quality	01/04/21 to 21/03/22	120 – 125	-	-	-	37.5 – 40	160 – 165

Salary and pension benefits 2020/21 – Shropshire CCG

Name	Title	Appointment details	Salary (bands of £5,000)	Expenses payments	Performance pay and bonuses	Long-term performance pay and bonuses	All pension related benefits	Total (bands of £5,000)

Shropshire, Telford and Wrekin Clinical Commissioning Group

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Ahmed *	Ash	Lay Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Allen *	Martin	Secondary doctor member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Bird	Matthew	Locality Chair	01/04/20 to 31/07/20	10-15	-	-	-	(5)-(7.5)	0-5
Braden *	Geoff	Lay Member - Governance & Audit - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Bryceland	Rachel	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	(72.5)-(75)	(60)-(65)
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	65-70	-	-	-	32.5-35	100-105
Evans *	David	Accountable Officer - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	90-95	-	-	-	-	90-95
Fortes-Mayer	Gail	Interim Director	01/04/20 to 31/10/20	55-60	-	-	-	112.5-115	170-175
George	Priya	GP Governing Body Member	01/04/20 to 31/07/20	5-10	-	-	-	2.5-5	5-10
James *	Stephen	GP Governing Body Member	01/04/20 to 31/07/20	15-20	200	-	-	-	15-20
James *	Stephen	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	35-40	-	-	-	-	35-40
Leaman *	Alan	Secondary Care Clinical Member	01/04/20 to 31/07/20	5-10	-	-	-	-	5-10
Lynch	Finola	GP Governing Body Member/Deputy Clinical Chair	01/04/20 to 30/04/20	0-5	-	-	-	0-2.5	5-10
Macarthur *	Donna	Lay Member - Joint post with Telford & Wrekin CCG	12/10/20 to 31/03/21	0-5	-	-	-	-	0-5
Matthee *	Michael	GP Governing Body Member	01/04/20 to 31/07/20	5-10	-	-	-	0-2.5	10-15
Matthee *	Michael	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	0-2.5	5-10
McCabe *	Julie	Nurse Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/01/21	0-5	-	-	-	-	0-5
Morris	Kevin	Practice Representative	01/04/20 to 31/07/20	15-20	-	-	-	27.5-30	45-50
Parker	Claire	Director of Partnerships - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	65-70	-	-	-	(0)-(2.5)	65-70
Pepper	John	GP Governing Body Member	01/04/20 to 31/07/20	5-10	-	-	-	10-12.5	25-30
Pepper	John	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	20-22.5	30-35
Porter *	Sarah	Lay Member - Transformation	01/04/20 to 31/07/20	5-10	-	-	-	-	5-10
Povey *	Julian	Chair (Clinical)	01/04/20 to 31/07/20	30-35	-	-	-	-	30-35
Povey *	Julian	Chair (Clinical) - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	35-40	-	-	-	-	35-40
Pringle	Adam	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	2.5-5	15-20
Shepherd	Deborah	Medical Director	01/04/20 to 31/07/20	20-25	-	-	-	7.5-10	30-35
Shepherd	Deborah	Medical Director - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	25-30	-	-	-	7.5-10	35-40
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	80-85	-	-	-	60-62.5	140-145
Smith	Alison	Director of Corporate Affairs - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	65-70	-	-	-	55-57.5	120-125
Smith *	Fiona (Danella)	Practice Representative - joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	-	10-15
Stanford *	Colin	Lay Member	01/04/20 to 31/07/20	5-10	-	-	-	-	5-10
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	65-70	-	-	-	37.5-40	105-110
Timmis *	Keith (Andrew)	Lay Member - Governance & Audit	01/04/20 to 31/07/20	0-5	-	-	-	-	0-5
Timmis *	Keith (Andrew)	Lay Member - Governance & Audit - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	5-10	-	-	-	-	5-10
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	75-80	-	-	-	(7.5)-(10)	65-70
Turner *	Gary	Lay Member - Joint post with Telford & Wrekin CCG	01/08/20 to 18/09/20	0-5	-	-	-	-	0-5
Vivian *	Meredith	Lay Member - Patient & Public Involvement	01/04/20 to 31/07/20	5-10	-	-	-	-	5-10
Vivian *	Meredith	Lay Member - Patient & Public Involvement - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	5-10	-	-	-	-	5-10
Wilde	Nicola	Interim Director	01/04/20 to 31/10/20	55-60	-	-	-	47.5-50	105-110
Young	Zena	Executive Director of Quality - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	70-75	-	-	-	170-172.5	245-250

* Not in the NHS Pension scheme in this employment

Salary and pension benefits 2020/21 – Telford and Wrekin CCG

Name	Title	Appointment details	Salary (bands of £5,000)	Expenses payments	Performance pay and bonuses	Long-term performance pay and bonuses	All pension related benefits	Total (bands of £5,000)

Shropshire, Telford and Wrekin Clinical Commissioning Group

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Ahmed *	Ash	Lay Member - Joint post with Shropshire CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Allen *	Martin	Secondary Care member	01/04/20 to 31/07/20	0-5	-	-	-	-	0-5
Allen *	Martin	Secondary Care member - Joint post with Shropshire CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Braden *	Geoff	Lay Member - Governance & Audit	01/04/20 to 31/07/20	0-5	-	-	-	-	0-5
Braden *	Geoff	Lay Member - Governance & Audit - Joint post with Shropshire CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Bryceland	Rachel	GP Governing Body Member	01/04/20 to 31/07/20	10-15	-	-	-	(57.5)-(60)	(45)-(50)
Bryceland	Rachel	GP Governing Body Member - Joint post with Shropshire CCG	01/08/20 to 31/03/21	5-10	-	-	-	(27.5)-(30)	(20)-(25)
Chan	Kwok Yin	GP Governing Body Member	01/04/20 to 31/07/20	10-15	-	-	-	2.5-5	15-20
Cooke	Jonathan	Interim Director	01/04/20 to 31/10/20	55-60	100	-	-	352.5-355	410-415
Davies	Julie	Director of Performance - Joint post with Shropshire CCG	01/04/20 to 31/03/21	35-40	-	-	-	17.5-20	55-60
Eastaugh *	Peter	Lay Member	01/04/20-31/07/20	0-5	300	-	-	-	0-5
Evans *	David	Accountable Officer - Joint post with Shropshire CCG	01/04/20 to 31/03/21	50-55	100	-	-	-	50-55
Fenton West	Carolyn	GP Governing Body Member	01/04/20 to 31/07/20	10-15	-	-	-	(135)-(137.5)	(120)-(125)
James *	Stephen	Interim Chief Clinical Information Officer - Joint post with Shropshire CCG	01/08/20 to 31/03/21	20-25	-	-	-	-	20-25
Leahy *	Joanne	GP Chair	01/04/20 to 31/07/20	30-35	-	-	-	-	30-35
Macarthur *	Donna	Lay Member - Joint post with Shropshire CCG	12/10/20 to 31/03/21	0-5	-	-	-	-	0-5
Matthee *	Michael	GP Governing Body Member - Joint post with Shropshire CCG	01/08/20 to 31/03/21	5-10	-	-	-	-	5-10
Maybury *	Neil	Lay Member	01/04/20-31/07/20	0-5	300	-	-	-	0-5
McCabe *	Julie	Nurse Member - Joint post with Shropshire CCG	01/08/20 to 31/01/21	0-5	-	-	-	-	0-5
Parker	Claire	Director of Partnerships - Joint post with Shropshire CCG	01/04/20 to 31/03/21	35-40	-	-	-	(0)-(2.5)	35-40
Pepper *	John	GP Governing Body Member - Joint post with Shropshire CCG	01/08/20 to 31/03/21	5-10	-	-	-	10-12.5	15-20
Povey *	Julian	Chair (Clinical) - Joint post with Shropshire CCG	01/08/20 to 31/03/21	20-25	-	-	-	-	20-25
Pringle	Adam	GP Governing Body Member	01/04/20 to 31/07/20	5-10	-	-	-	0-2.5	10-15
Pringle	Adam	GP Governing Body Member - Joint post with Shropshire CCG	01/08/20 to 31/03/21	5-10	-	-	-	0-2.5	5-10
Shepherd	Deborah	Medical Director - Joint post with Shropshire CCG	01/08/20 to 31/03/21	15-20	-	-	-	5-7.5	20-25
Skidmore	Claire	Executive Director of Finance - Joint post with Shropshire CCG	01/04/20 to 31/03/21	45-50	-	-	-	32.5-35	80-85
Smith	Alison	Director of Corporate Affairs - Joint post with Shropshire CCG	01/04/20 to 31/03/21	35-40	-	-	-	30-32.5	35-40
Smith *	Fiona (Danella)	Practice Representative - Joint post with Shropshire CCG	01/08/20 to 31/03/21	5-10	-	-	-	-	5-10
Tilley	Samantha	Director of Planning - Joint post with Shropshire CCG	01/04/20 to 31/03/21	35-40	-	-	-	20-22.5	55-60
Timmis *	Keith (Andrew)	Lay Member - Governance & Audit - Joint post with Shropshire CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Shropshire CCG	01/04/20 to 31/03/21	40-45	-	-	-	(2.5)-(5)	35-40
Turner *	Gary	Lay Member - Joint post with Shropshire CCG	01/08/20 to 18/09/20	0-5	-	-	-	-	0-5
Vivian *	Meredith	Lay Member - Patient & Public Involvement - Joint post with Shropshire CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Young	Zena	Executive Director of Quality - Joint post with Shropshire CCG	01/04/20 to 31/03/21	40-45	-	-	-	95-97.5	40-45

Pension benefits

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

Pension benefits 2021/22 – Shropshire, Telford and Wrekin CCG

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31.03.22 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31.03.22 (bands of £5,000)	Cash Equivalent Transfer Value at 31.03.22 (£'000)	Cash Equivalent Transfer Value at 01.04.21 (£'000)	Real increase in Cash Equivalent Transfer Value (£'000)	Employer's contribution to stakeholder pension (rounded to nearest £00)
Mark Brandreth	Interim Accountable Officer (01.09.21 – 31.03.22)	2.5 – 5	2.5 – 5	65 – 70	140 – 145	1,201	1,108	87	0
Laura Clare	Interim Director of Finance (01.04.21 – 31.08.21)	2.5 – 5	5 – 7.5	25 – 30	40 - 45	326	282	43	0
Julie Garside (nee Davies)	Director of Performance	0 – 2.5	0 – 2.5	25 – 30	40 – 45	485	442	41	0
Claire Parker	Director of Partnerships	0 – 2.5	0 – 2.5	25 – 30	45 – 50	528	483	43	0
Deborah Shepherd	Medical Director	0 – 2.5	0 – 2.5	15 – 20	25 – 30	301	265	35	0

Claire Skidmore	Interim Accountable Officer (01.04.21 – 31.08.21)	0 – 2.5	0 – 2.5	20 – 25	35 – 40	299	268	29	0
Claire Skidmore	Executive Director of Finance (01.09.21 – 31.03.22)	2.5 – 5	2.5 – 5	25 – 30	55 – 60	419	376	41	0
Alison Smith	Director of Corporate Affairs	0 – 2.5	0 – 2.5	40 – 45	0 – 5	572	529	41	0
Samantha Tilley	Director of Planning	0 – 2.5	0 – 2.5	30 – 35	65 – 70	577	534	40	0
Stephen Trenchard	Executive Director of Transformation	0 – 2.5	0 – 2.5	15 – 20	0 – 5	257	229	27	0
Zena Young	Executive Director of Nursing and Quality	0 – 2.5	5 – 7.5	50 – 55	155 – 160	1,219	1,146	67	0

Pension benefits 2020/21 – Shropshire CCG

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31.03.21 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31.03.21 (bands of £5,000)	Cash Equivalent Transfer Value at 31.03.21 (£'000)	Cash Equivalent Transfer Value at 01.04.20 (£'000)	Real increase in Cash Equivalent Transfer Value (£'000)	Employer's contribution to stakeholder pension (rounded to nearest £00)
Matthew Bird	Locality Chair	(0) – (2.5)	(0) – (2.5)	10 – 15	35 – 40	218	211	3	0
Julie Davies	Director of Performance (joint with T&W CCG)	2.5 – 5	0 – 2.5	25 – 30	40 – 45	442	388	47	0
Gail Fortes-Mayer	Interim Director	5 – 7.5	5 – 7.5	45 – 50	65 – 70	719	618	91	0
Priya George	GP Governing Body Member	0 – 2.5	(0) – (2.5)	0 – 5	10 – 15	73	69	3	0
Finola Lynch	GP Governing Body Member / Deputy Clinical Chair	0 – 2.5	(0) – (2.5)	15 – 20	35 – 40	272	262	5	0
Kevin Morris	Practice Representative	0 – 2.5	(0) – (2.5)	15 – 20	40 – 45	392	359	27	0
John Pepper	GP Governing Body Member (joint with T&W CCG)	0 – 2.5	5 – 7.5	10 – 15	25 – 30	239	182	54	0

Deborah Shepherd	Medical Director (joint with T&W CCG)	0 – 2.5	(0) – (2.5)	10 – 15	25 – 30	265	241	20	0
Claire Skidmore	Executive Director of Finance (joint with T&W CCG)	2.5 – 5	5 – 7.5	40 – 45	90 – 95	644	565	70	0
Samantha Tilley	Director of Planning (joint with T&W CCG)	2.5 – 5	0 – 2.5	30 – 35	65 – 70	534	476	50	0
Nicola Wilde	Interim Director	0 – 2.5	0 – 2.5	30 – 35	60 – 65	628	571	47	0

Pension benefits 2020/21 – Telford and Wrekin CCG

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31.03.21 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31.03.21 (bands of £5,000)	Cash Equivalent Transfer Value at 31.03.21 (£'000)	Cash Equivalent Transfer Value at 01.04.20 (£'000)	Real increase in Cash Equivalent Transfer Value (£'000)	Employer's contribution to stakeholder pension (rounded to nearest £00)
Rachel Bryceland	GP Governing Body Member (joint with SCCG)	0 – 2.5	(25) – (27.5)	15 – 20	25 – 30	238	366	-135	0
Kwok Chan	GP Governing Body Member	0 – 2.5	0 – 2.5	10 – 15	0 – 5	129	122	5	0
Jonathan Cooke	Interim Director	15 – 17.5	37.5 – 40	40 – 45	85 – 90	733	421	305	0

Carolyn Fenton West	GP Governing Body Member	0 – 2.5	(25) – (27.5)	10 – 15	20 – 25	259	394	-142	0
Claire Parker	Director of Partnerships (joint with SCCG)	0 – 2.5	(5) – (7.5)	25 – 30	40 – 45	483	475	-0	0
Adam Pringle	GP Governing Body Member (joint with SCCG)	0 – 2.5	0 – 2.5	10 – 15	30 – 35	249	235	10	0
Alison Smith	Director of Corporate Affairs (joint with SCCG)	2 – 5.5	0 – 2.5	35 – 40	0 – 5	529	453	68	0
Steven Trenchard	Interim Executive Director of Transformation (joint with SCCG)	0 – 2.5	0 – 2.5	15 – 20	0 – 5	229	234	-9	0
Zena Young	Executive Director of Quality (joint with SCCG)	10 – 12.5	32.5 – 35	45 – 50	145 – 150	1,146	845	286	0

Compensation on early retirement or for loss of office

Shropshire, Telford and Wrekin CCG does not have any to report during 2021/22 (nil in 2020/21).

Payment to past members

Shropshire, Telford and Wrekin CCG does not have any to report during 2021/22 (nil in 2020/21).

Pay ratio information

Percentage change in remuneration of highest paid director

2021/22	Salary and allowances	Performance pay and bonuses
Highest paid director: Percentage change compared to 2020/21	20.34%	N/A
All staff: Percentage change compared to 2020/21	12.25%	N/A

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

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

As at 31 March 2022, remuneration ranged from £12k to £180k (-37% to +21% against 2020/21: £19k to £149k) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

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

Remuneration of Shropshire, Telford and Wrekin CCG's staff

2021/22	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£21,777	£32,306	£54,764
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£21,777	£32,306	£54,764

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

The banded remuneration of the highest paid director/member in Shropshire, Telford and Wrekin CCG in the financial year 2021/22 was £175k to £180k (+20.6% to + 20% against 2020/21: £145k to £150k) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio	75th percentile salary ratio
8.1	8.1	5.1	5.1	3.1	3.1

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

Expenditure on consultancy

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

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, CCGs must publish information on their

highly paid and/or senior off-payroll engagements. The tables below show the existing arrangements as of 31 March 2022.

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

Number of existing engagements as of 31 March 2022	Number
Of which, number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

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

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

For all off-payroll engagements as at 31 March 2022 for more than £245* per day

Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	Number
Of which, number that have existed:	
Number not subject to off-payroll legislation(2)	0
Number subject to off-payroll legislation and determined as in-scope of IR35(2)	0
Number subject to off-payroll legislation and determined as out of scope of IR35(2)	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: Number of engagements that saw a change to IR35 status following review	0

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

Off-payroll engagements and senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022

Number of off-payroll engagements	Number
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year.(1)	0
Total no. of individuals on payroll and off-payroll that have been deemed 'Board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure should include both on-payroll and off-payroll engagements.(2)	22

Exit packages and severance payments

Exit packages agreed in the financial year 2021/22

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

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

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

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

Staff costs

Employee benefits and staff numbers

Employee benefits 2021/22

Employee benefits	Permanent Employees £'000	Other £'000	Total £'000
Salaries and wages	9,099	1,174	**10,273**
Social security costs	920	-	**920**
Employer contributions to NHS pension scheme	1,582	-	**1,582**
Other pension costs	-	-	**-**
Apprenticeship levy	34	-	**34**
Other post-employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	-	-	**-**
Gross employee benefits expenditure	**11,635**	**1,174**	**12,810**
Less recoveries in respect of employee benefits (note 4.1.3)	-	-	**-**
Total – net admin employee benefits including capitalised costs	**11,635**	**1,174**	**12,810**
Less: employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**11,635**	**1,174**	**12,810**

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

Staff Report (subject to audit)

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

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

Headcount by gender 2021/22

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

Percentage by gender 2021/22

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

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

Headcount by gender 2020/21

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

Percentage by gender 2020/21

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

Staff composition by pay band

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

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

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

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

Sickness absence data

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

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

Staff turnover

CCG Staff Turnover 2021-22	2021-22 Number
Average FTE Employed 2021-22	213.73
Total FTE Leavers 2021-22	42.49
Turnover Rate	19.88%

The CCG Staff Turnover Rate for 2021-22 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The CCG's Total FTE Leavers in year was 42.49. The CCG's Average FTE Staff in Post during the year was 213.73. The CCG Staff Turnover Rate for the year was 19.88%.

Other employee matters

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

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

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

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

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

Employees with a disability

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

The CCG's commitment to people with disabilities includes:

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

Trade union facility time

In 2021/22 we had no Trade Union officials within the Shropshire, Telford and Wrekin CCG.

Relevant union officials

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

Percentage of time spent on facility time

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

100%	0

Percentage of pay bill spent on facility time

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

Paid trade union activities

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

Health and safety

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

During 2021/22, due to the COVID-19 pandemic the majority of CCG staff have continued to work from home, but with a small number of staff having to work in the office environment due to the nature of their roles. In order to ensure that staff safety was paramount during the pandemic we have assessed the risk to all staff having to work from the office and put mask wearing protocols and social distancing and cleaning processes in place to allow them to do so safely. Some staff have been identified as having a greater risk and have been either redeployed or provided with equipment to allow them to work from home.

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

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

Statement as to disclosure to auditors

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

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

Parliamentary Accountability and Audit Report

The CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts and fees and charges are included as notes in the Financial Statements of this Annual Report at note 22.

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

Finance section of Accountability Report Corporate Governance

Information governance incidents

The CCG has reported a total of 10 incidents during 2021/22. All these incidents were graded as non-reportable – very low risk and therefore not reported to the Information Commissioner's Office (ICO).

Statement of disclosure to auditors

Each individual who is a member of the membership body at the time the Members' Report is approved confirms that they know of no information which would be relevant to the auditors for the purposes of their Audit Report, and of which the auditors are not aware, and has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Fraud

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

The CCG employed the services of assurance provider CW Audit Services during 2021/22 to provide its local counter fraud specialists. The CCG does not tolerate economic crime. The CCG has an Anti-Fraud, Bribery and Corruption Response Policy in place which is designed to make all staff aware of their responsibilities should they suspect offences being committed.

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

Audit Report

External audit fees, work and independence

The CCG's External Auditors are Grant Thornton UK LLP,
17th Floor, 103 Colmore Row, Birmingham B3 3AG. The contract value for 2021/22 was £84,400 excluding VAT. The contract included the core audit work of the financial statements and work to reach a conclusion on the economy, efficiency and effectiveness in the CCG's use of resources (Value for Money conclusion).

Annual Accounts

Information not available until after financial year end (END OF MAY)

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **The Governing Body of NHS Shropshire, Telford and Wrekin CCG at a meeting to be held on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.054	ICB Constitution – Proposal to NHS England

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Alison Smith Director of Corporate Affairs alison.smith112@nhs.net

Action Required (please select):									
A=Approval		R=Ratification	X	S=Assurance		D=Discussion		I=Information	

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
This paper was presented to the Chair and Interim Accountable Officer in consultation with the Lay Member for PPI for an emergency decision under section 6.3.16 and 6.3.17 of standing orders.	24th May 2022	A (Emergency Decision)

Executive Summary (key points in the report):

Introduction

The Health and Care Act 2022 states that the Clinical Commissioning Group (CCG) must propose the Constitution for the first Integrated Care Board (ICB) to be established for the ICB area. This paper presents the final draft of the NHS Shropshire, Telford and Wrekin ICB Constitution which is attached as appendix 1.

Decision Making

Due to the requirement for the proposal to be submitted to NHS England by 27th May, the Chair and Accountable Officer were asked to make an emergency decision under the CCG's Standing Order 6.3.16 and 6.3.17 which allow for powers of the CCG, which are delegated to or reserved by the Governing Body, for an urgent decision be exercised by the Chair and Accountable Officer having consulted with at least one Lay Member. The outcome of this emergency decision is being reported to the Governing Body for ratification, as required in standing orders.

Constitution

The first Constitution of the ICB will be formally approved by NHS England and therefore the Chair and Accountable Officer were asked to consider the process followed by the CCG to develop the Constitution and the engagement that has taken place with partner organisations on the content, to propose the Constitution for consideration by NHS England and to provide assurance to support their approval.

In line with NHSE Guidance the CCG has developed the ICB Constitution with our ICB designate leaders. We have used the ICB model Constitution produced by NHSE which includes mandated elements (legal or policy requirements) and elements which may be modified locally, broadly based on example wording.

To ensure that the CCG complied with the Health and Care Act 2022, there has been extensive discussions and reviews of drafts of the ICB Constitution with and by NHS England over the last 6 months, as the Bill proceeded through its parliamentary process and further supported by a number of webinars hosted by NHSE specialists. The last submission to NHS England was on 22nd April with minor changes agreed as a result.

The CCG has consulted with the ICB Designate Chair and ICB Designate Chief Executive Officer and bodies and organisations across the ICB area including partner Trusts/ Foundation Trusts, primary care representatives, relevant Local Authorities, VCS and Healthwatch on the content of the Constitution. Feedback has been positive with no specific issues raised that required action to amend or add to the content of the Constitution. More detail is provided in the attachment to this report.

Following the emergency decision to propose the Constitution, the CCG's Accountable Officer has formally communicated this decision and the proposed NHS Shropshire, Telford and Wrekin ICB Constitution to the NHSE Regional Director. The NHSE Regional Director will recommend to the NHSE Chief Executive whether the proposed Constitution should be approved.

It should be noted that the model Constitution allows for NHSE to attach conditions to its approval, for example where it is recognised that proposals may be appropriate initially but will need to be revisited, as Committees of the ICB – including Place Committees – are ready to take on greater responsibility.

The Health and Care Act 2022 provides, if necessary, for NHSE to determine a Constitution if the proposal is inappropriate or CCGs have not carried out appropriate consultation.

NHSE will bring the proposed ICB Constitution into effect for 1 July 2022 through the ICB Establishment Order and will publish all ICB Constitutions on its website in June.

There is no requirement for the first meeting of the ICB Board, currently scheduled for Friday 1 July 2022, to approve the Constitution. However, it will be important to ensure that all Board members are familiar with the Constitution and the provisions within it.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation? The CCG has the statutory responsibility to propose the ICB Constitution to NHS England.	Yes
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	Yes

	The Constitution has been discussed with CCG primary care members via the Locality Forum meetings to brief them on its content and seek views.	
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:
The Governing Body is recommended to RATIFY the emergency decision taken by the Chair and Interim Accountable Officer on 24th May 2022: • **CONSIDER the process and engagement outlined above to support the development of the ICB Constitution and take assurance that the content has been developed in line with NHS England guidance and the Health and Care Act 2022; and** • **APPROVE the submission of the proposed ICB Constitution to NHS England by the Accountable Officer.**

NHS Shropshire, Telford and Wrekin Integrated Care Board Constitution – Consultation

Please find attached the proposed final version of NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB) Constitution.

As required by the Health and Care Act 2022, NHS Shropshire Telford and Wrekin CCG has "consulted any persons they consider appropriate to consult" on the Constitution's content.

This has included:

- ICB Designate Chair and ICB Designate Chief Executive
- NHS Trusts and Foundation Trusts through their CEOs via the regular CEO Group meeting and Chairs attending the ICS/Shadow ICB meetings:
    - Shrewsbury and Telford NHS Hospital Trust,
    - Midlands Partnership NHS Foundation Trust,
    - Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust
    - Shropshire Community Health NHS Trust.
- Primary Care providers through the CCG's locality forums using an agreed structure of engagement that had been agreed between the CCG Medical Director, Director of Partnerships and the CCG membership which included:
    - An initial meeting held with CCG GP board members, clinical leads and locality chairs to present the Constitution structure and start the discussion.
    - Interim CCG AO attended the locality meetings in the autumn to discuss the developing structure.
    - The Medical Director in development with the clinical leads presented a couple of potential options of leadership understanding that the NHSE process for primary care board members was awaited.
    - A workshop of GP practices and Interim Designate ICB Chief Executive led the discussion on the Constitution and specifically around the primary Care partner members.
- Shropshire Council and Telford and Wrekin Council:
    - via their Leaders meeting directly with the ICB Chair
    - Chief Executives attending the regular CEO Group meetings.
- Healthwatch Shropshire and Healthwatch Telford and Wrekin via their Chief Officer and Chair respectively

- Councils for Voluntary Service (CVS) via their representatives on the ICB Shadow Board for Shropshire and Telford and Wrekin.

Feedback has been positive with no specific issues raised that required action to amend or add to the content of the Constitution. A summary of the feedback is below:

Organisation	Feedback	Action taken
NHS Shrewsbury and Telford Hospital Trust	Concern was raised that the focus on the structure of the ICB may distract from the real sense of joint partnership working	The Chair confirmed that part of the transition work was to ensure that the ICB had the legal framework in place but acknowledged that the value of the ICB was the way the partners worked together to achieve common goals of our population. No changes to the Constitution made as a result of the feedback
Healthwatch Shropshire and Healthwatch Telford and Wrekin	Both were content that Healthwatch would continue to attend ICB meetings in the future as attendees.	No action required and no changes to the Constitution made as a result of the feedback
Midlands Partnership Foundation Trust	Query was raised on the content of the role description of the Non Executive Directors on the ICB	Interim Chief Executive provided more detail on the role description that it was partly generic for all four roles but with tailored parts specific to the focus required from that individual and their skill set. No changes to the Constitution made as a result of the feedback.
	Query was raised about committee structure, capacity and configuration.	It was agreed given the ICS size that some committees would need to be configured together due to the capacity of the system to support and attend them. No changes to the Constitution made as a result of the feedback.
Shropshire Community Health NHS Trust	Queried whether the differentiation between voting and non voting ICB members was relevant given the	Interim Chief Executive confirmed that practically speaking a vote is rare but as a statutory body it is

	number of times decision are voted upon.	crucial that accountability of ICB members is clearly outlined. No changes to the Constitution made as a result of the feedback.

NHS Shropshire, Telford and Wrekin Integrated Care Board

CONSTITUTION

Version	Date effective from
Version 1	1st July 2022

CONTENTS

1. Introduction

1.1 Background/ Foreword

Shropshire, Telford and Wrekin Integrated Care Board (ICB) was created as a statutory body on 1st July 2022 as part of our wider Integrated Care System (ICS).

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to take collective responsibility to plan and deliver joined up services and to improve the health of people who live and work in their area.

Our ICS seeks to create a much more integrated system across Shropshire, Telford and Wrekin, working as a multi-organisational partnership both in terms of planning and commissioning services across our population, and in developing more integrated services on the ground.

Our partnership consists of the NHS (Shropshire, Telford and Wrekin ICB, The Shrewsbury and Telford Hospital NHS Trust, The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, Midlands Partnership NHS Foundation Trust, Shropshire Community Health NHS Trust and primary care/GPs), West Midlands Ambulance Service University NHS Foundation Trust, primary care through our Primary Care Networks (PCN), our local councils (Shropshire Council and Telford & Wrekin Council), along with the voluntary sector and other core partners involved in transforming the provision of health and care services across Shropshire, Telford and Wrekin for those we serve.

NHS England has set out the following as the four purposes of ICSs:

a) improve outcomes in population health and healthcare

b) tackle inequalities in outcomes, experience and access

c) enhance productivity and value for money

d) help the NHS support broader social and economic development

The ICB will lead the ICS and is the organisation with responsibility for NHS functions and budgets, supported by an Integrated Care Partnership (ICP); a statutory joint committee bringing together all system partners to produce a health and care strategy.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people

- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Shropshire, Telford and Wrekin Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is aligned with the two unitary authorities; County of Shropshire and Borough of Telford and Wrekin.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of and paragraph 1 of Schedule 1B to the 2006 Act, the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at [add web address]

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act, but there are also other specific pieces of legislation that apply to ICBs: examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);

b) exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);

c) duties in relation to children, including safeguarding, promoting welfare etc. (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);

d) adult safeguarding and carers (the Care Act 2014);

e) equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);

f) information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and

g) provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England, which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—

a) section 14Z34 (improvement in quality of services),

b) section 14Z35 (reducing inequalities),

c) section 14Z38 (obtaining appropriate advice),

d) section 14Z40 (duty in respect of research)

e) section 14Z43 (duty to have regard to effect of decisions)

f) section 14Z44 (public involvement and consultation),

g) sections 223GB to 223N (financial duties), and

h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act), and to intervene where it is satisfied that the

ICB is failing or has failed to discharge any of its functions, or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1st July 2022 by [*name and reference of establishment order*], which made provision for its Constitution by reference to this document.

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act, this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and

b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) Any ICB Member may propose a variation to the Constitution of the ICB by submitting their proposal in writing to the Chief Executive, who will then consult with the Chair and at least two ordinary members of the ICB; one an independent non-executive member and one a partner member. The Chief Executive will present the proposed amendments in a report to the ICB, together with comments from those they have consulted with.

b) The ICB will make the decision to vary the Constitution and make an application to NHS England to accept the proposed amendments.

c) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6, and the ICB's legal duty to have a Constitution:

a) **Standing orders–** which set out the arrangements and procedures to be used for meetings and the processes to appoint to the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published:

a) **The Scheme of Reservation and Delegation (SoRD)–** sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision map–** a high-level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision-making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions–** which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook–** This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The above documents (a) to (c)
- Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.

- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.

- The up-to-date list of eligible providers of primary medical services under clause 3.6.2

e) **Key policy documents–** which should also be included in the Governance Handbook or linked to it - including:

- Standards of Business Conduct Policy

- Conflicts of interest policy and procedures

- Framework and Principles for Public Involvement and Engagement

2. Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section three.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website [add link].]

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board", and members of the ICB are referred to as "board Members") consists of:

a) a Chair

b) a Chief Executive

c) at least three Ordinary members

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICBs functions.

2.1.5 NHS England Policy, requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:

- ICB Chief Finance Officer
- ICB Chief Medical Officer
- ICB Chief Nursing Officer

b) at least two non-executive members.

2.1.6 The Ordinary Members also include at least three members who will bring knowledge and a perspective from their sectors. These members (known as "Partner Members") are nominated by the following and appointed in accordance with the procedures set out in Section 3; below:

- Four NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description;

- Two primary medical services (general practice) providers within the area of the ICB and are of a prescribed description;

- Two local authorities which are responsible for providing Social Care and whose areas coincide with or include the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has eight Partner Members.

a) Four from NHS Trust/Foundation Trusts

b) Two bringing the perspective of primary medical services

c) Two from local authorities

2.2.2 The ICB has also appointed the following further Ordinary Members to the board

- Chair
- Chief Executive
- ICB Chief Medical Officer
- ICB Chief Nursing Officer
- ICB Chief Finance Officer
- ICB Executive Director for Delivery and Transformation
- Four Non Executive Directors

2.2.3 The Board is therefore composed of the following members:

- Chair
- Chief Executive
- Four Partner member(s) NHS and Foundation Trusts
- Two Partner member(s) Primary medical services

- Two Partner member(s) Local Authorities
- Four Non executive members
- ICB Chief Finance Officer
- ICB Chief Medical Officer
- ICB Chief Nursing Officer
- ICB Executive Director for Delivery and Transformation

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the ordinary board members will have the knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting, by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.

a) Chair, The Midlands Partnership NHS Foundation Trust

b) Chair, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

c) Chair, Shrewsbury and Telford Hospital NHS Trust

d) Chair, Shropshire Community Health NHS Trust

e) Leader Shropshire Council

f) Leader Telford and Wrekin Council

g) ICB Executive Directors and Directors other than those outlined in 2.1.6 above.

2.3.3 Observers will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting, by the Chair. Any such person may not address the meeting and may not vote unless given permission from the Chair by exception.

a) Chief Officer, Shropshire Healthwatch

b) Chair, Telford and Wrekin Healthwatch

c) Representative from local VCS Shropshire

d) Representative from local VCS Telford and Wrekin

2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders.

3. Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) comply with the criteria of the “fit and proper person test”

b) be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles);

c) fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member (“the candidate”) is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

a) in the United Kingdom of any offence; or

b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed, within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a Health Service Body, has been terminated on the grounds:

a) that it was not in the interests of or conducive to the good management of the Health Service Body or of the Health Service that the person should continue to hold that office;

b) that the person failed, without reasonable cause, to attend any meeting of that Health Service Body for three successive meetings;

c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest; or

d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A healthcare professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by anybody which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated;

b) the person's erasure from such a register, where the person has not been restored to the register;

c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded; or

d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; or

b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has, at any time, been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has, at any time, been removed or is suspended from the management or control of anybody under—

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities); or

b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) the Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) they hold a role in another health and care organisation within the ICB area;

b) any of the disqualification criteria set out in 3.2; apply.

3.3.4 The term of office for the Chair on establishment of the ICB will be two years initially and then three years for subsequent appointments and the total number of terms a Chair may serve is three terms.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

3.4.4 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply;

b) subject to clause 3.4.3a), they hold any other employment or executive role;

3.5 Partner Member(s) — NHS Trusts and Foundation Trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition which are:

a) Shrewsbury and Telford Hospital NHS Trust

b) Shropshire Community Health NHS Trust

c) The Midlands Partnership NHS Foundation Trust

d) The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

e) The West Midlands Ambulance Service University NHS Foundation Trust

3.5.2 These partner members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an Executive Director of one of the NHS Trusts or FTs within the ICB's area;

b) They must bring the perspective of one of the following sectors:

(i) One bringing the perspective of an NHS Acute Trust

(ii) One bringing the perspective of an NHS specialist Trust

(iii) One bringing the perspective of an NHS Community Trust

(iv) One bringing the perspective, knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

3.5.3 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply;

b) A conflict of interest is evident, as determined by the Chair or the selection panel, which results in the individual being unable to fulfil the role.

3.5.4 These members will be appointed by a panel composed of and determined by the Chair of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:

- when a vacancy arises, each eligible organisation listed at 3.5.1 will be invited to make one nomination per vacant role.

- Eligible organisations may nominate individuals from their own organisation or another organisation

- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step (b) below. If they do not the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment (subject to the approval of the Chair)

- The full list of nominees will be considered by a panel convened by the Chair

- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3.

- In the event that there is more than one suitable nominee the panel will select the most suitable for appointment.

c) Chair's Approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under (b) above.

3.5.6 The term of office for these Partner Members will be for two years.

3.5.7 There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the process outlined in 3.5.5 above.

3.6 Partner Member - Providers of Primary Medical Services

3.6.1 These Partner Members are jointly nominated by providers of primary medical services which hold a list of registered patients for the purposes of the health service within the ICB's area, that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.6.3 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) An individual wishing to be considered in one of these roles must be an individual who is a registered General Practitioner registered with the regulatory body (GMC).

b) Each must be a current provider of general medical services working as either a; partner, shareholder, employee or contractor of a GP Practice that holds a contract with NHS England to provide primary medical Services to populations located in the geographical area coterminous with Shropshire, Telford and Wrekin ICB

c) One must provide Primary Medical Services to populations located in the geographical areas coterminous with Shropshire

Council's boundary and one must provide Primary Medical Services to the population coterminous with Telford and Wrekin Council's boundary.

d) Bring the perspective of primary medical services

3.6.4 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply;

b) They are struck off by a relevant professional body

c) They are not or are no longer a partner, shareholder, employee or contractor of a GP Practice holding a contract to provide Primary Medical Services to populations located in the geographical area coterminous with Shropshire, Telford and Wrekin ICB

d) A conflict of interest is evident, as determined by the Chair or the selection panel, which results in the individual being unable to fulfil the role.

3.6.5 This member will be appointed by a selection panel composed of and determined by the Chair of the ICB including the CEO of the ICB and at least one other ICB member and supported by a suitably qualified and experienced HR and/or other adviser(s), and the appointment will be subject to the approval of the Chair.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:

- when a vacancy arises, each eligible organisation listed at 3.6.1 and listed in the Governance Handbook will be invited to make two nominations per vacant role
- The nomination of an individual must be seconded by one other eligible organisation.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step (b) below. If they do not the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment (subject to the approval of the Chair)

- The full list of nominees will be considered by a panel convened by the Chair

- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) via an interview process and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4

- In the event that there is more than one suitable nominee the panel will select the most suitable for appointment.

c) Chair's Approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under (b) above.

3.6.7 The term of office for this Partner Member will be for two years

3.6.8 There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the selection process outlined in 3.6.5 above.

3.7 Partner Member(s) - local authorities

3.7.1 These Partner Members are jointly nominated[*description to be inserted in accordance with the regulations*] by the local authorities whose areas coincide with or include the whole or any part of the ICB's area. Those local authorities are:

a) Shropshire Council

b) Telford and Wrekin Council

3.7.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 0;

b) bring the perspective of delivering local authority social care services

3.7.3 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply;

3.7.4 This member will be appointed by a panel composed of and determined by the Chair of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or

other adviser(s) and the appointment will be subject to the approval of the Chair.

3.7.5 The appointment process will be as follows:

a) Joint Nomination:

- when a vacancy arises, each eligible organisation listed at 3.7.1 will be invited to make two nominations per vacant role.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step (b) below. If they do not the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment (subject to the approval of the Chair)

- The full list of nominees will be considered by a panel convened by the Chair
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
- In the event that there is more than one suitable nominee the panel will select the most suitable for appointment.

c) Chair's Approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under (b) above.

3.7.6 The term of office for this Partner Member will be for 2 years.

3.7.7 There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the process outlined in 3.7.5 above.

3.8 ICB Chief Medical Officer

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

b) be a registered Medical Practitioner

c) Meets the requirements as set out in the Chief Medical Officer person specification.

3.8.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply;

b) They are struck off by a relevant professional body

3.8.3 This member will be appointed by a selection panel composed of and determined by the Chief Executive Officer of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.

3.9 ICB Chief Nursing Officer

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

b) be a registered Nurse;

c) current valid registration with the Nursing and Midwifery Council;

d) meets the requirements as set out in the Chief Nursing Officer person specification.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply;

b) They are struck off by a relevant professional body

3.9.3 This member will be appointed by a selection panel composed of and determined by the Chief Executive Officer of the ICB with at least one other ICB member and supported by a suitably qualified and experienced HR and/or other adviser(s) the appointment will be subject to the approval of the Chair.

3.10 ICB Chief Finance Officer

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

b) Qualified accountant with full membership and evidence of up-to-date continuing professional development.

c) Meets the requirements as set out in the Chief Finance Officer person specification.

3.10.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply;

b) They are struck off by their relevant professional body.

3.10.3 This member will be appointed by a selection panel composed of and determined by the Chief Executive Officer of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.

3.11 Non-Executive Members

The ICB will appoint four Non-Executive Members.

- One Non- Executive Member will be appointed as a 'Senior Independent Non-Executive Member', to take a role in appraisal of the Chair. This role cannot be fulfilled by the Chair or the Chair of the Audit Committee.

- These members will be appointed by a selection panel composed of and determined by the Chair of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.

- These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

    - not be employee of the ICB or a person seconded to the ICB;

    - not hold a role in another health and care organisation in the ICS area;

- one shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee;

- another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee;

- Meet the requirements as set out in the Non-Executive Director Person Specification

- have the skill and ability to identify, assess and suggest strategies to manage conflicts of interest if they arise during ICB or committee meetings in line with the Conflicts of Interest Policy.

- Individuals will not be eligible if:

  - any of the disqualification criteria set out in 3.2 apply;

  - they hold a role in another health and care organisation within the ICB area;

  - A conflict of interest is evident, as determined by the Chair or selection panel, which results in the individual being unable to fulfil the role.

- The term of office for an Non-Executive Member will be three years and the total number of terms an individual may serve is three terms after which they will no longer be eligible for reappointment.

- Initial appointments may be for a shorter or longer period, in order to avoid all Non-Executive Members retiring at once and to support continuity of membership on the Board.

- Subject to satisfactory performance assessed through appraisal the Chair may approve the reappointment of an Non-Executive Member up to the maximum number of terms permitted for their role.

3.12 Executive Director of Delivery and Transformation

3.12.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act;

b) meets the requirements as set out in the Executive Director of Delivery and Transformation person specification.

3.12.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply;

3.12.3 This member will be appointed by a selection panel composed of and determined by the Chief Executive Officer of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.

3.13 Board Members: Removal from Office.

3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.13.2 With the exception of the Chair, and ex officio members, board members shall be removed from office if any of the following occurs:

3.13.3:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;

b) If they fail to attend a minimum of 75% of the ICB meetings to which they are invited unless agreed with the Chair in extenuating circumstances

c) If they are deemed to not meet the expected standards of performance at their annual appraisal.

d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but is not limited to dishonesty, misrepresentation (either knowingly or fraudulently); defamation of any member of the ICBS (being slander or libel); abuse of position, non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.

e) Are deemed to have failed to uphold the Nolan Principles of Public Life

f) Are subject to disciplinary proceedings by a regulator or professional body.

3.13.4 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

3.13.5 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.6 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.7 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions, or that there is a significant risk that the ICB will fail to do so, it may:

- terminate the appointment of the ICB's Chief Executive; and
- direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee, in line with the ICB remuneration policy and any other relevant policies published [say where] and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for non-executive members will be set by a Remuneration Committee composed of the Chair, at least one executive ordinary member and at least one partner ordinary member of the Board.

3.14.2 Other terms of appointment will be determined by the Remuneration Committee.

3.14.3 Terms of appointment of the Chair will be determined by NHS England.

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as "designate ordinary members" prior to the ICB being established.

3.15.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5-3.7

3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5-3.12 of

this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and [one other] will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12

4 Arrangements for the Exercise of our Functions.

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB Standards of Business Conduct Policy is published in the Governance Handbook.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws, including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;

b) comply with directions issued by the Secretary of State for Health and Social Care;

c) comply with directions issued by NHS England;

d) have regard to statutory guidance, including that issued by NHS England;

e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England; and

f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with 0–f) above, documenting them as necessary in this Constitution, its Governance Handbook, and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees;

b) a committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act, the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full [add where].

4.4.2 Only the board may agree the SoRD, and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;

b) those functions that have been delegated to an individual or to committees and sub committees;

c) those functions delegated to another body, or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out, at a high level, its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published [add web address].

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB;

b) Commissioning functions delegated to committees and individuals;

c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;

d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and, therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

a) The Chair of the Committee or Sub Committee will prepare reports from the Committee or sub Committee which have delegated decision making will be presented to the ICB or in the case of a sub-committee to its parent committee at its next scheduled meeting. The reports will include the main items discussed and any delegated decisions made by the Committee or sub Committee.

b) Have the terms of reference of the Committee or sub Committee approved by the ICB or by the parent Committee if a sub committee and must be aligned with the Scheme of Reservation and Delegation.

c) Membership of Committees must be specified by the ICB.

4.6.5 Any committee or sub-committee established in accordance with clause 0 may consist of or include persons who are not ICB Members or employees.

4.6.6 All members of committees and sub committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the Standing Orders, as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) Audit Committee: This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a Non-Executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) Remuneration Committee: This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a Non-Executive Member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 0, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and, therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:

a) conducting the business of the ICB;

b) the procedures to be followed during meetings; and

c) the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB, unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2: and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published as part of the Governance Handbook [specify where].

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest, and do not (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest [which are published on the website].

6.1.3 All board, committee and sub-committee members, and employees of the ICB will comply with the ICB policy on conflicts of interest in line with their terms of office and/or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts, in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision making of the ICB and not otherwise covered by one of the categories above, has an interest or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, and the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;

b) be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;

c) support the rigorous application of conflict of interest principles and policies;

d) provide independent advice and judgement to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;

e) provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles:

a) Decision-making must be geared towards meeting the statutory duties of ICBs at all times including achieving the four principles:

- improve population health and healthcare;
- tackle unequal access, experience and outcomes;
- enhance productivity and value for money; and
- ensure the NHS supports broader social and economic development.

Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering direct or indirect financial, personal, professional or organisational interests.

b) ICBs have been created to give statutory NHS providers, local authority and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle, and it should not be assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations.

c) The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking need to be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision.

d) Actions to mitigate conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-

making wherever possible. Mitigation should take account of a range of factors including the impact that the perception of an unsound decision might have, and the risks and benefits of having a particular individual involved in making the decision.

e) ICBs should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way conflicts of interest are managed should reflect this distinction.

f) As is already established practice in the NHS, where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process.

g) The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) members of the ICB;

b) members of the board's committees and sub-committees;

c) its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, registers of interest are [published on the ICB website/add where].

6.3.3 All relevant persons as per 0 and 0 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 0.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business, such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;

b) follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles);

c) comply with the ICB Standards of Business Conduct Policy and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB, or otherwise providing services or facilities to the ICB, will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7 Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 The ICB:

a) will submit itself to appropriate scrutiny from the public about the decisions and actions it takes; and

b) ensure there will be transparency about the decisions and actions that the ICB takes, such as to promote confidence between the ICB and its staff, patients and the public.

7.3 Meetings and publications

7.3.1 Board meetings and committees composed entirely of board members or which include all board members undertaking public functions will be held in public, except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and Governance Handbook will be published as well as other key documents, including but not limited to:

a) Conflicts of Interest policy and procedures

b) Registers of interests

c) Standards of Business Conduct Policy

d) Framework and Principles for Public Involvement and Engagement

e) Scheme of Reservation and Delegation

f) Functions and Decisions Map

g) Standing Financial Instructions

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- sections 14Z34 to 14Z45 (general duties of integrated care boards), and
- sections 223GB and 223N (financial duties).

And

- proposed steps to implement the Shropshire and Telford and Wrekin joint local health and wellbeing strategies.

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-Executive Members will be appointed to the board, including the Chair; and all of the Board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) ensuring that there are internal decision-making structures that will allow for decisions around arranging healthcare services to be made in line with the NHS Provider Selection Regime;

b) this includes ensuring that there are appropriate governance structures that will deal with any challenges that may follow decisions about provider selection;

c) evidence that the ICB has properly exercised its responsibilities for arranging healthcare services set out in the NHS Provider Selection Regime;

d) this will include publishing ICB intentions for arranging services in advance, publishing contracts awarded and keeping records of decision making; and

e) ensure that local audit arrangements will be capable of auditing the decisions made under the NHS Provider Selection Regime

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards);

b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan);

c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and

d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007

8 Arrangements for Determining the Terms and Conditions of Employees.

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines, and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration Committee, which is chaired by a Non-Executive Member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by allowing it to:

a) seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;

b) obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

8.1.5 No individual member of Remuneration Committee should be present during any discussion relating to:

- any aspect of their own pay;
- any aspect of the pay of others when it has an impact on them.

8.1.6 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published [say where].

8.1.7 The duties of the Remuneration Committee include:

a) setting the ICB pay policy (or equivalent) and standard terms and conditions;

b) making arrangements to pay employees such remuneration and allowances as it may determine;

c) set remuneration and allowances for members of the board;

d) set any allowances for members of committees or sub-committees of the ICB who are not members of the board; and

f) any other relevant duties.

8.1.8 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board;

b) the development and consideration of proposals by the ICB;

c) for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals

(at the point when the service is received by them), or the range of health services available to them; and

d) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) Through a process of co-production with local communities, stakeholders and staff, the ICB will establish a clear strategic purpose and develop a strategy to deliver that purpose.

b) The ICB will deliver a series of public engagement and involvement activities with its communities and staff on the strategic development of the ICB in two stages; firstly to develop the ICB strategic purpose and secondly to develop the ICB long-term strategy. Citizens, patients, carers, services users, stakeholders and staff will be invited to get involved in the development of proposals to transform the way health and care are delivered in Shropshire, Telford and Wrekin.

c) Comprehensive and meaningful engagement will ensure local services are more responsive to people's physical, emotional, social and cultural needs. In both stages the ICB will take active steps to strengthen public, patient and carers' voice at place and system levels. In particular, the activities will focus on groups who are seldom heard and have the greatest health inequalities to ensure they are not excluded from the dialogue.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

a) Put the voices of people and communities at the centre of decision making and governance, at every level of the ICS;

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;

c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect;

d) Build relationships with excluded groups – especially those affected by inequalities;

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners;

f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust;

g) Use community development approaches that empower people and communities, making connections to social action;

h) Use co-production, insight and engagement to achieve accountable health and care services;

i) Co-produce and redesign services and tackle system priorities in partnership with people and communities; and

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 In addition, to reduce inequalities the ICB will need to draw on the knowledge of the local authorities, VCSE sector and other partners with experience and expertise in this regard. The VCSE sector is an important partner in the ICS and ICP and plays a key role in improving health, wellbeing and care outcomes. The ICB have established a Memorandum of Understanding (MOU) with the VCSE sector to further strengthen its place-based working. The MOU sets out key principles and commitments of the ICB, ICP and VCSE sector working together.

9.1.5 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Executive Member of the ICB	Those roles on the ICB that are appointed by the ICB under an employment contract and include the Chief Executive Officer, ICB Chief Finance Officer, ICB Chief Medical Officer, ICB Chief Nursing Officer
Functions and Decisions Map	High level description of where decision making on the functions of the ICB is undertaken under delegation by committees, joint committees and individuals.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts
ICB board	Members of the ICB.
ICB Chief Finance Officer	This role is the Chief Finance Officer for NHS Shropshire, Telford and Wrekin Integrated Care Board
ICB Chief Medical Officer	This role is the Chief Medical Officer for NHS Shropshire, Telford and Wrekin Integrated Care Board
ICB Chief Nursing Officer	This role is the Chief Nursing Officer for NHS Shropshire, Telford and Wrekin Integrated Care Board
Non-Executive Members	These roles are ordinary members of the ICB who are independent from the ICB and therefore are neither an employee or a contractor.

Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
NHS England	The operational name for the National Health Service Commissioning Board
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Partner Member of the ICB	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description. • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by

	Primary Care Network clinical directors or other relevant primary care leaders.
Sub-Committee	A committee created and appointed by and reporting to a committee.

Appendix 2: Standing Orders

1. Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS Shropshire, Telford and Wrekin Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1 The Standing Orders are effective from 1st July 2022.

2.2 Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made as per clause 1.6.2 in the Constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2 These Standing Orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the Board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Director of Corporate Affairs will provide a settled view which shall be final.

3.5 All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported

to the next formal meeting of the Board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the Board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than seven calendar days' notice in writing.

b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than fourteen calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board. If the Chair of a meeting is absent or is disqualified from participating by a conflict of interest, the Deputy Chair will preside. If the Deputy Chair is not in attendance or is also disqualified from participating by a conflict of interest then the remaining Board members will nominate one of their number to preside by a majority vote.

4.2.2 If the Chair of a meeting is absent, or is disqualified from participating by a conflict of interest, and there is no Deputy Chair appointed the remaining committee members will nominate one of their number to preside by a majority vote.

4.2.3 The Deputy Chair will be appointed by the ICB Board from the Non-Executive Members of the ICB Board, but may not be the same individual who is appointed as the Audit Committee Chair.

4.2.4 The Board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at [insert link].

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board, in accordance with the ICB policy as published in the Governance Handbook.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy may speak at the meeting but not vote on their behalf and will not count towards the quorum.

4.5.2 A deputy should be nominated according to availability on the day of a meeting or according to the agenda items under discussion; and would not necessarily have to be the same nominated deputy for the duration of the term of office of the Executive Director. Provided they

are appropriately experienced and that this is confirmed with the ICB Chair in advance of the meeting.

4.5.3 The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 Virtual attendance at meetings

4.6.1 The Board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be 50% of the total membership, including:

a) Either the Chief Executive or the Chief Finance Officer

b) Either The Chief Medical Officer or the Chief Nursing Officer

c) At least one independent Non Executive member

d) At least one Partner Member

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointment

4.8.1 The validity of any act of the ICB will not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the quorum will be calculated using the total number of members who are properly appointed.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.

b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional Participants and Observers (as detailed within section 2.3 of the Constitution) will not have voting rights.

d) A resolution will be passed if more votes are cast for the resolution than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful the Board may draw on third-party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply.

4.9.5 The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees)

subject to every effort having been made to consult with as many members as possible in the given circumstances.

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960, all meetings of the Board and all meetings of committees which are comprised of entirely Board members or all Board members, at which, public functions are exercised will be open to the public.

4.11.2 The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 (as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Board.

5. Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents.

6.1 The ICB will use a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature. A single signature from the following will be required.

a) the Chief Executive;
b) the Chair of the ICB;
c) the ICB Chief Finance Officer.

6.2 The following individuals are authorised to execute a document on behalf of the ICB by their signature. A single signature from the following will be required.

a) the Chief Executive;
b) the Chair of the ICB;
c) the ICB Chief Finance Officer.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.055	Transition to ICB - Due Diligence Assurance Report

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Alison Smith Director of Corporate Affairs alison.smith112@nhs.net

Action Required (please select):										
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information		

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
A paper was approved at the Governing Body meeting held on 8th September to delegate to the Audit Committee oversight on behalf of the CCG of the due diligence process for close down of the CCG and transition to the ICS Integrated Care Board in April 2021	8th September 2021	A & S
Following this, the proposed due diligence checklist issued by NHSE/I was presented and approved at the Audit Committee in September to be used as a reporting mechanism for progress of the due diligence process.	15th September 2021	A & S
Due Diligence Checklist was presented at the Audit Committee in November for assurance.	17th November 2021	A & S
Due Diligence Checklist and Due Diligence Assurance Panel Report was presented at the Audit Committee in January for assurance.	19th January 2022	A & S
Due Diligence Checklist and the Due Diligence Assurance Panel Report was presented to the Informal Governing Body meeting.	9th February 2022	S & D

Due Diligence Checklist and Due Diligence Assurance Panel Report and Responses were presented at the Audit Committee in March for assurance.	20th March 2022	A & S
Due Diligence Checklist and Due Diligence Assurance Panel Report and Responses were presented at the Audit Committee in March for assurance.	18th May 2022	A & S

Executive Summary (key points in the report):

This paper presents a consolidated oversight of the due diligence process followed by the CCG in preparation for the dissolution of NHS Shropshire, Telford and Wrekin CCG and the creation of an Integrated Care Board (ICB); NHS Shropshire, Telford and Wrekin on 1st July 2022.

The Audit Committee of NHS Shropshire, Telford and Wrekin CCG meeting, with representation from the shadow ICB Audit and Risk Committee on 20th May 2022, reviewed the evidence presented and were assured by the process undertaken.

This report is presented to the Governing Body of NHS Shropshire, Telford and Wrekin CCG to provide assurance on the process followed for close down and transition of CCG functions, property, liabilities and assets to the ICB.

The report has also been shared with the CCG Interim Accountable Officer to provide assurance to the Interim Designate ICB Chief Executive on 1st June 2022 as required by the due diligence guidance issued by NHSE/I.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? Some elements of due diligence relate to HR, however the HR function of the CCG and the new ICB is, and will be, provided by Midlands and Lancashire CSU and therefore any perceived conflict of CCG employees signing off on any of the HR activities is mitigated.	Yes
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation? Under the Health and Social Care Act 2022, the existing CCG will be dissolved on 30th June 2022 and a new single ICB created from 1st July 2022.	Yes
5.	Are there human rights, equality and diversity requirements? The CCG has undertaken Equality Risk Assessment on its employed staff, to quantify the impact of the creation of the ICB.	Yes
6.	Is there a clinical engagement requirement? The Membership of the CCG and partner organisations including NHS Trusts have been engaged in the development of the new Constitution for the ICB.	Yes

7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:
NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to note the report.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Transition to an ICB - Due Diligence Assurance Report

1.Introduction

1.1 In June 2021 NHS England/Improvement published "Integrated Care Systems: design framework" which set out in more detail the statutory basis of ICS's and outlined how component parts of the ICS were expected to operate. The publication also outlined some key principles for the transition from CCGs to ICSs and high level indicative outputs expected in every ICS; with one of the key outputs to begin due diligence planning in quarter 2 of 2021. The due diligence process was to ensure the ICB fully understood the assets and liabilities it would be taking on following its creation on 1st July 2022.

1.2 In response to this specific output, a paper outlining a proposal for the due diligence exercise that the CCG would be expected to undertake in partnership with existing ICS and the oversight of the process by both the CCG and ICS, was presented to both the CCG Governing Body in September 2021 and to the then ICS Board in November 2021 for approval. This is attached as **appendix 1.**

1.3 This report presents a consolidated oversight of the due diligence process followed by the CCG in preparation for the CCG's dissolution and the creation of an Integrated Care Board (ICB); NHS Shropshire, Telford and Wrekin on 1st July 2022.

2. Transition Planning including Due Diligence

2.1 The approach to due diligence outlined in appendix 1 was based upon national guidance published by NHSE/I and also included the recognised good practice from the CCG merger due diligence that was undertaken earlier in 2020/21.

2.2 The NHSE/I guidance was very clear that CCGs and existing ICS should work together in partnership to develop and implement a due diligence plan to support the transfer of people, property and liabilities. On this basis it was agreed that the management oversight of the due diligence process would form part of the ICS Transition Programme, overseen by the ICS Transition Steering Group which is composed of both ICS Executives and CCG Directors and an NHSE/I representative which reports to the ICS CEO Group.

2.3 To ensure an independent oversight of the due diligence process it was proposed that this was undertaken via the Audit Committee of the CCG and the Audit and Risk Committee of the ICS. In order to facilitate this process, the Governing Body of the CCG had agreed to delegate CCG oversight of the due diligence activities to the CCG Audit Committee. A similar recommendation was agreed by the ICS Board to delegate ICS oversight to the ICS Audit and Risk Committee. The Chairs of both Audit Committees for the CCG and ICS were consulted on the proposal and supportive of the approach.

2.4 In order to provide progress reporting and assurance to the Transition Steering Group and Audit Committees, the CCG adopted the due diligence checklist provided by NHSE/I.

The checklist was modified by the CCG following initial reporting to the two Audit Committees with rag rating for both progress against the specific action and then also rag rating risk level identifying where the asset or liability may hold a risk to the inheriting ICB and what mitigating action was being taken to reduce the risk. The final version of the checklist is attached as **appendix 2**.

3. Due Diligence Timeline in summary

3.1 The due diligence timetable is set out below.

Content	Meeting	Date 2021/22	NHSE Milestone
Overview report on due diligence process for approval, including seeking delegation to Audit Committees	CCG Governing Body (public sessions) Transition Steering Group/CEO Group (ICS) ICS Board	8th September 2021 24th August 2021 29th September 2021	
Due Diligence Activity Tracker for approval of activities	CCG Audit Committee CS Audit and Risk Committee Transition Steering Group/CEO Group (ICS)	15th September 2021 13th September 2021 16th September 2021	
Due Diligence Activity Tracker for noting level of progress in completion of activities	Transition Steering Group/CEO Group (ICS)	14th October 2021	
Due Diligence Activity Tracker for noting level of	CCG Audit Committee	17th November 2021	

progress in completion of activities	ICS Audit and Risk Committee Transition Steering Group/CEO Group (ICS)	8th November 2021 11th November 2021	
Due Diligence Activity Tracker for noting level of progress in completion of activities	Transition Steering Group/CEO Group (ICS)	Mid December - cancelled	
Due Diligence Panels x 2	□ CCG Chair of Audit Committee and at least one other CCG Lay Member □ ICs Chair of Audit and Risk Committee or deputy □ ICS Chair of People Committee of deputy □ ICS Executive Lead Workforce □ CCG Internal Auditor – Interim Consortium Director, CW Audit Services	6th and 10th December 2021	
Due Diligence Activity Tracker for noting further level of progress in completion of activities	CCG Audit Committee ICS Audit and Risk Committee Transition Steering Group/CEO Group (ICS)	19th January 2022 10th January 2022 20th January 2022	31/1/22- Confirm that the due diligence plan in place is rebased to take account of the revised establishment date, i.e. leads, process, sign off, etc. confirmed
Due Diligence Activity Tracker for noting further level of progress in completion of activities	Informal CCG Governing Body meeting Transition Steering Group/CEO Group (ICS)	9th February 2022	

		16th February 2022	
Due Diligence Activity Tracker for noting further level of progress in completion of activities	CCG Audit Committee ICS Audit & Risk Committee Transition Steering Group/CEO Group (ICS)	16th March 2022 16th March 2022 (to be invited to the CCG Audit Committee meeting) 17th March 2022	31/3/22- Ensure each CCG (and any other sending organisation) is on target to complete due diligence exercise and compile a comprehensive staff list, and for those CCGs impacted by boundary changes they are also on target to compile a comprehensive property list(s) (as required to support the Staff and Property Transfer Schemes)
Due Diligence Final Report noting completion of activities for recommendation to Governing Body/ ICS Board	Transition Steering Group/CEO Group (ICS)	14th April 2022	
Due Diligence Final Report noting completion of activities for recommendation to Governing Body/ ICS Board Due Diligence Report for use by CCG AO and Designate ICB CE to evidence due diligence processes have been completed and to support	CCG Audit Committee ICS Audit & Risk Committee Transition Steering Group/CEO Group (ICS) CCG AO and ICB CE	18th May 2022 (To be held as committees in common) 12th May 2022 30th May 2022 (for submission 1 June to NHSE/I) 01/05/22 – 15/06/22	13/5/22- Ensure CCG (and any other sending organisation) is on target to complete due diligence exercise and compile a comprehensive staff list, and for those CCGs impacted by boundary changes they are also on target to compile a comprehensive property list(s) (as required to

written assurance to NHSE/I	CW Audit Support of Director to Director Handover		support the Staff and Property Transfer Schemes)
Due Diligence Report to be received by existing CCG Governing Body	CCG Governing Body	8th June 2022 (confidential section)	1/6/22- Written assurance from CCG AOs to ICB designate CEs that due diligence processes have been completed
Due Diligence Report for receipt by new Integrated Care Board	New Integrated Care Board	1st July 2022 – tbc (confidential section)	

3.2 Reporting has been at multiple levels:

- Reporting monthly by each workstream lead to the Programme Manager. This information has been used to populate reports to the Transition Steering Group on a monthly basis and bi monthly reporting to the CCG Audit Committee and ICS Audit and Risk Committee. The Transition Steering Group meeting included representatives of NHSE/I Regional Team to both provide them with assurance on progress but to also seek advice and support if required.
- Reporting to the Transition Steering Group, composed of Directors from the ICS and CCG received regular monthly progress update reports of the due diligence checklist, collated and updated from information collected from workstream leads by the Programme Manager.
- The Governing Body of the CCG and ICS Board delegated oversight of the due diligence activities from their respective Audit Committees meeting individually and in common. An extraordinary Audit Committees in Common was convened in December 2020 to receive an initial tracking framework for approval with further reporting received in November 2021, January 2022, March 2022 and May 2022. Audit Chair reports reported by exception any issues to the CCG Governing Body and ICS Board.
- The CCG Governing Body also received an update on progress with the due diligence process at its informal meeting on 9th February 2022.
- Submission of the due diligence checklist and the approach to the due diligence checklist has been shared with NHSE/I on two occasions as part of the Readiness to Operate process which has overseen the whole of the development of the ICB and transition from the CCG for assurance purposes.

4. Assurance

4.1 Assurance on the process has been received from a number of different sources and at different points within the process to ensure that the approach was robust and was being consistently applied.

4.2 Due Diligence Assurance Review Panels

As scheduled, the Due Diligence Assurance Panels were held on the 6th and 10th December with representation from CCG, ICS partners and CCG Internal Auditor. In each panel meeting a small number of workstream leads presented their parts of the due diligence checklist and answered questions from the panel. The panel then came to its conclusion for each topic area. The summary report is attached as **appendix 3** and largely there was a good level of assurance across topic areas, with the panel highlighting some concerns around HR, quality and contracting. The report also outlined a number of recommended areas for workstream leads to focus upon to enhance assurance levels for future reporting which will be shared for action for the next reporting period. Following the panels the CCG Audit Committee received further assurance from the workstream leads for HR, contracting and quality to supplement the initial response to the recommendations made which are now included in the attached appendix.

4.3 Audit Committees

Following on from the meeting in November 2021 the respective Audit Committees received in January the first formal tracking report based upon completion of actions up to 31/10/21. Further meetings were held in January, March and April to track delivery of those elements of due diligence that were still outstanding.

At the January 2022 meeting the CCG Audit Committee and ICS Audit and Risk Committee members were generally assured by the process and progress being made. Some areas were highlighted for further work; contracting, quality and HR. These areas were reported specifically to the March, April and May meetings where the Audit Committee confirmed that they were assured on these areas specifically.

At the May meeting the Committees considered the progress made at that point and were assured on the due diligence process generally and were able to assure the Governing Body and ICB Shadow Board that all aspects of due diligence had been appropriately managed noting those areas that still had risk associated with either their completion or the inherent risk the ICB would inherit and which are summarised below.

The CCG Governing Body also received an update on the progress of the due diligence process at it development day on 9th February 2022.

4.4 NHSE/I assurance on progress on due diligence

NHSE/I have attended all the Transition Steering Group meetings and have been able to keep close scrutiny on progress through the monthly meeting reporting. In addition to this the CCG have also had to submit the due diligence checklist as part of the readiness to operate process in March and May 2022. There has been no feedback to action form NHSE/I following these submission dates.

4.5 Director Handover Process

The process also includes a formal handover of risks and liability information from CCG Directors to ICB Directors using the due diligence checklist as a basis, now that the recruitment to ICB roles has been completed. This is primarily to ensure that incoming Executive Directors of the ICB are fully appraised of the risks around the assets and liabilities the ICB will inherit from the CCG and to test consider the sufficiency of the mitigating actions. We have agreed with the CCG's Internal Auditors the terms of reference for this work, as they have agreed to facilitate this process to ensure it has the level of rigor required. There is no additional cost arising for this support as it has been designed as part of the internal audit plan for the first quarter of 2022/23 financial year. The handover process had

originally been scheduled for April but as the start dates of the new ICB Directors is dependent on their current employment status and notice periods this has now been rescheduled to take place in May/June.

4.6 NHSE/I Accountable Officer Assurance Letter

The NHSE/I Readiness to Operate process required a letter to be sent from the CCG Accountable Officer to the Interim ICB Chief Executive Designate and copied to the NHSE Regional Director. This has been sent on 1st June, providing confirmation that the due diligence for the transfer of property assets and liabilities from the CCG to the ICB had been completed for those actions required pre-30th June.

4.7 Legal Review

Given that the CCG and ICS fell within the due diligence level 1 risk criteria (outlined in detail in appendix 1) there was an expectation that the CCG would not require wholesale legal advice on all aspects of the due diligence process, having received this during the merger process. However, the CCG did request further advice on particular areas of complexity by exception within the due diligence checklist from the CCG's legal advisors for clarity as and when it was required.

5. Risks and Issues

Following the due diligence process being completed, there remain some issues that carry a level of risk that cannot be mitigated further. These are listed separately in **appendix 4** by exception. Many of these are rated amber because the nature of the action described will continue up to and including the 30th June – 1st July and so are shown as amber rating for progress simply because they cannot yet be formally closed.

The remaining risks can be summarised as follows:

Ref	Due Diligence Checklist action	Risk and mitigation Amber and Red Risk RAG ratings
1.3.19	Open learning points from Emergency Preparedness, Resilience and Response (EPRR) that would transfer	Progress risk: Plans for EPRR function for the ICB is in development and includes learning points, with a draft being submitted to NHSEI on the 27/5/22
1.3.25	Agree the new committee structure and develop terms of reference, as necessary. Committees may include: • Remuneration committee; • Audit & risk committee; • Quality committee (following NQB guidance); • Priorities Committee; • Primary Care Commissioning committee; • IFR; • Finance committee • Capital committee Consider other committees that are an	Progress risk: Drafts of TOR currently being further amended for submission to NHSEI. Directors meeting scheduled on 10th June for final agreement. However further refinement is expected up to 30/6/22.

	integral part of the governance structure or that are required due to the nature of the ICB. Agree their purpose, terms of reference and appropriate duration. For example, should they be: Permanent or time limited.	
1.3.26	Agree new logo, letter head, signage, harmonise all corporate documents, standard documents and inform staff where these can be accessed - for ICB	Progress risk: Relates to ICB set up Plan is being discharged, all actions to be completed by 30 June 2022.
1.3.27	New website for ICB	Progress risk: Relates to ICB set up Plan is being discharged, all actions to be completed by 30 June 2022.
1.5.1	Outstanding claims / litigation that would transfer	Inherited risk for ICB – Financial and reputational The CCG has some current litigation in the Court of Protection which are likely to transfer to the ICB. Of these there is a financial and reputational risk with one case which has accrued significant legal costs. Legal advice is being taken to minimise risks. Director of Planning overseeing cost approval with legal firm.
1.6.2	Ensure that all leases are listed to assist with work associated with IFRS 16 (this could be addressed by including all leases in the contracts register or by holding a separate list of all leases) - to include all lease terms, start dates, end dates, break dates, parties to lease, CCG lead or on behalf of, etc.	Progress and inherited risk for ICB Oversight of leases not held/managed by the Contract Management Team needs to be stronger Lease and Contract owners contacted to provide information/update register, email reminders scheduled Procurement Oversight Group now covers the Goods & Services contract holders, so contract issues can be discussed and risks escalated as required. Risk that liabilities in all leases have been fully understood prior to 1st July.
1.6.3	Agreements / service agreements in place	Progress and inherited risk for ICB Currently no clinical agreements/service agreements in place. Lease and contract owners contacted to ensure the provided information on the register is up to date.

		Procurement oversight group now covers the goods and services contract holders so contract issues can be discussed and risks escalated as required.
1.6.4	Confirm which contracts are expiring at point of transfer or due for renewal in first quarter of 2022/23 and a clear plan in place to take forward each one.	Progress and inherited risk for ICB The contract register details expiry dates of contracts, the monthly procurement oversight group receives and discusses a expiring contracts log for clinical services which details all contracts expiring within the next 12 months and plans for each contract discussed, actions agreed and papers for approval of plans for each one taken to the Strategic Commissioning Committee. 4 clinical contracts/agreements expire within first three months of the ICB. Discussion at Procurement Oversight Group, in March 2022, paper to Strategic Commissioning Committee/Governing Body for agreement of next steps/recommendations in June 2022.
1.9.1	Details of intellectual property used, enjoyed, exploited or held	Progress risk Plans are in place to ensure that relevant information is transferred to the ICP but no further update provided.
2.1.3.7	Establish arrangements for the identification, transfer and retention of staff records in line with the NHS Records Management Code of Practice	Progress risk Work has started with a communication out to line managers w/c 28/02/2022. Plan to have this completed by end of June 2022. Arrangements established and work well underway to identify, transfer and retain staff records with more than half completed and planned to be finalised by end of June. Work is being overseen by the Director of Corporate Affairs.
3.1.3	If key staff leave before the CCG(s) close, robust exit management arrangements should be employed to retain and manage vital business knowledge in relation to accounts preparation and assets and liabilities.	Progress risk and inherited risk for ICB All staff will TUPE over to the new organisation on 1st April 2022 so risk is minimal. Any changes in staffing outside of this process will need to be addressed if & when they arise. Additional resources being sourced and internal cover used where possible. Interim Financial Accountant appointed Dec 21 and previous member of FA team remains within wider finance team so knowledge of year-end processes is retained.

3.1.16	Review, revise and agree a risk management strategy, policy and procedures. This must include an approach to setting an agreed risk appetite and identifying, evaluating and managing risks. Mechanism for risk share across organisations to be agreed.	Progress risk Discussion on approach has been agreed with Governance Leads from ICS partner organisations in February. A draft Risk Strategy will be drafted based on this approach. Good Governance Institute has been commissioned to run workshops to develop risk appetite and initial ICS BAF content. There is a risk around timeframes and capacity as this is unlikely to be completed for the 1st July with work needed up to mid July.
3.1.18	Assess the financial impact of the strategic objectives and business plan for the new ICB	Inherited risk for ICB 22/23 system financial plan submitted on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years. Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG
3.3.19	Develop procedures and policy for: - travel expenses - training expenses - relocation - excess travel - lease cars - telephones including mobiles - long service awards	Progress risk Many of these policies will be inherited by the ICB from the CCG as this is a requirement as part of equivalent TUPE transfer of staff - Training expenses - The CCG have a learning and development policy which covers training expenses - Travel expenses- STW CCG Excess Mileage and Additional Travel Guidance for Managers in place - STW CCG Excess Mileage and Additional Travel Guidance for Managers in place - long service awards - STW CCG Long Service Award policy in place - telephones and mobiles - In draft form (IT)

		- Relocation - Not a HR policy in place for this but will use the national rate determined by HMRC - Lease cars - Not offered at the moment, decision on whether ICB offer lease cars has not been confirmed. ICB CE and CFO discussing at the moment. Risk is that a policy on lease cars if agreed will not be drafted by 30 June.
3.3.35	Prepare and agree an ICB financial plan	Inherited risk for ICB: 22/23 system financial plan submitted on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years Risk that place will not be sufficiently developed for place level budget delegation to operate in 22/23 Risk that place will not be sufficiently developed for place level budget delegation to operate in 22/23
3.3.36	Prepare and agree place based budgets	Progress risk: Action is dependent on place partnership set up and delegation agreed - unlikely to have budgets delegated at place level until 23/24
3.3.37	Review the cost improvement programmes and determine a new programme for the ICB	Progress risk and inherited risk for ICB: 22/23 efficiency programme included as part of 22/23 financial plan submission. At point of submission £1m of plans unidentified and £0.7m running cost efficiency badged as high risk. System transformation plan savings also included within system plan submission with £2.9m unidentified gap currently held in CCG position. Risk that full efficiency programmes and system transformation savings will not be identified which will contribute to financial deficit of organisation and system

3.3.39	Produce a finance team structure to meet its identified role within agreed management cost envelope	Progress and inherited risk for ICB: DoF level discussions regarding teams working closer together across the system commenced with various workstreams set up led by system deputies to explore options. Initial CCG structure to lift and shift into ICB but will be reviewed to develop system wide finance structure as other areas develop Risk around capacity within existing finance team in CCG to pick up all system wide work
3.3.40	Consult with NHSEI to: • agree new control totals for ICB • determine performance against previously agreed control totals	Progress and inherited risk for ICB: 22/23 planning guidance released 24.12.21. System now working through detailed 22/23 financial plan development for final submission at end of April Risk that system transfomation and organisational efficiencies will not be fully identified in order to meet control total
3.3.48	Agree a framework for capital prioritisation and allocation across the system	Progress risk: Governance proposal going to IDB/Sustainability cttee in March with a view to establishing a capital governance and process that sits alongside the revenue process (closely linked and not operating in isolation) with a view to then evolving into a single process over time. Aim to have that up and running in April/May.
7.1.3	Ensure a defined governance and escalation process is established for quality which ensures that risks are identified, mitigated and escalated effectively through System Quality Groups (SQG) and links to Regional NHSEI quality oversight and reports to the ICB. This will link to the broader ICS risk management strategy, policy and procedures (see 3.1.13). The System Quality Group will serve as, or align with any Quality Committee (see 1.3.24).	Inherited risk for ICB: In accordance with National Quality Board (NQB) and NHSEI published guidance, we have set up our local quality governance, implementing a structure and function in accordance with the needs of our system. We are awaiting a further NQB publication which will inform the approach to Place-based quality governance. As part of our emergent system-level governance arrangements, we are reviewing how risks to quality are captured, escalated and managed effectively to ensure that our future system risk arrangements reflect our development as an ICS. We are awaiting the NQB guidance on risk escalation and will adopt this when published.

		We do not yet have a complete shared view of system quality risks, however providers publication of their Quality Accounts by the end of June 22 will inform this work. The system approach to risk appetite needs to be confirmed along with consideration of adopting a unified risk scoring system / matrix as a number of different ones are in use in the system. The NED chair of the QPC has yet to be announced. The actions relating to requirement are built into our forward quality governance plan (Quality Roadmap). We are well-placed to adopt the NQB guidance on risk escalation when it is published, which should be in the next few weeks.

6. Conclusion

6.1 The transition to ICB Due diligence process has delivered on its key objectives and deliverables within the agreed time period. Some tasks and actions have still to be completed, but there are processes in place to continue these risks to progress. The main high level risks identified from the process are around the financial planning for the ICB, which the ICB CFO is engaging on with NHSE/I.

7. Recommendations/Actions Required:

NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to note the report.

Appendix one – Approach to Due Diligence

STW CCG Transition to ICB – Approach to Due Diligence

1 Introduction

Following the publication in June 2021 by NHS England/Improvement of "Integrated Care Systems: design framework" and the recently published guidance there is a clear requirement that the CCG will undertake a due diligence exercise in preparation for the establishment of a Integrated Care Board (ICB).

This report sets out a proposed approach to undertaking due diligence in respect of the establishment of Shropshire Telford and Wrekin Integrated Care Board and the dissolution of the current CCG and the transfer of assets and liabilities to the successor organisation.

2 What does due diligence mean?

There is no legal definition of due diligence but it is generally recognised as a detailed examination of an organisation and its records and action that is considered reasonable for people to take to keep themselves or others and their property safe. Risks involved in a transaction should be identified, assessed and mitigated as part of due diligence.

Upholding governance standards and maintaining appropriate and accurate records of all NHS activity are always necessary. However, it is particularly important to preserve corporate memory when NHS organisations are changing, being created or abolished, and to ensure the safe and effective transfer of people and 'property'. The term 'property' is used here in its widest possible sense, i.e. not just the estate (buildings), but all assets, including equipment, contracts, licenses, rights, claims and organisational policies. Liabilities must also be considered.

The legal transfer of people, property and liabilities

Due diligence is necessary to underpin the legal transfer of people, property and liabilities from the CCG to the ICB through a 'transfer scheme'.

The guidance suggests there are three different starting points and corresponding levels of complexity for CCGs in the ICS implementation programme and the level of due diligence to be undertaken should reflect these starting points:

Level 1: where the boundary of a CCG is coterminous with its existing ICS, due diligence will involve listing all staff, property and liabilities so that this information is available to the new ICB. The listing is not required for legal purposes, i.e. for the transfer scheme, as this scheme will simply make provision for all CCG staff, property and liabilities to transfer to the ICB in a straightforward 'lift and shift' arrangement.

Level 2: where there will be no ICS boundary changes but there are multiple CCGs within an ICS there will be additional complexity and a need for co-ordination, with consideration of the processes to bring together the staff, property and liabilities from multiple CCGs. Whilst each CCG is accountable for their own staff, property and liabilities, further joint work may be required between CCGs to consider how organisational policies, processes, assets and liabilities may be consolidated and to ensure that arrangements are fit for purpose for a single ICB. As for level 1, the transfer scheme will make provision for the legal transfer of all people, property and liabilities of the CCGs to the ICB.

Level 3: where there will be changes to existing ICS boundaries, particularly any which involve CCGs being 'split' between ICBs, there will be further complexity as multiple CCGs will be involved in the development of the new ICB configurations and, where any ICS boundary change cuts across an existing CCG boundary, a full CCG 'lift and shift' arrangement cannot apply. In such circumstances, comprehensive lists will be required to confirm the specific people, property and liabilities to be transferred from each CCG to each ICB, and the lists will need to be included in a schedule to the transfer scheme. There will need to be joint working and information sharing between CCGs and existing ICSs to ensure the accuracy of the lists and that there are no gaps or duplication.

This system is fortunate in that the merger of the two pre-existing CCGs earlier in the year and the coterminosity of the CCG with the ICS boundary, means that it falls within the level 1 criteria above and therefore the complexity is limited and the risk would be expected to be at a lower level. The proposed approach outlined takes into account the level of risk and expected complexity.

There is a range of preparatory work that will assist in the effective implementation of the due diligence plan and subsequent transfers of staff, property and liabilities. Examples include cleansing of ESR (Electronic Staff Record) system data, clearing unallocated cash and balance sheet items, and ensuring that the CCG's list of authorised signatories is up to date. The CCG, having already undertaken this process as part of merger, is in a strong position as most of the foundations of good housekeeping are already in place and the focus will be on maintaining this structure rather than having to create and populate it from a starting position.

CCG close down and ICB establishment due diligence checklist

NHSE/I have issued with the due diligence guidance a practical tool to support / guide the due diligence process which has been co-produced by NHS England and NHS Improvement, CCGs and other stakeholders including the Healthcare Financial Management Association (HFMA).

The checklist is designed to be a live working document that can be updated as the due diligence process progresses. It is for use by CCGs and existing ICSs to provide evidence of due diligence, and to be passed on to ICBs so that there is a clear picture of the people, property, liabilities, risks and issues that they are receiving on legal establishment.

It is proposed that the CCG adopts this comprehensive checklist to be used as the basis for the due diligence exercise. The Governing Body is asked to note that completion of the full checklist is not itself mandated by NHSEI. However, the information on individual members of CCG staff must be provided by either completing the relevant tab in the checklist or in another form using the same data fields. The due diligence checklist will be the key mechanism for capturing progress and highlighting risk and reporting this to the CCG Audit Committee, ICS Audit and Risk Committee and ICS Transition Steering Group. The due diligence checklist may be used to reflect any work that has already been undertaken and adapted as necessary to be proportionate to local circumstances. A review of the content of the checklist will be undertaken and any recommendations to amend or adapt will be presented to the September meetings of the Audit Committees and Transition Steering Group for formal adoption.

Support, advice and assurance

NHS England and NHS Improvement regional teams are expected to provide assistance to CCGs and ICSs with implementation of the due diligence guidance and carry out 'light touch' assurance of the due diligence process. The assurance by NHSE/I has not been outlined

and the approach to due diligence and/or timeline may need to be amended once this becomes clearer, to ensure we have clear reporting milestones captured and agreed.

Proposed Due Diligence approach

2.1 Phase 1: Review of documentation

The ICS transition programme plan sets out the key steps required in ensuring all relevant actions have taken place in relation to the preparation for the dissolution of the CCG for Governance, Finance, Workforce, Communications and Engagement, Quality, Commissioning, Digital/Data/Technology and Population Health Management. Regular reports on progress including highlighting identified risks and issues will continue to take place at the ICS Transition Steering Group meetings.

The due diligence process is part of this wider transition programme plan and will be overseen by designated Transition Leads. Each Transition lead is expected to oversee the progress of actions within their area (including on due diligence) and ensure there is sufficient capacity to deliver the project within the required timescales. The ICS Programme Director oversees the due diligence programme of work as Senior Responsible Officer (SRO) with the support of the CCG Director of Corporate Affairs and the Programme Manager, who together will ensure the due diligence process outlined is followed in addition to providing support should this be required, to the Transition Leads on a day to day basis is provided and liaising with NHS England/Improvement Regional Team.

The first stage of the due diligence process is for Transition Leads to undertake a review of the due diligence checklist and ensure all key actions are understood and plans for completion are made and documentation that supports the due diligence process is collated and captured. All relevant documentation will be assessed and confirmed as appropriately completed by 31st November 2021. There may at this stage require some legal advice on any areas identified as complex or of a higher level of risk.

Any outstanding steps can then be planned for and completed within the final 13 weeks in the run up to the 31st March.

2.2 Phase 2: Due Diligence Checkpoint

It is proposed that in December 2021/January 2022 two full day checkpoint workshops take place where Transition Leads are able to present their work highlighting all completed actions. This will be an opportunity for panel challenge where any final gaps are identified or there remain unmitigated risks. An overview summary of the panel's findings will be presented to the CCG Audit Committee and the ICS Audit and Risk Committee for assurance purposes.

It is suggested that this panel process includes as a minimum, the CCG Chair of Audit Committee and at least one other CCG Lay Member, CCG Internal Audit Services – Interim Consortium Director of CW Audit Services, the Chair of the ICS Audit and Risk Committee (or deputy), the Chair of the ICS People Committee (or deputy) and the ICS Executive Lead for Workforce (or deputy).

It is at this stage that an element of external scrutiny could offer support and greater assurance that all issues or risks have been addressed. It is therefore proposed that the CCG considers seeking legal support where necessary to work with Transition Leads on areas of complexity or areas of higher risk in these final critical stages. Their feedback and independent assurances would be used to confirm that a thorough process has been

followed and all issues have been appropriately addressed. This information would form part the due diligence assurance report.

2.3 Phase 3: Report to the Audit Committees and to NHSE/I

A full report on the due diligence process together with any independent assurances from a legal professional would be presented to the CCG Audit Committee and ICS Audit and Risk Committee in March. This in itself would form part of a clear hand over into the new ICS and could then be presented to the ICS Integrated Care Board at its first meetings as a statutory body.

In addition at the end of the due diligence process, the Accountable Officer of the CCG and ICB chief executive (designate), will be required to write to the relevant NHSE/I regional director confirming that an appropriate level of due diligence has been undertaken using the due diligence report and due diligence checklist as the basis for this assurance.

Appendix 2 – Due Diligence Checklist – see separate attachment

Appendix 3 – Due Diligence Assurance Panels

Due Diligence Assurance Panel Outcomes & Responses Report

As outlined in the due diligence approach report that was presented to both the CCG Governing Body in September and to the ICS Board in November two assurance panels were convened during week commencing 6th December 2021 to provide an independent overview of progress on actioning the due diligence tracker and also on the risk that the due diligence work has highlighted so far for the ICB.

Configuration of the panels

The two panel meetings were held on 6th and 10th December and were composed of:

Monday 6th December:

- Geoff Braden – CCG Audit Chair and Lay Member
- Meredith Vivian – CCG Lay Member
- Donna MacArthur – CCG Lay Member
- Paul Capener – Director, CW Audit Services (CCG Internal Audit function)

The panel focussed upon the following parts of the Due Diligence checklist:

Governance, Contracts and Finance.

Friday 10th December 2021:

- Geoff Braden – CCG Audit Chair and Lay Member (not in attendance for the HR section)
- Meredith Vivian – CCG Lay Member
- Donna MacArthur – CCG Lay Member
- Harmesh Darbhanga – Audit Chair and Non Executive Director- Shropshire Community Trust
- Paul Capener – Director, CW Audit Services (CCG Internal Audit function)
- Teresa Boughey – Non Executive Director Shrewsbury and Telford Hospital Trust (attended for the HR section only)
- Victoria Rankin – ICS Executive Lead for Workforce (attended for the HR section only)

The panel focussed upon the following parts of the Due Diligence checklist:

HR, IG & IT and Quality.

Panel review outcomes

The following table summarises:

1) The findings of both panel days for each topic area;

2) The score indicating level of assurance on progress to date and a RAG rating indicating the level of assurance on risk; and

3) Recommendations to workstream leads for consideration on areas of further work to supplement the assurance provided.

1. Finance	
Section score and comments Progress not quite as far as needed, however there are plans in place to address this	**3**
Areas requiring focused action	**No risks or Low Risk or Very Low Risk**
Panel recommendation	**Response**
Update 'greyed out' ICB actions for the next submission.	Amended on latest version of DD checklist (tabs 3.1-3.7).
Provide an update to the 'cleansing' process.	All ledger actions on target (see circulated project board update).
Provide an update to increased Finance team staff resilience.	Included on latest version of checklist (3.1.3).
Provide a formal update from NHSE's views on the finance teams progress and CCG financial position.	Monthly progress meetings held between CCG Finance (Claire Skidmore/Laura Clare/Maria Tongue), and NHSEI (Laura Mills). Plans are progressing well and no issues have been raised by NHSEI. Anticipate any additional feedback to be provided through the CSU's regular project team meetings with NHSEI.
Finance team to circulate their reports to any further relevant committees.	Actioned – circulated to finance committee each month.
Update final assessment columns (M, N and O) in the Due Diligence checklist document.	Complete in latest version of checklist.
2. Contracts	
Some preparation evident but needs close monitoring , concerns with planning or progress	**2**
Areas requiring focused action	**Moderate Risk**
Panel recommendation	**Response**
Update on key risk contracts; IS, patient care services, integrated urgent care, out of area and any other primary care and local area contracts.	No inherent contract risks have been identified as part of the due diligence work and transfer to the ICB. Part of on-going business as usual processes is to identify risks as part of contract negotiations with providers for a new contract term, any risks identified will be escalated and

	addressed. To date the main risk identified relates to requests for financial uplifts to address rising provider costs - this has been escalated to finance and is recorded as a potential financial pressure.
Update on the plan for more longer-term contracts so 'waivers' are not used, consultation process with orgs to explain the process.	Historically the CCG and predecessor organisations has directly awarded contracts on an annual basis: Over the past 12 months a new process for managing renewal of contracts has been introduced; Contracts are discussed at matrix working groups, to understand contract expiry dates in the context of transformation programmes; They are further discussed at the procurement oversight group to understand the procurement risk; For 2022 approval has been sought to directly award 17 contracts - the contract period being dependent on the timescales for transformation and service being delivered, varying from 1 - 3 years; Going forwards the contract team will work with Procurement advisors to develop a robust process in line with the Provider Selection Regime (final requirements yet to be published).
Update and circulate the procurement forward plan.	The procurement forward plan is a LIVE document, the latest version dated 01/03/2022 was circulated to panel.
Update on hospice grants in the long-term plan to convert to contracts.	The current position is that the CCG/ICB will continue to fund the majority of Hospice services via a grant; A formal contract will however be considered/negotiated for services commissioned in addition to core Hospice Services, provided there is a clear specification and outcomes such as "Hospice at Home".
3. Governance	
Section score and comments Progress not quite as far as needed, however there are plans in place to address this	**3**
Areas requiring focused action	**No risks or Low Risk or Very Low Risk**
Panel recommendation	**Response**
Further update on high-risk actions.	1.1 DD Checklist area core 1.1.5 - Consideration given to the need for additional assurance / legal advice through the use of external / internal audit / consultancy / legal support. This should focus on high risk areas as identified through the assessment of risk One area has been identified since the Assurance Panels took place in December 2021 for additional internal audit advice. This is to facilitate the handover process between existing CCG Directors and incoming ICB Directors. Discussion on the scope of this work have taken place in February and Internal Audit are currently draft terms of reference for agreement which is planned to take place in April 2022.

	1.2 DD Checklist area core 1.3.1 - Details of any concerns expressed by the Secretary of State, DHSC or NHSEI in relation to CCG actions - those identified by NHSE/I in ICS quarterly performance meetings are in regard to the financial deficit position of the CCG/system which is being addressed via the development of a system financial plan and the quality issues at the main acute Trust which are being addressed through the SaTH CQC action plan. The risk rating for these two areas has not changed and remains at red. 1.3 DD Checklist area core 1.5.1 – Outstanding claims / litigation that would transfer - Significant financial risk for one court of protection case that is likely to transfer to the ICB. See comments in paragraph 4 below.
Update on progress to model constitution in Q4.	The model constitution template has been updated on 11th February by NHSE and these changes have been updated into the STW version 0.10. There are, however, two areas that the STW ICS will need to consider further on the recent amendment to the Bill; to allow councillors to be nominated by local authority partners to sit on the ICB and how to facilitate primary care partners to be jointly nominated by all practices in STW. These discussions are currently taking place with the CE and Chair of the ICS. NHSE are planning that secondary legislation which will be released in April 2022 will require further amendments to the model constitution, which will mean a further iteration of the local STW ICB Constitution will be required.
Review ToR for committee structure.	Work to start pulling together terms of reference for the Quality and Safety Committee, Audit Committee, Remuneration Committee and Primary Care Commissioning committee has started. However further discussions are being led by the new Interim Designate Chief Executive on the committee structure, particularly around finance assurance, people committee and a strategic oversight function and place based committees.
Update on court hearing.	The CCG currently has 10 cases that it is accessing legal advice for, with 3 of these likely to transfer to the ICB and one of these three being classed as high risk due to the length of time the case has been open, that it is subject to legal proceedings in the Court of Appeal with legal complexities and for the significant cost accrued so far. The case is in reference to meeting patient need. There is no likelihood of the case being resolved prior to 1st July 2022.
Update on backlog of complaints and MP letters.	The backlog is now down to three outstanding complaints, two of which have drafted responses to the complainants currently with CCG Directors for sign off. The third has gone back to the provider following the draft being checked at Director level for

	further information to be added. This was due on 17th February and is being actively chased.
Coordination of a review of hard copies of HR personnel documents- Support provided by HR.	Communications have gone out to line managers w/c 28/02/22 to complete an initial review of all HR files they hold. HR will be supporting line managers with queries and any highlighted gaps in documentation.
Update on statutory duties of the ICB and to plan where they sit in the new org.	The high level functions and decisions map required as part of the key documentation for creation of the ICB has now been developed by the CSU Strategy Unit for the ICB. The more detailed work on where functions sit at what level and therefore what decisions will be made where, has yet to be determined as this will partly be dictated by the portfolios of the new ICB Directors, which is currently being worked through by the Chief Executive Designate.
4. HR	
Progress not quite as far as needed, however there are plans in place to address this	3
Areas requiring focused action	**Moderate Risk**
Panel recommendation	**Response**
Robust comms plan with partners, stakeholders and agencies is required.	The responsibility of HR is to ensure that the CCG has a robust communications plan in place for communicating with its staff and ICB staff in scope to transfer with regards to the consultation and their transfer to the new organisation – I don't believe that our responsibility extends to communications plans with partners, stakeholders and agencies. This would fall jointly to the CCG and the ICB via their own communication teams. With regards to communicating with staff we have a communication plan within the consultation document and this would be extended to those not currently employed by the CCG but who are in scope to transfer. We are also now linking in with HR colleagues at the organisations who employ ICB staff in scope to transfer to ensure that communications are consistent.
Review RAG rating to improve consistency.	All dates have been adjusted to reflect the extended timescales and everything is on green which means it is either complete (indicated on the checklist) or on track and there are no risks of not completing.
More context needed on final assessment.	This has now been updated.
What actions are a priority to be completed prior to April.	• The first element is the consultation with all staff who have been identified as being in scope to transfer, which will start on 4 April 2022. This is all CCG staff and those ICB staff who may be employed by other system organisations. We have received a list of ICB staff not currently employed by the CCG so all in scope have been identified. The EQIA has been completed and the consultation document is ready to use. We also have to obtain formal sign off from the CCG for the transfer which is taking place on 9 March. We have also notified our trade union colleagues that we will start

	consultation on 4 April. Therefore all steps have been completed and we are ready to start consultation on 4 April. • The second element is the provision of employee liability data at least 28 days before the date of transfer. Colleagues in ESR have uploaded the template at 2.2 into ESR have been testing this with interim data since January 2022. By the end of March 2022 they will finalise the CCG employee liability data into this template. The data will then be sent to colleagues in payroll who will upload payroll elements that are obtained automatically from ESR. At the end of April the information will then be passed to the HR Team who will manually upload the data that is not automatically populated from ESR. The team will also run a series of checks that all data is present and correct before it is shared with the ICG by 1 June 2022. All our workstreams to collect any data are on track to complete by 31/03/2022 or 30/04/2022 which will allow enough time for the manual upload and checking process.
More assurance required on Maternity, Paternity and sick leave.	All HR communications that go to line managers include a reminder to forward on to those who may be absent from work due to maternity, paternity, sick leave, secondment and career break. In addition the team will obtain a report from ESR which will list all those absent for these reasons and will link in directly with line managers to ensure that comms has been forwarded.
5. IG & IT	
Section score and comments Progress not quite as far as needed, however there are plans in place to address this	**3**
Areas requiring focused action	**No risks or Low Risk or Very Low Risk**
Panel recommendation	**Response**
More detail on closure of actions.	Detail has been added to the action plan.
More assurance required regarding physical paperwork.	Paper audit has been completed and updated to detail the new locations of the records after the move from William Farr House. All departments responded in the audit to detail the new location.
Review dates, more accurate dates required to demonstrate prioritisation of actions.	More detailed review dates have been added to the action plan.
Share process for improving/reviewing record, referred to as the 'main focus'.	Process for reviewing and data cleansing the information is in the policy for locally managed records. The shared drive will combine the data and make access to the CCG data straight forward for teams.
More detail on timeline leading up to voluntary toolkit submission next year.	This has been completed.

Update final assessment column.	Updated
6. Quality	
Section score and comments Good evidence of work in hand and progress being made at this time	**2**
Areas requiring focused action	**Moderate Risk- High Moderate**
Panel recommendation	**Response**
More narrative required on all actions.	All actions updated.
Records of meetings which will identify jointly owned position of risks is required.	All actions have been updated with additional information and the risk levels re-scored. An internal Quality Directorate information checking process has confirmed that required information is contained within various quality monitoring processes and is up to date as of 14/04/22 and can be made available at the point of request. All systems will be maintained on-going and will transfer to the ICS.
More mitigations to risks to be included.	This is via the Quality and Performance Committee, the System Quality Group and the Maternity governance forums of LMNS and Peri Natal Quality Surveillance (PNQSG). Terms of reference for all of these forums have been or are being updated and approved. Work is underway to collate the system view of quality risks. It requires work to be done by the system governance lead and others to confirm the system appetite for risk, and finalise the governance operating model. These actions are included in the Quality Roadmap.
More detail on comms and engagement required.	A small number of actions have associated risks and details of mitigating actions are included. All risks have been scored as 'green' with the additional mitigations confirmed as being in place.
More evidence of plan for the transition phase (beyond April 22').	The Quality Governance Road Map is appended for information. This has been received to ICB March 2022 as version 2, and further updated is now provided as of April 22 as version 3. The Road Map confirms that the core requirements as defined by NQB are met, with information on our plans to further develop ICS quality governance.
Dates to be reviewed and actions prioritised.	These have been further updated on the Due Diligence database at tabs 1 and 7.
Provide any updates on the development of quality metrics.	A task & finish group with system representatives is established to finalise the format and content of reporting requirements to the various quality forums. We have a prototype report which incorporates all of the core requirements of the NQB toolkit (the minimum requirement) as well as some localised priority metrics. Metrics at Place are also under development, but do exist at a population health level. Our reporting metrics report format and content will undergo further development over the next few months and is included within the Quality Roadmap.

	There is system Business Support identified for this and good system engagement to progress this work. A prototype dashboard was presented to QPC at the March meeting and met with approval, and work in progress was noted.
Provide update to increasing the quality of data (as discussed from a single source and not retrospective) and in particular an update on the maternity deep dive.	A above; the development of quality metrics requires confirmation of the data quality and this is incorporated into the work of the task and finish group with business support via the CSU. A robust assurance process is in place regarding achievement of progress against the Ockenden recommendations. A paper on maternity data quality was received to LMNS Programme Board March 2022. This provided limited assurance and further assurance was requested from SaTH regarding the pace of improvements and to ensure SaTH Board were sighted on the concerns. A response to correspondence to the DoN and CEO is awaited and this action is recorded on the LMNS Programme Board action tracker.
Provide update on any additional complaints found.	Information on each provider position relating to complaints is monitored. There is a backlog of complaints responses at SaTH which is being monitored and progress is being made against their remedial plans.
Provide updates on recruitment (ongoing).	The CCG Quality team is experiencing a turnover of staff and staffing plans and vacancies are being actively recruited to and this position is kept under review. Additional temporary senior nurse support is in place to ensure the quality governance oversight arrangements are maintained and developed.
Update on IT subscriptions as we move into an ICB.	All current quality system subscriptions and medicines management systems will be maintained and will transfer to the ICS. This work was undertaken as part of the Single Strategic Commissioner due diligence process and remains valid.
Update on progress of reviewing low priority meds management policies (due to be completed by 31st March).	This work is all underway as per plan and an update was recently presented to Audit Committee (February 2022). No delays were identified.
Complete final assessment columns.	This information has been updated.

Appendix 4 – Due Diligence Checklist - Risk and Issues Exception Report – see separate attachment

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

Introduction to the CCG Close Down and ICB Establishment Due Diligence Checklist v2

IMPORTANT - THIS CHECKLIST SHOULD ONLY BE USED ONCE YOU HAVE READ THE ICB ESTABLISHMENT GUIDANCE ENTITLED: 'DUE DILIGENCE, TRANSFER OF PEOPLE AND PROPERTY FROM CCGs TO ICBs AND CCG CLOSE DOWN' AND THE CONTENT OF THIS TAB.

The checklist has been co-produced by NHS England & NHS Improvement (from this point referred to as NHSEI), CCGs, ICSs, the Helathcare Financial Management Association (HFMA) and other stakeholders as a practical tool for use by CCGs and existing ICSs to provide evidence of due diligence in the transition from CCGs to ICBs. In all cases CCGs and ICSs must undertake an appropriate level of due diligence and it is recommended that this comprehensive checklist is used as the basis for the exercise. It is particularly important that the property list is sufficiently detailed for 'level 3' due diligence, where potentially property and liabilities are to be allocated between ICBs. **Completion of the full checklist is not itself mandated by NHSEI**, however, the information on individual members of CCG staff must be provided by either completing the relevant tab in the checklist (ref 2.2) or in another form using the same data fields. The checklist may be used to reflect any work that has already been undertaken and adapted as necessary to suit local circumstances. It is recognised that some areas of the checklist will be more important than others - and the level of detail provided should be proportionate to local circumstances. The checklist is designed to be a live working document that can be updated as the due diligence process progresses.

It is for use by CCGs and existing ICSs to provide evidence of due diligence, and to be passed on to ICBs so that there is a clear picture of the people, property, liabilities, risks and issues that they are receiving on legal establishment. It will help as the basis on which the Accountable Officer of each existing CCG will formally confirm that an appropriate level of due diligence has been undertaken. This will support the legal transfer of people and property, close down of the CCG(s) and establishment of the ICB.

NHSEI regional system support teams will provide assistance with the due diligence process, including how to use this checklist - and they will also undertake 'light-touch' assurance to ensure that there is consistency of approach, for the benefit of CCGs, existing ICSs and the new ICBs (once established).

Note: the checklist includes reference to a number of activities to establish ICBs (shaded in grey), and some of these areas are subject to NHSEI guidance which is currently under development. The checklist currently includes a number of 'placeholders' and will evolve.

The checklist is colour coded to highlight key areas. The core checklist is tab 1 - this cross-references to further tabs which provide for further detail to be recorded if necessary. NOTE: The information on individual members of CCG staff MUST be provided either by completing tab 2.2, or in another form using the same data fields as outlined on tab 2.2, and adding local data fields as necessary.

The contents are as follows:

Additional checklists will be included as required

Version Control

The current version of the Due Diligence Checklist is made available via the Hub / FutureNHS platform. Strict version control is being applied and the current version number and date of issue included below; any prompt changed / added is highlighted in yellow in column A on each tab, including the version in which the change took place; and the changes made logged on the version control log tab.

Current version number	V2
Date of current version	14/10/2021
Details of changes made	See Version Changes Tab

Comments Regarding Versions Released

V1 was released on 18.08.21

V2 provides an update as at 14.10.21 and the change log indicates all changes made to date

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

1.0. CORE CCG DUE DILIGENCE CHECKLIST TO SUPPORT TRANSFER OF PROPERTY TO THE INTEGRATED CARE BOARDS (ICBs)

Name of ICB:	
Name of CCG(s):	
Date:	
Completed by:	
Contact details:	

Level of due diligence based on the level of complexity determined	**Select from drop down list below**
Level of complexity determined and the process as covered in section 1 below can be adjusted to respond to the level of complexity - select applicable option in column J	Level 1 - Single CCG to coterminous ICS and no boundary changes

			Initial Assessment						**Final Assessment**			**Risk the ICB will inherit related to the specific property or liability**		
Ref	**Due Diligence Area for Review** *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	**Comments**	**Person Responsible**	**Start Date**	**End Date**	**New ICB Timeline Due Date**	**RAG**	**Further action required Y'es / No)**	**Action required**	**Due Date for Further Action**	**Final RAG**	**Risk identified**	**Mitigating Action/Comments**	**Risk RAG**
1.1	**Due diligence process**													
1.1.1	Due diligence process is fully documented and agreed at the Executive or Board	Due Diligence process approach was presented to CCG Governing Body and ICS Board in September 2021 for approval. Delegation to respective Audit committees also supported.	Alison Smith	01/09/2021	29/09/2021		Green	No	N/A	N/A	Green			Green
1.1.2	SRO for due diligence for the CCG(s) agreed	Director of Corporate Affairs STW CCG agreed as SRO reporting to ICS Programme Director	Alison Smith	01/09/2021	29/09/2021		Green	No	N/A	N/A	Green			Green
1.1.3	Key dates for internal sign off for the overall due diligence process and staffing and property lists agreed	Plan for sign-off outlined in the Due Diligence Process Approach report - AO signoff of Due diligence following final report to Audit Committee of CCG in mid May 2022.	Alison Smith	01/03/2022	13/05/2022		Green	Yes	Plan in place to be enacted in May 2022	31/03/2022	Amber	No risk identified	N/A	Green
1.1.4	Due diligence process risks considered and assessed	Initial assessment to be undertaken in November following first checklist reporting to CCG and ICS Audit Committees in preparation for panel assurance meetings in December. Further assessment will be undertaken at the end of March 2022.	Alison Smith	01/11/2021	31/03/2022		Green	Yes	Plan in place enacted in March 2022. Risk around contracts and quality identified.	12/05/2022	Green	Due Diligence Assurance Panel identified Quality and Contract workstreams as needing further focussed work	Due diligence risks have been mitigated where possible, with may actions now completed or risk minimised to green rated.	Green
1.1.5	Consideration given to the need for additional assurance / legal advice through the use of external / internal audit / consultancy / legal support. This should focus on high risk areas as identified through the assessment of risk	Due diligence approach report outlines a two day assurance panel that includes Lay members and ICS NEDs and CCG internal Audit Director to scrutinise progress and areas of risk to provide assurance to Audit Committees meeting in January 2022. Further internal audit support has been identified for the handover process between CCG Directors and ICB Directors which is currently being scoped.	Alison Smith	01/11/2021	12/05/2022		Green	Yes	Assurance panel dates in December delivered. Internal audit support of handover process has been agreed and dates for handover meetings are being arranged.	12/05/2022	Green	Risk that incoming ICB Directors are not fully appraised of three assets and liabilities they will be inheriting from the CCG.	Scope includes a face to face handover between directors where possible which will be facilitated by Internal Audit and fully documented as part of the Transition handover report.	Green
1.2	**Staff and Staff Benefits**													
1.2.1	**Staff and Staff Benefits - HR / People Due Diligence Checklist is included at tab 2.1**	List of staff benefits is already held by the HR team which will be provided along with the Employee Liability information 28 days before the date of transfer	Lisa Kelly/Alison Smith	01/10/2021	31/03/2022	31/1/22 (initial), 1/6/22 (final checkpoint)	Green	No	List of benefits is available to be made available as part of the employee liability information	31/03/2022	Green			
1.2.2	**A template is provided for sender organisations to provide employee liability information (ELI) (and broader due diligence) to facilitate the safe transfer or staff to receiving organisations, in this case ICBs. See covering guidance and tab 2.2 for the legal requirements - Template is included at tab 2.2**	Template has been uploaded into CSU workforce systems and will be used to pull together the employee liability information 28 days prior to transfer	Lisa Kelly/Alison Smith	01/10/2021	31/03/2022		Green	No	Employee liability information to be compiled 28 days before the date of transfer	28/02/2022	Green			
1.3	**Constitutional, Corporate and Regulatory Matters**													
1.3.1	Details of any concerns expressed by the Secretary of State, OHSC or NHSEI in relation to CCG actions	None identified to date. Processes are in place to identify these if & when they occur and to capture in the due diligence process	Alison Smith	01/10/2021	30/06/2022		Amber	Yes	This is amber as it is a continuing action but none identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.2	Details of any concerns expressed by internal auditors, external auditors or the National Audit Office concerning powers, rights or duties	External auditors have highlighted the CCG(s) failure to remain within its resource limit in its 2020/21 ISA260 reports. Also the CCG's failure to address its underlying deficit is highlighted in their VFM conclusion for 2020/21.	Laura Clare	01/11/2021	02/11/2021		Green	Yes	Copies of external auditors reports & VFM conclusion are available upon request	TBC	Green			Green
1.3.3	Details of any disciplinary action taken by the CCG in relation to CCG Governing Body members, Directors or Officers relating to their acts or omissions relating to powers and duties of the CCG	None identified to date. Processes are in place to identify these if & when they occur.	Lisa Kelly/Alison Smith	01/11/2021	30/06/2022		Amber	Yes	This is amber as it is a continuing action but none identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.4	Details of any material breach of Public Procurement Regulations, Standing Orders or Standing Financial Instructions	None identified to date. Processes are in place to identify these if & when they occur.	Laura Clare	01/11/2021	31/03/2022		Green	No			Green			Green
1.3.5	Details of any breach of the Code of Conduct, Code of Accountability or other equivalent guidance	None identified to date. Processes are in place to identify these if & when they occur.	Alison Smith	01/10/2021	30/06/2022		Amber	Yes	This is amber as it is a continuing action but none identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.6	Details of investigations by supervisory or regulatory bodies, statutory or government bodies, the Health and Safety Executive, the Environment Agency, the police, NHS Counter Fraud and Security Management Services (CFSMS), or any other circumstances, that would transfer	None identified for H&S, Environment Agency, Security Management Services. Processes in place to identify these if and when they occur. Counter fraud investigations are reported on regularly to CCG Audit Committee	Alison Smith/Laura Clare	01/10/2021	30/06/2022		Amber	Yes	This is amber as it is a continuing action but none identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.7	Current inspections by the Care Quality Commission (CQC) that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracey Slater	Ongoing	30/06/2022		Green	Yes	Maintenance of records on-going.	30/03/2022	Green	No risks identified currently.		Green
1.3.8	Total number of CQC warning notices (GP practices, Care Homes and NHS funded providers) in last 24 months	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracey Slater	Ongoing	30/06/2022		Green	Yes	Maintenance of records on-going.	31/03/2022	Green	No risks identified currently.		Green
1.3.9	Total number of CQC inadequate inspection ratings (GP practices, Care Homes and NHS funded providers) in last 24 months	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracey Slater	Ongoing	30/06/2022		Green	Yes	Maintenance of records on-going.	01/04/2022	Green	Highley Medical Practice rated IA	Action plan in place and progress being made - reported to PCC.	Green
1.3.10	Open CQC action plans that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracey Slater	Ongoing	30/06/2022		Green	Yes	Maintenance of records on-going.	02/04/2022	Green	SaTH overall rated IA.	Action plan in place and monitored via SOAG. EoLC improvement plan in place with NHSEI national team and STW CCG support.	Green
1.3.11	Open public consultations regarding service change / reconfiguration that would transfer	There is no plan to have any public consultations as we are not proposing any services changes in relations to becoming a statutory ICS. 2/12/21- No change	Chris Hudson/Edna Boampong	01/10/2021	30/06/2022		Green	Yes	No public consultation is being carried out that would require transition to the ICB.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.12	Open learning points from past System Oversight Framework assessments that would transfer	Reviewing open learning points of system oversight framework assessments from last 12 months	Claire Skidmore	01/11/2021	30/06/2022		Amber	Yes		30/06/2022	Green			Green
1.3.13	Open risks that would transfer (provide risk register of all risks, including HR, financial / accounting, quality risks, etc)	Risks at Board Assurance Level and Directorate level are captured in regular bi monthly risk reporting to the Audit Committee and Governing Body.	Alison Smith	01/10/2021	15/06/2022		Amber	Yes	Open risks will be reported to the CCG audit committee on the 15th June which will form the information that will be transferred to the ICB.	15/06/2022	Green	No risks identified currently.	N/A	Green
1.3.14	Open Memoranda of Understanding (MOUs) in place that would transfer	All contract owners will be contacted to identify leases held independently or within contracts. Once identified these will be added to the contract register workbook as a separate tab.	Kay Holland/Julie Garside	01/11/2021	31/03/2022		Green	Yes	All active MoUs have been transferred to the 2021/23 contracts in a separate MoU / Grant Tab	31/01/2021	Green	N/A	N/A	Green
1.3.15	Clinical and non-clinical policies (provide policy register(s))	A significant amount of work to align policies has already been undertaken since the establishment of the new STW CCG to align the clinical and non-clinical policies of the former Shropshire and Telford & Wrekin CCGs. The majority of these policies have now been aligned and approved by the Governing Body or relevant Committee. Progress is monitored through two Policy Trackers, one held by Medicines Management for the clinical policies and the other by Tracy Eggby Jones for all other non-clinical policies. The Medicines Management Team (MMT) have prioritised (RAG rated) their policies for review and have been working through these systematically, which has been challenging due to the support they have been providing to the Covid pandemic response. Currently there are 2 documents on the MMT policy tracker to be completed, which relate to the Memorandum of Understanding (MoU) and Information Sharing Agreement (ISA) for the Prescription Ordering Direct (POD) service. These are in the process of being completed and subject to Information Governance approval. There is 1 policy on the corporate policy tracker yet to be approved. This is the IVF policy and a significant amount of work has been undertaken to align the former two CCGs policies, which has included engagement work. The policy is due to be presented to the SCC meeting on 18 May 2022 for approval. The policy trackers have been presented to the CCG's Audit Committee for assurance, with the next update on 18 May	Tracy Eggby Jones/Alison Smith	01/04/2021	27/05/2022	27/05/2022	Green	Yes	This will need to be reviewed and updated over the period leading up to June 2022. First review to be undertaken from April 2022, with progress reporting taking place from May 2022 to identify risk areas.	01/05/2022	Green	x commissioning policy remains to be approved - due to Strategic Commissioning committee in May.	There will be a need for all CCG policies to be reviewed and rebranded (i.e. new logo etc) for the new ICB. This is planned to take place from April 2022. Whilst this work is undertaken the new ICB will need to adopt all existing CCG policies at their first Board meeting in July 2022.	green

1.3.16	Where there are multiple CCGs in an ICS, assessment of risk posed by having different policies (e.g. IVF commissioning policy) and clear plan to consolidate all policies. This includes the need to agree the position and timescales for any 'high risk' policies not consolidated at the point of establishment of the ICB	See 1.3.15 above. Specifically in relation to the IVF Policy, which is due to be presented to the SCC meeting on 18 May 2022 for approval.	Tracy Eggby Jones/Alison Smith	01/10/2021	27/05/2022	27/05/2022	Green	Yes	This will need to be reviewed and updated over the period leading up to June 2022. First review to be undertaken from April 2022, with progress reporting taking place from May 2022 to identify risk areas.	01/05/2022	green	All CCG policies have been aligned as per the CCG merger plan agreed in 2021 and now are being rebranded.	No risk remains.	Green
1.3.17	Subject access requests (SARs) that would transfer (links to 5.15)	A SARs register is held by Tracy Eggby-Jones, which identifies all SARs received, their current status with RAG rating. Any open SARs at 30.6.22 will transfer to the new ICB and requesters notified.	Tracy Eggby Jones/Alison Smith	01/10/2021	30/06/2022		Amber	Yes	This list will be kept under review and updated over the period leading up to 30 June 2022.	31/06/2022	Amber	There is a potential for some SARs not to be completed by 30 June 2022 and therefore any open requests will carry forward to the ICB. There is a low risk of the SARs are not completed within the 28 days statutory timeframe as a result of transition but this is mitigated by the same team overseeing this process being in place in the ICB on 1st July for continuity. Amber risk rating reflects the ongoing nature of the action rather than the risk around particular SARs.	The list of open SARs will be kept under review to ensure they transfer to the new ICB and requestors informed. Any areas of concern will be escalated to the Director of Corporate Affairs.	Green
1.3.18	Freedom of Information (FOIs) requests that would transfer (links to 5.18)	The process for overseeing FOI requests is managed by the Midlands & Lancashire CSU. They can provide a list of open FOIs at any point and relevant parties of those that are not concluded by 30 June 2022 will be notified of the transfer to the new ICB.	Tracy Eggby Jones/Alison Smith	30/06/2022	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	31/06/2022	Amber	There is a potential for some FOIs not to be completed by 30 June 2022 and therefore any open FOIs will carry forward to the ICB. There is a low risk if the FOIs are not completed within the 20 working days statutory timeframe as a result of transition but this is mitigated by the same team in the CSU and CCG overseeing this process being in place in the ICB on 1st July for continuity. Amber risk rating reflects the ongoing nature of the action rather than the risk around particular FOIs.	The Corporate Services Manager will liaise closely with the MLCSU to ensure any open FOIs are transferred to the new ICB and requesters informed. Any areas of concern will be escalated to the Director of Corporate Affairs.	Green
1.3.19	Open learning points from Emergency Preparedness, Resilience and Response (EPRR) that would transfer	Plans are in place to ensure that learning points will transfer to ICB as appropriate	Sam Tilley	01/11/2021	30/06/2022		Amber	Yes	Plans for EPRR function for the ICB is in development with a draft being submitted to NHSEI on the 27/5/22	30/06/2022	Green	No risks identified currently		Green
1.3.20	Details of any other material information relating to the constitution and governance of the CCG	None identified to date. Processes are in place to identify these if & when they occur.	Alison Smith	01/10/2021	30/05/2022		Green	Yes	No issues relating to CCG constitution or governance framework identified.	12/05/2022	Green	No risks identified currently.	N/A	Green
1.3.21	Assess whether the ICB will need a new Economic Operators Registration and identification (EORI) number	This will not apply to ICBs as they will not need this license.	N/A				N/A	N/A			N/A			N/A
1.3.22	Ensure that the Establishment Order is in place to create the ICB and dissolve the CCG(s) - *Note that this is to be undertaken nationally*	Relates to ICB set up - the creation of the Order will be done by NHSE	Nicky O'Connor/Alison Smith	01/04/2022	27/05/2022	27/05/2022	Green	Yes	Final ICB constitution has been submitted on 26/5/22 to allow NHSEI to create the establishment order.	26/05/2022	Green			Green
1.3.23	Ensure that the appropriate staff and property transfer schemes have been created and approved to transfer people and property from the CCG(s) to the ICB - *Note that this is to be undertaken nationally*	Relates to ICB set up - the creation of the schemes will be done by NHSE but informed by a list of staff to be provided by the CCG. Please refer to worksheet 2.1 HR Due Diligence Checklist for detailed Action and Risk ratings and commentary	Lisa Kelly/Alison Smith	01/05/2022	01/06/2022	01/06/2022	N/A	No						
1.3.24	New Constitution agreed for ICB - Model Constitution guidance currently under development	Relates to ICB set up. Model Constitution has been drafted. A rm amended version of the model constitution has been released on 11 February and amendments ae currently being actioned. Final Constitution will be submitted to NHSE by deadline 20 May	Alison Smith	15/10/2021	12/05/2022	31/1/22 (initial), 11/3/22 (2nd draft), 22/4/22 (third draft), 20/5/22 (final)	Green	Yes	This will need to be reviewed and updated over the period leading up to March 2022 Reviewed in January 2022. Further review being undertaken by new interim Designate ICB Chief Executive in first two weeks of February 2022. Additional amendments to the model have been released which are being actioned for 22 April 2022 Further model due for release w/c 2 May 2022. Final Constitution will be submitted to NHSE by deadline 20 May	15/05/2022	Green	Final Constitution will be submitted to NHSE by deadline 20 May	N/A	Green
1.3.25	Agree the new committee structure and develop terms of reference, as necessary. Committees may include: • Remuneration committee; • Audit & risk committee; • Quality committee (following NQB guidance); • Priorities Committee; • Primary Care Commissioning committee; • IFR; • Finance committee • Capital committee Consider other committees that are an integral part of the governance structure or that are required due to the nature of the ICB. Agree their purpose, terms of reference and appropriate duration. For example, should they be: Permanent or time limited.	Relates to ICB set up Some model terms of reference have been released by NHSE/I to use. ICS already has committees in place which will be retained and added to. New ICB Interim Designate CE is in discussions with CCG and ICS Execs on changes to the current Committee and governance structure. Work has started to review current ICS Committee TOR and align will developing thinking on new structure.	Alison Smith	01/02/2022	10/06/2022		Amber	Yes	Drafts of TOR currently being developed for submission to NHSEI on 10/6/22 however further refinement is expected upto 30/6/22.	30/06/2022	Green	Ensuring triangulation between the TOR.	Discussions to refine committee structure continue to take place.	Green
1.3.26	Agree new logo, letter head, signage, harmonise all corporate documents, standard documents and inform staff where these can be accessed - for ICB	Relates to ICB set up naming convention now agreed and we are in the process of looking at all corporate templates. New NHS DTW logo has been developed. Corporate stationary is being worked up and will be ready for circulation from mid-June.	Chris Hudson/Edna Boampong	22/10/2021	30/06/2022		Amber	Yes	Plan being dischanched, all actions to be ready by 30 June 2022.	01/07/2022	Green			Green
1.3.27	New website for ICB	Relates to ICB set up Move to one website, with the CCG site becoming the ICB website and the ICS site being discontinued. There will be a section on the ICB site for ICS content. The planning for this change is under way.	Chris Hudson/Edna Boampong	01/10/2021	01/07/2022	01/07/2021	Amber		Plan being dischanched, all actions to be ready by 30 June 2022.		Green			Green
1.4	**Quality Governance**													
1.4.1	Infection control records	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. There is a recent IPC quality concern for RJAH. We have a system approach to ensuring aligned response to any changes to national guidance relating to Covid-19.	Jill Hassall/Vanessa Whatley	01/11/2021	30/06/2022		Green	Yes	Continued support to RJAH CNO and IPC team and close monitoring of the progress of their IPC action plan. This is formally via SQG. System response to IPC guidance - on-going. Maintenance of records on-going.	30/06/2022	Green	There is a risk that RJAH IPC improvement plan will not be fully delivered at the point of ICB authorisation.	NHSEI improvement director for IPC in situ at RJAH.	Green
1.4.2	Open outstanding / ongoing complaints that would transfer (links to 1.4.2)	The CCG's Patient Services Team are able to run a report from Ulysses of all open complaints, PALS and MP letters at any point and will notify relevant parties of cases not concluded by 30 June 2022 that their case will be transferred to the new ICB.	Tracy Eggby Jones	01/10/2021	30/06/2022	30/06/2022	Amber	Yes	This is amber rated as this is a continuing action up to 30 June 2022. None identified to date.	30/06/2022	Green	No risks identified currently.		Green
1.4.3	Open Serious Incidents (SIs) that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracey Slater	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.	30/06/2022	Green	No risks identified currently.		Green
1.4.4	Open whistleblowing / FTSU cases that would transfer	None identified at the moment. Annual reporting on Freedom to speak up concerns to the Audit Committee	Alison Smith	01/10/2021	30/06/222		Amber	Yes	This is amber rated as this is a continuing action up to 30 June 2022. None identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.4.5	Open quality action / improvement plans that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Tracy Slater/Zena Young	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.	30/06/2022	Green	No risks identified currently.		Green
1.4.6	Personal Health Budgets held that would transfer	All of the PHB information is held on an electronic patient management system and the shared drive. It will be accessible in the same way on 01/07/2022 ie on 30/06/2022. No physical transfer required and software supplier has confirmed access will be uninterrupted. The financial information is contained on the finance system Oracle and the wider finance system access will ensure that system information and access transfers over.	Brett Toro/Claire Parker	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.	30/06/2022	Green	No risks identified currently.		Green
1.4.7	Open Individual Funding Requests or appeals that would transfer	Plans are in place to ensure that relevant information is transferred to the ICP	Clare Stallard/Claire Parker	01/11/2021	30/06/2022		Amber	Yes	Any open IFR cases will automatically transfer to the new organisation, the status of any outstanding IFR cases will not change and any required actions or panel meetings will take place as previously planned, any appeals will also transfer to the new organisation		Green			Green
1.4.8	Deferred Individual Funding Requests that would transfer	Plans are in place to ensure that relevant information is transferred to the ICP	Clare Stallard/Claire Parker	01/11/2021	30/06/2022		Amber	Yes	Any IFR cases awaiting further information to support the application will continue as per policy, a 28 day deadline will still apply for the provision of further information to be provided and this will be continually reviewed in old and new organisation to ensure the policy is correctly applied		Green			Green
1.4.9	Open independent investigations, including mental health homicide reviews and domestic homicide reviews that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. DHRs: Details are provided on a quarterly basis of all open DHRs to NHSEI. Under local and legislative arrangements the oversight of these sits with the Community Safety Partnership and the ultimate governance rests with the Statutory Safeguarding Partnership arrangements. No issues have been identified.	Maria Hadley	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.	30/06/2022	Green	Maternity - WMP Operation Lincoln work ongoing post 31/03/22 Telford independent inquiry into Child Sexual Exploitation (TIICSE) to be published in March 22	CCG executive engaged with WMP liaison meetings for Op Lincoln. CCG have replied to the Maxwellisation process for TIICSE - awaiting report publication.	Green
1.4.10	Open safeguarding adults reviews that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. Governance arrangements are in place and again Section 44 of the Care Act overarching accountability rests with the Safeguarding Adult Board. There are no concerns or challenges about CCG activity in support of ongoing SARs. Plans are in place to ensure that relevant information is transferred to the ICP.	Maria Hadley	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.		Green	No risks identified currently.		Green
1.4.11	Open serious case reviews / child safeguarding practice reviews that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. Details are provided on a quarterly basis of all open CSPRs to NHSEI. Under local and legislative arrangements the oversight of these rests with the Statutory Safeguarding Partnership arrangements. No issues have been identified.	Maria Hadley	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.		Green	No risks identified currently.		Green
V4 1.4.11bi	Number of Looked After Children cases that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Maria Hadley		30/06/2022		Green	Yes	Maintenance of records on-going.		Green	No risks identified currently.		Green
V4 1.4.11bii	Number of Deprivation of Liberty Safeguarding (DOLS) cases that would transfer	Legislation relating to the implementation of Liberty Protection Safeguards is due to be introduced during 2022/23 and the CCG safeguarding team are leading the system response to this. There is a risk recorded on the CCG risk register in relation to this (rated yellow).	Claire Parker/Paul Cooper	TBC	TBC		Green	Yes	The CCG safeguarding team provide on-going expertise to the CHC team in such cases.		Green	DOLS will cease to exist and it will be covered by new legislation under Liberty Protection Safeguards (LPS) . LPS introduction was delayed due to COVID and at present is still going through national consultation process, with an unknown implementation date. Legislation relating to the implementation of Liberty Protection Safeguards is due to be introduced during 2022/23	The CCG safeguarding team are leading the system response to this. This is a continuing action and an unknown risk.	Amber
1.4.12	Open mortality review reports / medical examiner referrals that would transfer – i.e. any cases being reviewed by the CCG, such as cases referred by a medical examiner which the CCG is following up or has an outstanding action for the CCG	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Zena Young	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.		Green	No risks identified currently.		Green
1.4.13	Open Regulation 28 Coroner reports that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Tracey Slater	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.		Green	No risks identified currently. Actions relating to previously received Regulation 28 notices have all been enacted and complete.		Green
1.4.14	Enforcement notices (served on the CCG in the last 24 months) that would transfer	There are no such enforcement notices - the CQC does not regulate CCG's	Zena Young	01/11/2021	30/06/2022		Green	Yes	Nil as the CQC does not regulate the CCG		Green	N/A		Green
1.4.15	Open Learning Disabilities Mortality Review (LeDeR) cases that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. This information is reported nationally to NHSEI.	Tracey Slater	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.		Green	No risks identified currently.		Green
1.4.16	Open Eliminating Mixed Sex Accommodation (EMSA) cases that would transfer	Numbers of EMSA breaches form part of quality monitoring.	Tracey Slater	01/11/2021	30/06/2022		Green	Yes	Monitored and tracked as part of SQG reporting.		Green	No risks identified currently.		Green
1.4.17i	Open learning points from patient surveys and feedback	Plans are in place to ensure that relevant information is transferred to the ICP	Edna Boampong/Zena Young	01/11/2021	30/06/2022		Green	Yes	Maintenance of records on-going.		Green	No risks identified currently.		Green

V4	1.4.17c	Open learning points from clinical audits	This information is monitored as part of routine quality oversight of providers.	Tracey Slater		30/06/2022		Green	Yes	Maintenance of records on-going.		Green	No risks identified currently.			Green
V4	1.4.18	Open learning points from complaints, incidents, clinical audits, quality matters, etc. that would transfer	Cases are tracked as part of routine quality monitoring processes. An internal Quality Directorate information checking process has confirmed that this	Zena Young		30/06/2022		Green	Yes	Maintenance of records on-going.		Green	There is a backlog of complaints responses at SATH	Remedial plans are in place to address this which are progressing.		Green
	1.4.19	Establish approach for the transfer and retention of legacy organisation information on quality in accordance with Caldicott principles and share intelligence on quality, including safety (as per NQB guidance)	Plans are in place with relevant quality leads. The data cleanse exercise, securing, transfer and storing of records is underway and will be complete by 20/04/22	Zena Young	01/11/2021	20/04/2022		Green	No			Green	No risks identified currently.			Green
V3 /4	1.4.20	Agree the approach to maintaining quality during the transition and improving quality following the establishment of the ICB as outlined in: Position statement: https://www.england.nhs.uk/publication/national-quality-board-position-statement-on-quality-in-integrated-care-systems/ Shared Commitment to Quality: https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/ National Quality Board's Publications: NHS England » National Quality Board publications for Integrated Care Systems.	Relates to ICB set up													
	1.4.21	Quality Checklist (relating to ICB set up) included at tab 7.0	Relates to ICB set up													

1.5	**Claims, Litigation and Insurance**														
1.5.1	Outstanding claims / litigation that would transfer	The CCG has some current litigation in the Court of Protection which is likely to transfer to the ICB	Alison Smith	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022. Live cases are recorded for reporting purposes if required.	30/06/2022	Green	Financial and reputational risk with one case which has accrued significant legal costs	Legal advice is being taken to minimise reputational risk. Director of Planning oversees cost approval with legal firm	Amber
1.5.2	Pending claims / litigation (including any incidents that may become claims) that would transfer	No pending litigation identified for the purposes of reporting to NHS resolution. This will be kept under review up to 30/6/22.	Alison Smith	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Green	No risks identified currently.		Green
1.5.3	Outstanding and pending claims / litigation under Environmental Information Regulations (EIR) that would transfer	None identified at moment. Regular reporting via NHS Resolution and CCG solicitors allows capture of data.	Alison Smith	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Green	No risks identified currently.	N/A	Green
1.5.4	Outstanding and pending claims / litigation under Data Protection Act (DPA) or General Data Protection Regulation (GDPR) that would transfer	None identified at moment. Regular reporting via NHS Resolution and CCG solicitors allows capture of data.	Alison Smith/Laura Clare	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Green	No risks identified currently.	N/A	Green
1.5.5	Details and copies of documents relating to insurance arrangements that the CCG(s) has in place	NHS Resolution provide insurance to the CCG and documentation setting out this arrangement is available. NHS Resolution will need to be notified of the closedown of STW CCG and establishment of the new ICB. Member contributions will need to be paid in advance in order for insurance to commence on 1 July 2022, this may require support from Finance Team.	Tracy Eggby Jones/Alison Smith	01/01/2021	30/06/2022		Green	Yes	CCG documentation is in place and available to share so this action is complete. NHS Resolution have confirmed that insurance will be in place for the ICB from 1 July 2022.	30/06/2022	Green	There is a legal and financial risk to the ICB if adequate insurance is not arranged through NHS Resolution. No risks identified currently.	Liaison with the CCG's Finance Team is required to ensure membership with NHS Resolution and appropriate fees paid.	Green
1.5.6	Open learning points from litigation and claims that would transfer	None identified at moment. Regular reporting via NHS Resolution and CCG solicitors allows capture of data.	Alison Smith	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Green	No risks identified currently.	N/A	Green
1.6	**Contracts, Leases and Commercial Agreements**														
1.6.1(i)	Contracts register: Ensure all contracts located and in place (clinical and non-clinical) - to include fields for clinical / non-clinical, contract terms, start dates, end dates, break dates, parties to contract, named leads and contact details for both parties of the contract including the name of the CCG lead (or on behalf of), etc. The contracts register should also include arrangements that are not formally documented as contracts but are still contracts.	A list of all contracts, based on the contracts review undertaken as part of CCG merger exists, however contract holders will be contacted to check the accuracy of the information already captured.'	Kay Holland/Julie Garside	30/10/2021	31/03/2022		Green	Yes	Contracts reviewed and updated	31/03/2022	Green	Oversight of contracts not held/managed by the Contract Management Team (e.g. Medicines Management contracts) needs to be stronger	Procurement Oversight Group invitation in held on a monthly basis which now has a standing agenda for Goods & Services and the relevant contract holders are invited to attend and present updates.	Green
V5 1.6.1(ii)	Cross check the contract register / schedule of contracts to the CCG's payments ledger to ensure that it is complete	Ensure all contract payments match the payments from the ledger	Kay Holland/Julie Garside	01/04/2022	31/05/2022		Green	Yes	Monthly validation of ledger payments match the contract values agreed	30/04/2022	Green	If any payments are highlighted as being different from the Ledger to contract values	Monthly validation of values to ensure contract register and ledger payments agree	Green
1.6.2	Ensure that all leases are listed to assist with work associated with IFRS 16 (this could be addressed by including all leases in the contracts register or by holding a separate list of all leases) - to include all lease terms, start dates, end dates, break dates, parties to lease, CCG lead or on behalf of, etc.	All contract owners will be contacted to identify leases held independently or within contracts. Once identified these will be added to the contract register workbook as a separate tab.	Kay Holland/Julie Garside	30/10/2021	31/03/2022		Amber	Yes	As per 1.3.14 - Lease and Contract owners contacted to provide information/update register, email reminders scheduled	31/03/2022	Green	Oversight of leases not held/managed by the Contract Management Team needs to be stronger	Procurement Oversight Group now covers the Goods & Services contract holders, so contract issues can be discussed and risks escalated as required	Green
1.6.3	Agreements / service agreements in place	Currently no clinical agreements/service agreements in place Contract leads will be asked to confirm for Goods & Services.	Kay Holland/Julie Garside	30/10/2021	31/03/2022		Amber	Yes	Lease and Contract owners contacted to ensure provide information on register is up to date	31/03/2022	Green	Oversight of agreements not held/managed by the Contract Management Team needs to be stronger	Procurement Oversight Group now covers the Goods & Services contract holders, so contract issues can be	Green
1.6.4	Confirm which contracts are expiring at point of transfer or due for renewal in first quarter of 2022/23 and a clear plan in place to take forward each one	The contract register details expiry dates of contracts, the monthly procurement oversight group reviews and discusses a expiring contracts log for clinical services which	Kay Holland/Julie Garside	30/01/2021	31/01/2022		Amber	Yes	Expiring contracts for clinical services discussed at Procurement Oversight Group on 18th May , next steps identified and paper drafted for Strategic	31/01/2022	Green	4 clinical contracts/agreements expire within first three months of the ICB	Discussion at Procurement Oversight Group on 18th May , paper to Strategic Commissioning	Green
1.6.5	Number of open tenders / procurements on the register	Currently no open clinical procurements on the register. Contract leads will be asked to confirm the number of open tenders/procurements for Goods & Services.	Kay Holland/Julie Garside	30/01/2021	31/03/2022		Green	Yes	Ensure Procurement Pipeline document is kept up to date	31/01/2022	Green	Only 1 procurement active and at award stage, which will conclude by 31st May 2022	All Active Procurements are discussed monthly at the Procurement Oversight Group. Also includes any	Green
1.6.6	Confirm contact with counterparties to contracts and clarify transfer of contracts / continuation of contracts if required (noting that this is likely to involve more than one contact to ensure that there is clarity)	Counterparties will be identified and contacted as appropriate and record of contact made noted in the comments section of the contract register.	Kay Holland/Julie Garside	30/01/2021	31/03/2022		Amber	Yes	On-going - will be reviewed and updated over the period to 30/06/2022	30/06/2022	Green	Counterparties to contracts and clarify of the transfer of contracts is not recorded on the contract register.	Contract Register updated to now include details of counterparties to the contract	Green
1.6.7	Consider if there are any 'hard to replace' services provided by independent sector providers that are not yet designated as Commissioner Requested Services. Further information via link below: https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/information-for-commissioners/	Contracting team will work with commissioning team to consider if any action needs to be taken.	Kay Holland/Julie Garside	30/01/2021	31/03/2022		Amber	Yes	On-going - will be reviewed and updated over the period to 30/06/2022	30/06/2022	Green	No 'hard to replace' services have currently been identified that are provided by independent providers	N/A	Green
1.6.8	**Contract Checklist included at tab 1.5**														
1.7	**Real Estate, and Other Assets and Liabilities**														
1.7.1	Where CCGs are currently holding property which should be held by NHS provider organisations (e.g. buildings providing community services which have been historically mis-allocated to CCGs), they should take the opportunity now to make arrangements to transfer it to the relevant provider by the end of December 2021. This way it will not be part of the property which is subsequently transferred to the ICB	This has been checked with both the CCG's legal advisors and with NHS Property Services and they have both confirmed that the CCG does not hold any property.	Alison Smith	01/11/2021	31/12/2021		Green	No	N/A	N/A	Green	N/A	N/A	Green
1.7.2	Confirm contact with counterparties related to real estate and other assets in this section as required	Counterparties will be identified and contacted as appropriate and record of contact made noted.	Kay Holland/Julie Garside	01/11/2021	31/03/2022		Green	Yes	N/A	N/A	Green	N/A	N/A	Green
1.7.3	**Assets and Liabilities Checklists included at tab 3.6 and 3.7**														
	Real Estate														
1.7.4	Details of all properties owned by the CCG(s)	Not applicable - no properties are owned by the CCG	Alison Smith	N/A	N/A		Green	N/A	N/A	N/A	N/A			N/A
1.7.5	Details of all properties leased by the CCG(s)	List of property leased by the CCG exists and is based upon information received from NHS Property Services and one property leased from Shropshire Council	Alison Smith	01/10/2021	31/03/2022	31/03/2022 (first draft), 6/5/22 (second draft), 20/5/22 (third draft)	Green	Yes	Information captured but will be reviewed in May	12/05/2022	Green	No risk identified	N/A	Green
1.7.6	Details of all legal charges on properties	List of property leased by the CCG exists and is based upon information received from NHS Property Services and one property leased from Shropshire Council. Further investigations with CCG legal advisors has not identified any legal charges within this category.	Alison Smith	01/10/2021	31/03/2022	31/03/2022 (first draft), 6/5/22 (second draft), 20/5/22 (third draft)	Green	Yes	N/A	N/A	green	No risk identified	N/A	Green
1.7.7	Details of all properties occupied by the CCG(s) and not included in the categories above	Not applicable to the CCG	Alison Smith	N/A	N/A		Green	N/A	N/A	N/A	N/A			N/A
	IT Assets, IT and Records Management														
1.7.8	Details of all IT systems, both clinical and non-clinical	List of systems and software collated System suppliers to be contacted once new name of organisation is confirmed	Sara Spencer/Laura Clare	01/11/2021	31/05/2022		Green	Yes	All systems suppliers to be contacted to detail the transfer to the new ICB once the official ICB name and invoice address is confirmed	31/05/2022	Green	No risk identified	No mitigation	Green
1.7.9	Details of any actual or potential disputes regarding IT systems	No disputes have been raised with the system suppliers	Sara Spencer/Laura Clare	01/11/2021	30/06/2022		Green	No	No action. Complete	N/A	Green	No risk identified	No mitigation needed	Green
1.7.10	Details of all IT equipment (apply a materiality approach)	Asset lists managed by the CSU IT team detail the hardware assigned to all staff and primary care member	Sara Spencer/Laura Clare	01/11/2021	31/03/2022		Green	No	No action. Complete	N/A	Green	No risk identified	No mitigation needed	Green
V3 J1 1.7.11	Ensure that records management transition plans are in place - **See briefing paper providing records management guidance located on FutureNHS (this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place).** the link is as follows: https://future.nhs.uk/ICSGuidance/view?objectID=108090909	All departments have been requested to identify and cleanse the data held in the shared folders. A team is working with the departments to ensure that all information assets are mapped and arranged in one place on the shared drive. The shared drive merge is planned to be complete by end of May 2022.	Sara Spencer/Laura Clare	01/11/2021	31/05/2022	31/05/2022	Green	Yes	Regular meetings with the project team to ensure the progress stays within agreed timelines Working with teams to understand the process to migrating the data Weekly progress meetings in place with the project team	30/04/2022	Green	Some teams are still under pressure with managing the COVID and winter pressures so are moving through the process at a slower pace	Working with the team to complete the final migration to the shared drive	Green
V2 J1 1.7.12	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for Inquiries, including the forthcoming Covid Inquiry (this prompt is covered by a number of prompts on tab 4.0 to ensure that all prompts associated with records management are in one place - review tab 4.0 for full details)	A process is in place for the review of records and a policy for records management. All records have been reviewed. Records that are held as part of the stop notice have been retained.	Sara Spencer/Laura Clare	01/11/2021	31/05/2022	31/05/2022	Green	Yes	Data retention work due to complete by 31st May	31/05/2022	Green	One service due to complete the final checklist, there is a risk to the migration on 21st May	Working with the team to complete the final migration to the shared drive	Green
1.7.13	**Records Management, IT and IT Assets Checklist included at tab 4.0**		Sara Spencer/Laura Clare												
	Equipment														
1.7.14	Details of all other equipment, e.g. office furniture (apply a materiality approach)	List of equipment from CCG merger process in existence which as been reviewed and updated following an audit of equipment across two CCG sites	Alison Smith/Tracy Eggby Jones	01/12/2021	31/01/2022		Green	No	Action completed	N/A	Green			Green
1.8	**Environment**														
1.8.1	List and supply copies of all environmental licences, consents, permits and authorisations necessary of the operations of the CCG	Not applicable to CCG as contracts associated with environmental licenses are held by NHS Property Services	Alison Smith	N/A	N/A		Green	N/A	N/A	N/A	N/A			Green
1.8.2	Open requests for information under Environmental Information Regulations (EIR)	None received to date.	Alison Smith	01/11/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Amber	No risks currently identified	N/A	Green
1.8.3	Details of any enforcement notices related to Environmental Information Regulations (EIR) served in the last 24 months	None received to date.	Alison Smith	01/11/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Amber	No risks currently identified	N/A	Green
1.8.4	Open environmental problems or potential liabilities that would transfer (e.g. relating to disposal of clinical waste, substances buried underground, spillage / leakage, potential water pollution, health hazards, etc)	None received to date.	Alison Smith	01/11/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Amber	No risks currently identified	N/A	Green
1.9	**Intellectual Property**														
1.9.1	Details of intellectual property used, enjoyed, exploited or held	Plans are in place to ensure that relevant information is transferred to the ICP	Kay Holland/Julie Garside				Amber	Yes			Green			Green

1.10	**Finance**														
1.10.1	Provide the annual accounts for the previous three years	Copies are available on the shared drive & can be provided upon request.	Maria Tongue/Laura Clare	01/11/2021	28/02/2022		Green	Yes	Copies will be made available when required - date not yet communicated	TBC	Green	No risks currently identified		Green
1.10.2	Provide external audit report on the annual accounts for the previous three years - this should include the audit opinion, the ISA(260) report, the auditors' annual report and any other statutory reports	Copies are available on the shared drive & can be provided upon request.	Maria Tongue/Laura Clare	01/11/2021	28/02/2022		Green	Yes	Copies will be made available when required - date not yet communicated	TBC	Green	No risks currently identified		Green
1.10.3	Where there are multiple CCGs in an ICS, undertake a review of the standing financial instructions to identify any differences and determine the way forward	N/A							N/A					
1.10.4	Ensure that all finance transition actions outlined by NHS SBS and NHSEI finance have been completed	Full transition plan in place with SBS. Initial meeting held 13/10/21, detailed work has commenced and is on track	Maria Tongue/Laura Clare	13/10/2021	30/06/2022		Green	Yes			Green	No risks currently identified		Green
1.10.5	**Financial Due Diligence Checklists on tabs 3.1 to 3.7 inclusive**													
1.11	**Informatics, Digital and Information Governance - DSPT and ODS checklists are included at tab 5 and 6**													
1.11.1	Ensure that the actions outlined in the Data Security and Protection (DSPT) Toolkit have been completed - DSPT Checklist included at tab 5.0	CSU IG team working through DSPT checklist as BAU activity, regular reporting on this to audit committee. The DSPT 21/22 has now been completed and published	CSU IG	31/01/2022	31/03/2022		Green	Yes	CSU IG team working through DSPT checklist as BAU activity, regular reporting on this to audit committee. Complete	03/08/2022	Green	No risk identified	No mitigation	Green
1.11.2	Ensure that the actions outlined in the ODS Reconfiguration Toolkit have been completed - ODS Checklist included at tab 6.0	NHSEI has confirmed there will be no ODS code change, therefore not applicable to the action plan. Statement for no ODS change is within the ODS tab.	Steve Glover/Craig Lovatt	N/A	N/A	29/4/22 (initial), 3/6/22, final point TBC	Green	No	No action	No	Green	No risk identified	No mitigation	Green
1.12	**Any Other Significant Information (if applicable)**													
1.12.1	*Insert and add rows as applicable*						Green	Yes			Green			Green
1.12.2	*Insert and add rows as applicable*						Green	Yes			Green			Green
1.12.3	*Insert and add rows as applicable*						Green	Yes			Green			Green

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

2.1 CCG HR DUE DILIGENCE CHECKLIST: STAFF TRANSFER, EMPLOYEE LIABILITY AND DUE DILIGENCE CHECKLIST

This document provides a checklist of due diligence activity that will support sender organisations and receiver organisations, in this case Integrated Care Systems, to prepare for the safe and effective transfer of their staff within the change and transition process. A people impact assessment should be completed to identify staff in scope of transfer. It is then a legal requirement under the Transfer of Undertaking (Protection of Employment) Regulations (TUPE) or those actions required under Cabinet Officer Statement of Practice (COSoP) guidance for employee liability information (ELI) to be provided to receiving organisations or all in scope staff at least 28 days prior to the transfer date, but organisations are asked to share anonymised data as early as possible to allow both parties to make preparations for transfer. A separate template to capture individual level staff information is provided on tab 2.2. Further details around the activities covered by this due diligence list can be found in the **HR Framework.**

	2.1.1 Employee Liability Information - *the following information should be collated by sending organisations and provided to receiving organisations at least 28 days prior to transfer*	CCG Close	ICB Set Up	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	Rag Rating	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
2.1.1.1	Complete a people impact assessment to identify individual staff in scope of transfer in line with the Employment Commitment and TUPE/COSOP, including those on fixed term contracts and secondments and in Board level positions	Yes	Yes	Lisa Kelly	01/10/2021	28/02/2022		Green	People impact assessment including identification of those on secondments and fixed term posts has been completed and is updated on a regular basis to reflect starters and leavers. All FTC and secondments have been reviewed to reflect the extended timescales **COMPLETE**			Very low
2.1.1.2	Identity age of employees in scope of transfer	Yes		Lisa Kelly	01/10/2021	31/05/2022		Green	Those who are in scope of transferring have been identified as part of the people impact assessment and will be included in the employee liability information to be provided 28 days before transfer			Very low
2.1.1.3	All the written information contained in the transferring employees contract of employment (written particulars)	Yes		CCG	01/10/2021	30/05/2022		Green	CCG are currently undertaking an audit of personnel files to ensure that contractual information is included in files	Risk is that action to adderss any issues coming out of the review are not concluded by the transfer date	CCG is using HR advice to action where contracts of emoloyemrnt are eithe rmissing or incomplete.Risk is low.	Low
2.1.1.4	Details of any formal disciplinary action being taken against transferring employees in the last two years	Yes		Lisa Kelly	01/10/2021	31/05/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022.			Very low
2.1.1.5	Details of any formal grievances raised by the transferring employee in the last two years	Yes		Lisa Kelly	01/10/2021	31/05/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022.			Very low
2.1.1.6	Details of any legal action brought, or that there is a reasonable belief may be brought, against the sending organisation by any transferring employee in the last 2 years	Yes		Lisa Kelly	01/10/2021	31/05/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022.			Very low
2.1.1.7	Information about collective agreements that will have affect after the transfer	Yes		Lisa Kelly	01/10/2021	31/05/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022.			Very low
2.1.1.8	Total number of temporary or agency workers working for the sender including details of the work they do	Yes		CCG	01/10/2021	30/04/2022		Green	Finance to provide details of any temporary and interim staff who are not engaged via the CCG's payroll and details of their term and work they do will be included as part of the information sent to the ICB. HR are currently in contact with finance to obtain this data. **COMPLETE**	No risks identified to date	N/A	Very low
	2.1.2 Other due diligence Information to support the transfer of staff - *the following information should be collated by sending organisations to provide further helpful due diligence information about transferring employees that will support the safe and effective transfer of staff*	CCG Close	ICB Set Up	Person Responsible				Rag Rating	Comments			
2.1.2.1	Details of active employee benefit schemes and who participates (examples include lease cars, salary sacrifice schemes, etc - see tab 3.3 for more information)	Yes	Yes	Lisa Kelly	01/10/2021	30/04/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022.			Very low
2.1.2.2	Details of ongoing training commitments/ funding and agreed time off to study for transferring employees	Yes		CCG/HR	01/10/2021	30/04/2022		Green	Information has been requested from line managers via a checklist with guidance on what information needs to be provided. Confirmation of information collected from each team will be sent back to line managers who will be asked to sign their submission off as correct for their team.			Very low
2.1.2.3	Creation of a bank of active job descriptions	Yes		CCG/HR	01/10/2021	30/04/2022		Green	HR are currently undertaking an exercise of the job descriptions that they hold on behalf of the CCG. The data held will be sent to the CCG for them to formalise a final set of all job descriptions. **COMPLETE**			Very low
2.1.2.4	Creation of a bank of employment policies identifying those that are contractual and non contractual	Yes		Lisa Kelly	01/10/2021	28/02/2022		Green	Work has been completed on contractual and non contractual policies and a final position will be provided as part of the employee liabiity information **COMPLETE**			Very low
2.1.2.5	Details of any flexible working arrangements, whether contractual or custom and practice	Yes		CCG	01/10/2021	30/04/2022		Green	Information has been requested from line managers via a checklist with guidance on what information needs to be provided. Confirmation of information collected from each team will be sent back to line managers who will be asked to sign their submission off as correct for their team.	No risks identified to date	N/A	Very low
2.1.2.6	Any other custom and practice arrangements not already identified that transferring employees may reasonably believe will continue such as any variations to regular pay dates and agreements around annual leave accrual	Yes		CCG	01/10/2021	30/04/2022		Green	Information has been requested from line managers via a checklist with guidance on what information needs to be provided. Confirmation of information collected from each team will be sent back to line managers who will be asked to sign their submission off as correct for their team.	No risks identified to date	N/A	Very low

2.1.2.7	Identify individual pension arrangements including NHS Pensions and opt out provisions such as NEST. Pension providers will need to be informed of any changes of employer	Yes		Payroll	01/10/2021	31/05/2022		Green	Information is currently held by payroll and will be uploaded to the employee liability information during April when the payroll data is added			Very low
2.1.2.8	Summary of accrued annual leave for transferring employees and agreements around carry forward (including the method of calculation)	Yes		CCG/HR	01/01/2022	31/05/2022		Green	Carry over is limited to 5 days only (pro rata) and is only allowed due to extenuating circumstances.. All carry over is reported to finance so information will be obtained directly from finance.			Very low
2.1.3 Due diligence activity to support the transfer of staff - *the following activity will support sending and receiving organisations to prepare for*		**CCG Close**	**ICB Set Up**	**Person Responsible**				**Rag Rating**	**Comments**			
2.1.3.1	Develop a management of change business case in preparation for formal information and consultation with staff in scope of transfer	Yes		Lisa Kelly	04/04/2022	06/05/2022		Green	Document is complete and available to start consultation on 4 April 2022. Consultation incudes a process for communicating to all staff in scope including those ICB staff who are currently not engaged by the CCG. Those on maternity leave and long term sick leave will be identified and contacted directly by line maagers to ensure they recieve the same information as staff currently in work. **COMPLETE**	No risks identified	N/A	Very low
2.1.3.2	Identification of potential measures that ICS envisage making in relation to transferring employees. This could include, but is not limited to, anticipated base, line management or pay date changes, as well as Board level roles	Yes	Yes	Lisa Kelly	04/04/2022	29/04/2022		Green	Will be included in the consultation document **COMPLETE**	No risks identified	N/A	Very low
2.1.3.3	Schedule information and consultation activity with transferring staff and their representatives in good time prior to the date of transfer, ideally at the beginning of Q4 of 2022. This will include identifying employee representative and partnership working groups through which	Yes	Yes	Lisa Kelly	01/10/2021	30/06/2022	4/4/22 start and end 06/05/22	Green	Engagement with trade union represenatives has already started and will be ongoing until after the date of transfer. Revised dates for onsultation are from 4/4/2022 until 29/04/2022	No risks identified	N/A	Very low
2.1.3.4	Conduct an initial equality impact assessment (EQIA) to assess the potential impact of the proposed changes on transferring staff groups, including those with protected characteristics	Yes	Yes	CCG/HR	01/10/2021	28/02/022		Green	**COMPLETE**	No risks identified	N/A	Very low
2.1.3.5	Conclude consultation with transferring staff prior to the transfer date	Yes	Yes	CCG	04/04/2022	06/05/2022	06/05/2022	Green	Consultation will concluded on 06/05/2022. **COMPLETE**	No risks identified	N/A	Very low
2.1.3.6	Determine current service providers for key people services for payroll, occupational health, expenses, employee assistance and whether they will roll forward or cease at the point of transfer	Yes	Yes	CCG	01/01/2022	31/03/2022		Green	Current contracts to transfer to the ICB. **COMPLETE**	No risks identified	N/A	Very low
2.1.3.7	Establish arrangements for the identification, transfer and retention of staff records in line with the NHS Records Management Code of Practice	Yes	Yes	CCG	01/10/2021	30/06/2022		Amber	Work has started with a communications out to line managers w/c 28/02/2022. Plan to have this completed by end of June 2022	Risk is that capacity of line managers is limited	Arrangements established and work well underway to identify, transfer and retain staff records with more than half completed and planned to be finalised by mid June.	Very low
2.1.3.9	Complete the ESR IBM data collection template to identify the changes required within ESR to establish the ICS ESR VPD taking the existing CCG VPD structures into account. Submission will generate the allocation of a merge event within the IBM programme calendar from [see dates in the ICB Establishment Timeline] (also included on financial governance tab 3.1)	Yes	Yes	Jason Howle (MLCSU)/Maria Tongue	01/12/2021	31/05/2022		Green	Separate workforce / payroll group set up with the CCG to capture these elements	No risks identified	PA to Director of Corporate Affairs to hold the ring on collating and chasing information from line managers, liaising with HR colleagues when line maagers raise issues. Resolution deadline by	Very low
2.1.3.10	Produce a plan for payroll migration in line with the guidance on ESR transition for ICS to include plans to establish PAYE tax references for the ICS (also included on financial governance tab 3.1)	Yes	Yes	Jason Howle (MLCSU)/Maria Tongue	01/12/2021	31/05/2022		Green	Separate workforce / payroll group set up with the CCG to capture these elements	No risks identified		Very low
2.1.3.11	Ensure process in place to produce and submit end of year taxation returns (P11D and P60) (also included on financial governance tab 3.1)	Yes		Jason Howle (MLCSU)/Jane Boon	01/12/2021	31/03/2022		Green	Separate workforce / payroll group set up with the CCG to capture these elements	No risks identified		Very low
2.1.3.12	Agree a set of core employment policies and employment terms that will apply to new recruitment within the ICS. It is noted that existing contracts and HR policies for existing staff will transfer		Yes	Lisa Kelly	01/02/2021	30/06/2022			New set of policies to be created for the ICB			

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH

2.2 CCG HR DUE DILIGENCE CHECKLIST: STAFF TRANSFER, EMPLOYEE LIABILITY AND DUE DILIGENCE CHECKLIST
(Supports tab 2.1 and provides a template to capture individual level staff information - Note share anonymised data only)

This form provides a template for sender organisations to provide employee liability information (ELI) (and broader due diligence) to facilitate the safe transfer of staff to receiving organisations, in this case Integrated Care Systems. It is designed so that individual employee details can be populated below each field. It is a legal requirement under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) or those actions required under the Cabinet Officer Statement of Practice (COSoP) guidance for ELI information to be provided at least 28 days prior to the transfer date, but organisations are encouraged to share anonymised information as early as possible to enable both parties to make preparations for transfer.

NOTE: This information MUST be provided either by completing tab 2.2, or in another form using the same data fields as outlined on tab 2.2. and adding local data fields as necessary.

Name of ICB:	
Name of CCG(s):	
Date:	
Completed by:	
Contact details:	

	1. Employing Organisation		2. Employee Relevant data							3. Contractual Terms									
V2	Organisation		Surname (number when anonymised)	Forename (number when anonymised)	Role/Job title	Professional Registration (Body)	Professional Registration (Unique identifier)	Professional Registration (Expiry Date)		Employed by CCG (Type of employment contract)	Agency Worker (Yes or NO)	Contractor/ Interim (Yes or No)	Secondee (Yes or NO)	Full/Part-time working (See Column S for actual hours)	Terms & Conditions (AFC, VSM, other)	Notice period required	Contract/fixed term end date if applicable	Annual leave entitlement	

4. Pay and Financial arrangements												5. Job info - Location / Line Manager				
Pay Band	Pay Spinal Point	Next Increment Date	Basic Salary	Salary Value	Weekly Hours worked	FTE	Clinical Sessions	HCAS / London Weighting Allowance(inner or Outer)	Protected Pay (Amount and time period)	Amount of Other Allowances	Other Allowance Type	Department	Staff Group	Base Location	Contractual Base Location (if different)	Line Manager - Job title

6. Personal Data										
D.O.B.	Gender	Ethnicity	Marital Status	Disability	Sexual Orientation	Religious Belief	Start Date with this Employer	NHS Start Date (Continuous Date)	Reckonable Service	Return date following previous redundancy

7. Pension Scheme	
Pension Scheme	Does the employee have special class status?

8. Other Data														
Flexible Working arrangements (if agreed)	Flexible Retirement arrangements (if agreed)	Company / Lease Car	Value of Car Lease	Lease car end date	Lease car cash alternative	If Yes Lease car cash alternative amount	Other loans	Season Ticket Loan Value	Cycle to Work Scheme Repayments	Other deductions	Childcare Vouchers	Notice Period (Emp to Co)	Notice Period (Co to Emp)	

9. Other Leave Information					
Is the employee on maternity , adoption, paternity or parental leave? Please state which	If yes, please specify dates	Has the employee given notice to exercise right to maternity, adoption, paternity or parental leave?	If yes, please specify dates	Has the employee agree any other form of special leave beyond the transfer date?	Will the employee carry forward any annual leave to 2022/2023

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

3.1 FINANCIAL DUE DILIGENCE CHECKLIST: Financial Governance

The organisation needs to provide assurance to the Board and Audit Committee that appropriate arrangements are in place to closedown the accounts and financial systems of the entity by 30 June 2022.
The organisation should also ensure it has robust working papers for the new body. It should also ensure appropriate arrangements for archiving of financial and accounting records for the appropriate retention period.

V4

		Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk Rag Rating
Accounts	3.1.1	Identify the process / board / people (eg ICB Finance Director & Chief Executive) who will sign off the CCG accounts	Y	Y	Maria Tongue/Alison Smith	01/03/2022	30/04/2022		Green	Meetings scheduled for audit committee to review draft accounts in April and June and process established for full sign-off of audited accounts in June for 21/22 accounts. National guidance awaited re CCG 3 month accounts.	No risks currently identified		Low
	3.1.2	Produce as many documents / briefings as practical which form part of the statutory accounts prior to the year end. As a minimum, this should include all Directors Statements, Governance Statement and an initial draft of the annual report.	Y		Maria Tongue/Alison Smith	02/12/2021	01/05/2022		Green	Plan shared with Audit Committee of sign off of accounts and draft accounts and annual report is being shared with the Audit Committee in April	No risks currently identified	N/A	Very low
	3.1.3	If key staff leave before the CCG(s) close, robust exit management arrangements should be employed to retain and manage vital business knowledge in relation to accounts preparation and assets and liabilities.	Y		Maria Tongue	01/11/2021	30/06/2022		Amber	All staff will TUPE over to the new organisation on 1st April 2022 so risk is minimal. Any changes in staffing outside of this process will need to be addressed if & when they arise	2 members of FA team leaving Nov 21. Risk to month 9 & year-end accounts process.	Additional resources being sourced and internal cover used where possible. Interim Financial Accountant appointed Dec	Moderate
Planning	3.1.4	Ensure the finance project plan is closely aligned to other transition project plans with interdependencies clearly identified.	Y	Y	Maria Tongue	01/10/2021	30/06/2022		Green	Plan aligns with ESR/payroll project plan and SBS (ledger) project plan & regular meetings have been set-up to monitor this.	No risks currently identified		Very low
	3.1.5	Ensure there are clear terms of reference for any local transition group	Y		Maria Tongue	01/10/2021	13/10/2021		Green	ToR outlined for SBS (ledger) project group which forms the majority of the work for finance	No risks currently identified		Very low
	3.1.6	Ensure each aspect of the closedown plan is risk assessed monthly and reported through local transition governance arrangements as well as the audit committee/finance committee	Y	Y	Alison Smith	01/11/2021	12/05/2022		Green	Feeds into overall due diligence plan and is reported to audit committees; there will be internal audit presence on the panel at planned due diligence panel dates	No risks currently identified	N/A	Very low
	3.1.7	Agree how all of the governing bodies involved will be informed of progress against the project plan so they can act in an integrated way. This may be through a committee structure or an individual post (for example, the chair, governing body secretary or company secretary)	Y		Alison Smith	01/11/2021	12/05/2022		Green	Only one CCG Governing Body involved therefore risk is significantly reduced. Due Diligence work feeds into overall due diligence plan and is reported to audit committees bi monthly and teh ICB Transition Steering group on a monthly basis; there will be internal audit presence on the panel at planned due diligence panel dates; audit committee and internal audit have seen and approved the due diligence proposal paper Progress reported to the CCG Govenring Body Infomal meeting in February 2022	No risks currently identified	N/A	Very low
	3.1.8	Agree and implement robust assurance arrangements including internal and external audit plans		Y	Laura Clare	01/12/2021	30/06/2022		Green	Internal and external audit plans approved at audit committee	Low risk around securing an external audit provider for the new organisation - procurement under way		Very low
Audit Committee	3.1.9	Ensure that the audit committee meetings are scheduled in line with the requirements of the business, including one very close to the 30 June 2022 to provide an appropriate formal closure report. Schedule meetings for approval to submit draft and final accounts and report.	Y		Maria Tongue/Alison Smith	01/02/2022	30/04/2022		Green	In place - see 3.1.1 above	No risks currently identified	N/A	Very low
Working files	3.1.10	The asset and liability handover process should • include set up of initial handover file, fully indexed that can hold information as soon as is relevant/is available; • include copies of original relevant documents and details of where originals are held; • identify future accounting/management requirements for the asset or liability; • include documentation of estimates, assumptions and judgements. Documentation should be held in accordance with guidance on retention of records.	Y		Maria Tongue	01/10/2021	30/06/2022		Green	Will be completed as part of work with SBS on the ledger transition. Process was robust for the CCG merger work and a similar process will be followed.	No risks currently identified		Very low
Payroll and ESR	3.1.11	Complete the ESR IBM data collection template to identify the changes required within ESR to establish the ICS ESR VPD taking the existing CCG VPD structures into account. Submission will generate the allocation of a merge event within the IBM programme calendar from May 2022 onwards (also included on HR tab 2.1)	Y	Y	Jason Howle (MLCSU)/Maria Tongue	01/04/2022	30/06/2022		Green	Regular meetings being held with HR to discuss progress & ensure key deadlines are met. First SR raised 1/4/22 in line with detailed plan.	No risks currently identified		Very low
	3.1.12	Produce a plan for payroll migration in line with the guidance on ESR transition for ICS to include plans to establish PAYE tax references for the ICS (also included on HR tab 2.1)	Y	Y	Jason Howle (MLCSU)/Maria Tongue	01/10/2021	01/07/2022		Green	Regular meetings being held with HR to discuss progress & ensure key deadlines are met. Indicative amended date for requesting PAYE number from HMRC is 1st July and deadline for re-registering for CT61 returns is 1st July.	No risks currently identified		Very low
	3.1.13	Ensure process in place to produce and submit end of year taxation returns (P11D and P60) (also included on HR tab 2.1)	Y	Y	Jason Howle (MLCSU)/Jane Boon (MLCSU)				Green				Very low
Internal Audit	3.1.14	Ensure internal audit have representation on transition working groups.	Y	Y	Laura Clare/Alison Smith	01/10/2021	12/05/2022		Green	DD process set up and agreed. Proposal paper signed off. Includes Internal Audit input.	No risks currently identified	N/A	Very low
	3.1.15	Seek internal audit comment on the adequacy of transition plans. Internal audit plans should have some focus on the key risks associated with cessation, and verify that appropriate internal controls are in place. IA plan should specifically considers risks of fraud during transition and recommendations have been acted upon.	Y	Y	Laura Clare/Alison Smith	01/11/2021	31/03/2022		Green	Internal audit involved via due diligence assurance panel; cross reference to 3.2.13.3	No risks currently identified	N/A	Very low
Risk Management	3.1.16	Review, revise and agree a risk management strategy, policy and procedures. This must include an approach to setting an agreed risk appetite and identifying, evaluating and managing risks. Mechanism for risk share across organisations to be agreed.		Y	Alison Smith	01/11/2021	22/07/2022		Amber	Discussion on approach has been agreed with Governance Leads from ICS partner organisations in February. A draft Risk Strategy will be drafted based on this approach. Good Governance Institute has been commissioned to run workshops to develop risk appetite and initial ICS BAF	There is a risk around timeframes and capacity	Agreed CCG Director of Corporate Affairs will take work forward with support from the good governance institute	Moderate
Declarations	3.1.17	Establish transparent arrangements for declarations, including: - - register of gifts and hospitality - register of interests		Y	Alison Smith/Tracey Eggby Jones	01/10/2021	12/05/2022		Amber	This is amber rated as its a continuing process. A register of interests for the ICS Board has already been developed and is presented to their Board meetings and publically available on their website. A Conflicts of Interest Policy and Standards of Business Conduct Policy have been developed, setting out the ICS approach to managing conflicts of interest and gifts hospitality and sponsorship. The draft policies are currently with Internal Audit and Counter Fraud Team for comment/feedback.	There is a risk that register of interests for staff will not be fully completed with some individual members of staff conflicts needing to change. However the CCG has an upto date register of interests for its staff which has recently been audited.	By using existing CCG registers as the basis for the ICB, this will mean staff can restate their interests where they have not changed and a focus can be put on new staff or staff who have changing interests to ensure these are captured.	Very low

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk Rag Rating
	Business Plan	3.1.18	Assess the financial impact of the strategic objectives and business plan for the new ICB		Y	Claire Skidmore	01/11/2021	28/04/2022		Green	22/23 system financial plan submitt4ed on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years	Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG	Regular system discussions around plan development through DoFs, CEOs and system sustainability committee. IDB overseeing delivery of efficiency and system transformation	High
V4	Budgets	3.1.19	Budgets and contracts will need to be agreed for the ICB (essentially before the 1 July), agree how this will happen ensuring the required governance is in place. This should also be reflected on the risk register. [Note the need to agree budgets and contracts for the CCG before 1 April for 3 months and for the ICB before 1 July for 9 months]		Y	Claire Skidmore	01/11/2021	31/03/2022		Green	22/23 system financial plan submitted on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Finance committee sign off of budgets in line with plan in April 2022 with subsequent issue to budget holders before M2 reporting (May 2022). Budget holders/directors actively involved in plan development. Work underway to map 22/23 budgets to new director portfolios but budget managers will not change immediately on transfer. ***Also see comments in submission from Contracts team***	Budgets will not be agreed and signed off until 1.5 months into the financial year due to the timing of the planning round	Regular updates/discussion with budget holders.	Very low
V4	CCG Functions	3.1.20	Map all existing CCG functions	Y	Y	Alison Smith	01/11/2021	28/02/2022		Green	Functions and duties map received from Browne Jacobson Solicitors to use by the CCG to capture as a full list.	No risks currently identified	N/A	Very low
V4		3.1.21	Map all existing CCG Statutory Duties	Y	Y	Alison Smith	01/11/2021	28/02/2022		Green	Functions and duties map received from Browne Jacobson Solicitors to use by the CCG to capture as a full list.	No risks currently identified	N/A	Very low
		3.1.22	Liaise through ENGLAND.SMTinfo@nhs.net to provide PCSE with the GP Pensions information and authorised user list ensuring aligned to organisational standard financial instructions			Maria Tongue	01/12/2021	31/05/2022		Green	Will be addressed as part of the SBS transition plan	No risks currently identified		Very low
		3.1.23	Liaise through ENGLAND.SMTinfo@nhs.net to provide PCSE with the GP Pensions information and authorised user list ensuring aligned to organisational standard financial instructions			Maria Tongue	01/12/2021	22/04/2022		Green	Initial information sent March 2022	No risks currently identified		Very low
V3	Stationery	3.1.24	Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes. Inform suppliers and users of address for invoices / queries. [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Y		Maria Tongue/MLCSU	01/12/2021	31/05/2022		Green	Included within the transition plan with the CSU/SBS	No risks currently identified		Very low
V4	Apprenticeships	3.1.25	Ensure that plans are in place to take actions in line with the guidance issued 'Impact on Apprenticeships and Apprenticeship Service Accounts'. Three documents are available on the FutureNHS platform under 'Finance' - 'Supporting Resources'.	Y		Maria Tongue	01/12/2021	22/04/2022		Green		No risks currently identified		Low
		3.1.26	Liaise through ENGLAND.SMTinfo@nhs.net to provide PCSE with the GP Pensions information and authorised user list ensuring aligned to organisational standard financial instructions			Maria Tongue	01/12/2021	22/04/2022		Green	Initial information sent March 2022	No risks currently identified		Very low
V3	Stationery	3.1.27	Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes. Inform suppliers and users of address for invoices / queries. [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Y		Maria Tongue/MLCSU	01/10/2021	30/06/2022		Green	Included within the transition plan with the CSU/SBS	No risks currently identified		Very low
V4	Apprenticeships	3.1.28	Ensure that plans are in place to take actions in line with the guidance issued 'Impact on Apprenticeships and Apprenticeship Service Accounts'. Three documents are available on the FutureNHS platform under 'Finance' - 'Supporting Resources'.	Y		Maria Tongue	01/03/2022	31/05/2022		Green		No risks currently identified		Low

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3.2 FINANCIAL DUE DILIGENCE CHECKLIST: Accounts and audit

The organisation needs to ensure the 2021/22 annual accounts are in a position to be produced and audited within given timescales and to a satisfactory level to provide information for the new organisation.

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
	Annual report and Accounts	3.2.1	Produce and agree a timetable for completing all sets of annual report and accounts and the required resourcing of the process. This timetable should cover the whole of the process including the annual report, governance statement, accountable/ accounting officers' statements and audit as well as the preparation of the accounts. - Ensure key individuals are identified with appropriate knowledge and skills (assess the need for temporary staff) - Signing of the Accounts & Annual Report arrangements - continuing body sign off requirement (identify individuals) - Brief the Governing Body & Audit Committee of the demising organisation & new organisation on their responsibilities - AGM arrangements - Identification of assurances required for the new organisation from the demising organisation - Ensure that any necessary information is obtained to prepare final accounts (for example, information relating to pensions for the remuneration report). In particular, consider whether appropriate information is available relating to demising bodies and the members of their governing bodies Ensure that the resourcing of this process is agreed	Y	Y	Maria Tongue/Alison Smith	01/04/2022	30/06/2022		Green	See 3.1.1. re accounts sign-off process. Plan for the preparation of annual accounts & annual report presented to Audit Cttee in January 2022. Work on track to submit accounts in line with national deadlines for 21/22. Awaiting national guidance around completion of CCG 3 month accounts & AR	No risks currently identified		Very low
		3.2.2	Review guidance from all appropriate regulatory bodies to ensure that all of the necessary documents are produced in the correct format. This includes: • the governance statement • the remuneration report • staff report • quality report	Y		Edna Boampong/Alison Smith	01/01/2022	20/04/2022		Green	Plan for production of content schedule in existence and will be supported by the Communications team. Draft Annual Report is being rpesented to the Audit Committee in April, to the CCG Govenring Body on 8th June and final sign off dekegated to Audit Committee on 15th June.	No risks currently identified	N/A	Very low
	External Auditors	3.2.3	Consider whether external auditor contracts can and / or should be rolled over or whether the contract should be subject to tender. Agree handover arrangements between the outgoing auditors and the new auditors (re pre-ICB accounts / opening balances) - if required	Y	Y	Maria Tongue	01/11/2021	31/03/2022		Green	Tender process complete to appoint new auditors. Existing contract terminates 30/06/22 - new contract to be formally approved by meeting of ICB on 1st July 2022	No risks currently identified		Very low
		3.2.4	Ensure that links exist and work between external and internal audit	Y		Maria Tongue	01/11/2021	31/03/2022		Green	Teams have worked together over the last several years and links are well established. Re-tendering process for new external auditors included questions around liaison with internal audit.	No risks currently identified		Very low
		3.2.5	Discussion with the external auditors should include: - confirmation that the necessary work has been completed prior to the dissolution of the CCGs - what evidence they require from both the old and the new bodies	Y		Maria Tongue	01/01/2022	31/05/2022		Green	Discussed with external auditor as part of interim audit work in Jan/Feb 2022. Will be continued during main audit in April/May	No risks currently identified		Very low
		3.2.6	Agree an external audit schedule/plan and timetable for working papers production with the external auditors. The organisation should ensure that the pre-accounts interim audit focuses on areas that will reduce the workload during the final accounts audit.	Y		Maria Tongue	TBC	TBC		Green	Awaiting national guidance regarding timing of the audit of the CCG's 3 month accounts.	No risks currently identified		Very low
		3.2.7	Discuss with all auditors what third-party assurances they will require and arrange for those to be provided by the appropriate auditor. Ensure that appropriate external assurances (for example the service auditor report on SBS, ESR and local shared service providers) are received for any systems used prior to the establishment of the ICB by any of the bodies involved even if the system is not used by the new body/bodies	Y		Maria Tongue	01/01/2022	31/05/2022		Green	Process well established for receiving SARs in respect of ESR/GP payments/SBS/CSU and this will operate as normal for the 21/22 financial year. Awaiting national guidance regarding this for the CCG's 3 month accounts.	No risks currently identified		Very low
		3.2.8	Ensure that the external auditors for the dissolving CCG and establishing ICB are notified of the change in Accountable Officer and Finance Director			Maria Tongue	01/12/2021	31/03/2022		Green	Complete	No risks currently identified		Very low
	Internal Auditors	3.2.9	Consider internal audit work both before and after the establishment of the ICB in the light of the risks that it poses and adjust the nature and timing of work accordingly	Y	Y	Laura Clare	01/11/2021	31/03/2022		Green	Discussed regularly with inernal auditors as part of plan review in year, flex plans according to need	None identified		Very low
		3.2.10	Make arrangements for a Head of Internal Audit opinion to be signed in relation to all closing accounts	Y		Maria Tongue	01/02/2022	TBC		Green	HoIA process in place for CCG 21/22 accounts. Awaiting national guidance re completion of CCG 3 months accounts & AR	No risks currently identified		Very low
		3.2.11	Review outstanding Internal Audit actions and ensure that responsibility for their completion is transferred to the ICB	Y	Y	Maria Tongue	01/09/2021	30/06/2022		Green	Monitoring process already established	No risks currently identified		Very low
		3.2.12	Ensure that Internal Audit is involved in reviewing proposed new systems prior to implementation & that there is audit review of new systems once implemented	Y	Y	N/A				Green	N/A - systems will remain the same with data being transferred over			Very low
V2	Fraud	3.2.13.1	Ensure the ICB has an accredited and nominated Local Counter Fraud Specialist (LCFS) with full access to NHS Counter Fraud Authority (NHSCFA) guidance, intelligence and case management systems.	Y	Y	Laura Clare	01/11/2021	31/03/2022		Green	IA contract incs counter fraud services and named LCFS. Contract will be novated to ICB	None identified		Very low
V2		3.2.13.2	Ensure appropriate handover arrangements are in place between CCG and ICB LCFSs to ensure: -continuity and progression of reactive work; including investigations, sanctions and recoveries -the ICB LCFS receives all relevant information from the CCG LCFS to inform ICB LCFS work plan	Y	Y	Laura Clare	01/11/2021	31/03/2022		Green	(see above)	None identified		Very low
V2		3.2.13.3	Ensure an agreed LCFS work plan is in place which should include (not exhaustive): -consideration of proactive work both before and after the establishment of the ICB in the light of the risks that it poses and adjust the nature and timing of work accordingly. -fraud risk assessment activity considering increased risk of fraud and asset loss during times of change (this is a major risk on reorganisation). -appropriate action to ensure compliance with the NHS Requirements of the Government Functional Standard GovS013 Counter Fraud	Y	Y	Laura Clare	01/11/2021	31/03/2022		Green	21/22 LCFS plan in place and available to view, will review 22/23 plan early in new financial year	None identified		Very low
		3.2.14	Set up account for National Fraud Initiative (NFI)		Y	Laura Clare	01/11/2021	31/03/2022		Green	Account will novate across - will check name change actioned etc	None identified		Very low
	Records	3.2.15	Establish arrangements for the identification, transfer and retention of financial and accounting records.	Y	Y	Maria Tongue	01/10/2021	30/06/2022		Green	All records are held on the secure, shared drive and this will still be in use in the ICB. The Finance team are working closely with IT & IG teams to ensure that any records to be archived are stored	No risks currently identified	No risks currently identified	Very low
V3		3.2.16	Ensure all appropriate records are kept, and emails are retained for any key staff that may leave during the transition period [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Y		Maria Tongue	02/10/2021	30/06/2022		Green		No risks currently identified		Very low

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

3.3 FINANCIAL DUE DILIGENCE CHECKLIST: Ledger, Financial and Cash Management

The organisation should put itself into a position to ensure all financial commitments and obligations are identified within budgets and appropriately accounted for within forecasts and the annual accounts.
The organisation should put itself into a position to ensure they have the required cash balances to meet creditor demands as they fall due and do not hold excessive cash balances at the year end.

		Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
Control Accounts	3.3.1	For all control accounts • All outstanding balances cleared (none greater than one month old wherever possible). • All accounts assigned to designated officer. • Supporting documents are attached to all items over one month old and clear, time-bound route to resolution identified. This should be reconciled to cash planning. Ensure all control account reconciliations have been completed. Document any reconciling balances in full so that they can be followed up	Y		Maria Tongue	01/04/2021	30/06/2022		Green	Control accounts completed monthly by CSU/SBS and reviewed by CCG Financial Accountant. 2nd review carried out quarterly by Associate Dir of Finance - Financial Accounting, Planning & Reporting	No risks identified		Very low
Cashflows	3.3.2	Cash forecasts should be reviewed to ensure all constraints on cash have been factored, including any balance sheet items that may be expected to be cleared due to the closedown of the organisation. However, any change to cash requirements must be agreed. Prepare cash forecast for new entity.	Y	Y	Maria Tongue	01/04/2021	30/06/2022		Green	The CCG has a well established cash forecasting process. Cash forecast for April for ICB will be prepared in advance of the national deadline	No risks identified		Very low
	3.3.3	For cash purposes, consider any payments that may go out on the 30/06 or 01/07 to ensure fully factored into transitioning arrangements	Y	Y	Maria Tongue	01/10/2021	31/05/2022		Green	Consideration given & no payments identified. Will continue to be reviewed.	No risks identified		Very low
	3.3.4	Notify the NHSE cash funding team of the chief financial officer's name, the ICB's address and the GBS account number nhsenglandcash.management@nhs.net		Y	Maria Tongue	01/04/2022	29/04/2022	31/05/2022	Green	Will be submitted in line with national deadline	No risks identified		Very low
	3.3.5	Submit consolidated forecast for the new entity on a new CFF1 form nhsenglandcash.management@nhs.net		Y	Maria Tongue	01/06/2022	18/05/2022	18/05/2022	Green	Will be submitted in line with national deadline	No risks identified		Very low
	3.3.6	Appoint one cash manager with responsibility for overseeing cash management and establish systems to monitor implementation of cash action plan. Agree final reconciliation of bank accounts.	Y	Y	Maria Tongue	01/04/2021	30/06/2022		Green	Already established. Bank account recs completed by SBS.	No risks identified		Very low
Working Papers	3.3.7	Establish arrangements to prepare full working papers with back up documentation	Y		Maria Tongue	01/04/2021	30/06/2022		Green	Already established.	No risks identified		Very low
	3.3.8	Reconcile opening balances to year end accounts		Y	Maria Tongue	TBC	TBC		Green	Awaiting national guidance re completion of 3 month CCG accounts	No risks identified		Very low
	3.3.9	For accruals, ensure that a full list of accruals carried forward from the CCGs has been documented and that all accruals are matched to the ICB's payment system so they can be written off as they are paid	Y		Maria Tongue	01/06/2022	31/07/2022		Green	Will be completed as part of the CCG 3 month accounts process	No risks identified		Very low
	3.3.10	For prepayments, undertake a detailed review and ensure robust working papers are in place (ensure the good/service which has already been paid for is received in the future)	Y		Maria Tongue	01/06/2022	31/07/2022		Green	Will be completed as part of the CCG 3 month accounts process	No risks identified		Very low
	3.3.11	For deferred income, undertake a detailed review and ensure robust working papers are in place	Y		Maria Tongue	01/06/2022	31/07/2022		Green	Will be completed as part of the CCG 3 month accounts process	No risks identified		Very low
	3.3.12	For provisions, and any contingent liabilities, undertake a detailed review and ensure robust working papers are in place	Y		Maria Tongue	01/06/2022	31/07/2022		Green	Will be completed as part of the CCG 3 month accounts process	No risks identified		Very low
	3.3.13	Review the annual leave accrual	Y		Maria Tongue	01/03/2022	30/06/2022		Green	Annual leave calculated and accrual amended for 21/22 year-end. Further guidance awaited for CCG 3 month accounts.	No risks identified		Very low
	3.3.14	Consider any need for a redundancy provision, early retirement provisions or ill health retirement provisions - this should include any clinicians covered by the 2019/20 pension annual allowance charge compensation policy	Y		Maria Tongue	01/06/2022	31/07/2022		Green	Review and calculations complete for 21/22 year-end. Further guidance awaited for CCG 3 month accounts.	No risks identified		Very low
	3.3.15	Review the losses and special payments schedule in detail. Try to identify any transactions which could result in a loss or special payment at an early stage	Y		Maria Tongue	01/06/2022	31/07/2022		Green	Review and calculations complete for 21/22 year-end. Further guidance awaited for CCG 3 month accounts.	No risks identified		Very low
	3.3.16	Undertake a detailed review of suspense codes and clear them as necessary	Y		Maria Tongue	01/04/2022	30/06/2022		Green	Control accounts completed monthly by CSU/SBS and reviewed by CCG Financial Accountant. 2nd review carried out quarterly by Associate Dir of Finance - Financial Accounting, Planning & Reporting	No risks identified		Very low
	3.3.17	Ensure that all closing balances are appropriately transferred and complete a reconciliation between closing and opening balances to ensure that no balances are 'lost'. Ensure robustness of working papers to support.	Y	Y	Maria Tongue	01/07/2022	31/07/2022		Green	Will be completed as part of SBS transition plan	No risks identified		Very low
	3.3.18	Where multiple CCGs are merging to then form the ICB, consider producing a consolidated position to provide financial history/audit trail	N	N	N/A				Green	N/A			Very low
Procedures	3.3.19	Develop procedures and policy for: - travel expenses - training expenses - relocation - excess travel - lease cars - telephones incl mobiles - long service awards		Y	Alison Smith for existing CCG policies	01/11/2021	30/06/2022		Amber	Many of these policies will be inherited by the ICB from the CCG as this is a requirement as part of equivalent TUPE transfer of staff - Training expenses - The CCG have a learning and development policy which covers training expenses - Travel expenses- STW CCG Excess Mileage and Additional Travel Guidance for Managers in place - STW CCG Excess Mileage and Additional Travel Guidance for Managers in place - long service awards - STW CCG Long Service Award policy in place - telephones and mobiles - In draft form (IT) - Relocation - Not a HR policy in place for this but will use the national rate determined by HMRC - Lease cars - Not offered at the moment, decision on whether we offer lease cars has not been confirmed. CS & SW discussing at the moment.	Where policies do not exist - lease cars there is a risk that a decisio is not made to create one prior to the 1/7/22.	Discussions on lease ar policy being taken forward at the meeting for the ICB. CCG does not have one in place.	Moderate
	3.3.20	Create financial procedures manual including losses and compensations register (& system to maintain). Issue to staff, train staff as required: - payroll - expenses - entering into off-payroll arrangements - creditors - receivables including debt recovery - losses		Y	Maria Tongue	01/11/2021	31/05/2022		Green	Current CCG procedures were refreshed in 20/21 & will be reviewed for use in the ICB	No risks identified		Very low
	3.3.21	Prepare scheme of reservation and delegation (SoRD) for the ICB		Y	Maria Tongue	01/03/2022	31/05/2022		Green	Draft financial scheme of delegation completed March 2022. To be finalised May 2022	No risks identified		Very low

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
		3.3.22	Prepare SFIs for the ICB		Y	Maria Tongue	01/11/2021	31/05/2022		Green	Draft SFIs completed March 2022. To be finalised May 2022	No risks identified		Very low
	VAT	3.3.23	Inform HMRC of organisational change, obtain new VAT registration and VAT number, arrange submission of pre-ICB establishment VAT returns Recalculate partial exemption		Y	Maria Tongue	01/02/2022	27/05/2022 & 12/08/2022		Green	VAT1 form to be submitted to HMRC by 27/5/22 for new VAT No. Deadline for informing national team of submission of final CCG VAT is 12/08/2022	No risks identified		Very low
		3.3.24	Ensure the correct VAT number appears on all relevant stationery		Y	Maria Tongue/Laura Clare		27/05/2022		Green	Included within SBS transition plan			Very low
V4	Budget Holders	3.3.25	Budget holders: - Agree budget holders for ICB (accountability framework) - Agree format and content of budget holder reports - Agree process and timetable for establishing base budgets (both revenue and capital) - note this will need to be done ahead of 1 July 2022 - Review budgeting assumptions and consider if they are still valid following the establishment of the ICB - Ensure that budget holders are aware of their budget responsibilities and arrange training as necessary - Amend budgets to reflect any changes in activity and resources resulting from discussions with commissioners / providers - Obtain approval of base budgets from the governing body [Note the need to agree budgets and contracts for the CCG before 1 April for 3 months and for the ICB before 1 July for 9 months]		Y	Angus Hughes	01/01/2022	30/04/2022		Green	Budget setting process being developed as part of the 22/23 plan. Budgets will be issued to all budget holders before the end of March for sign off in line with the plan submission. Budget holders are actively engaged with finance on the development of the plan and the corresponding budgets.	Budgets will not be agreed and signed off until 1 month into the financial year due to the timing of the planning round	Regular updates/discussion with budget holders.	Very low
	Franking	3.3.26	Review franking machine requirements and ensure facilities are in place		Y					N/A				Very low
	SBS	3.3.27	Ensure that the necessary arrangements for access to ISFE have been made (access will be required to CCG(s) as well as ICB's ledgers). Set up the users for the new system	Y	Y	Maria Tongue	01/03/2022	30/06/2022		Green	To be completed as part of SBS transition plan	No risks identified		Very low
		3.3.28	Minor Works Order Raised detailing cost directly chargeable to the CCG	Y	Y	N/A				Green	N/A - cost be bourne centrally by NHSEI			Very low
		3.3.29	To set up BI Super User Licences applications to be submitted to england.oraclequeries@nhs.net		Y	Maria Tongue	01/01/2022	30/05/2022		Green	To be completed as part of SBS transition plan	No risks identified		Very low
		3.3.30	Chart of Accounts mapping	Y	Y	SBS				Green	To be completed as part of SBS transition plan			Very low
	Reporting	3.3.31	Define and set up standard reports for budgetary, statutory and management reporting (for ICB with timescales)		Y	Claire Skidmore					CCG current reporting will transition into ICB as startpoint. System reporting also currently in place for ICS level financial reports to sustainability committee. These will transfer into ICB but with a development trajectory to improve both the streamlining of production of these reports and format as the organisation develops	No risks identified		Very low
	Systems	3.3.32	Ensure superseded system(s) are maintained to enable the production of annual accounts for the accounting period prior to establishment of the ICB	Y		Maria Tongue/SBS	01/10/2021	30/06/2022		Green	To be completed as part of SBS transition plan	No risks identified		Very low
		3.3.33	Establish control procedures (for example, passwords, journal input etc)	Y		Maria Tongue	01/01/2022	30/06/2022		Green	To be completed as part of SBS transition plan	No risks identified		Very low
	Interface	3.3.34	Evaluate ability to interface with other potential systems (for example, payroll, payables, receivables, personnel, BACS, contracting, supplies, capital systems)		Y	SBS				Green				Very low
	Plans	3.3.35	Prepare and agree an ICB financial plan		Y	Claire Skidmore		17/3/22 (draft), 28/4/22 (final)		Green	22/23 system financial plan submitt4ed on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years	Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG	Regular system discussions around plan development through DoFs, CEOs and system sustainability committee. IDB overseeing delivery of efficiency and system transformation	High
		3.3.36	Prepare and agree place based budgets		Y	Laura Clare		31/03/2022		Red	Action is dependent on place partnership set up and delegation agreed - unlikely to have budgets delegated at place level until 23/24	Risk that place will not be sufficiently developed for place level budget delegation to operate in 22/23	Place discussions continue across the system	Very low
		3.3.37	Review the cost improvement programmes and determine a new programme for the ICB		Y	Kate Owen	01/11/2021	20/01/2022		Amber	22/23 efficiency programme included as part of 22/23 financial plan submission. At point of submission £1m of plans unidentified and £0.7m running cost efficiency badged as high risk. System transformation plan savings also inlcuded within system plan submission with £2.9m unidentified gap currently held in CCG position.	Risk that full efficiency programmes and system transformation savings will not be identified which will contribute to financial deficit of organisation and system	Integrated Delivery board reviewing progress against both internal organisation efficiency plans and system transformration plans on a monthly basis	Moderate
		3.3.38	Agree financial framework for distributing allocations across the ICB		Y	Laura Clare	01/04/2021	30/09/2021		Green	Initial financial framework agreed across system at Sept 21 governing bodies and system committees. IFP arrangements also agreed in principle. Development of more sophisticated funding flows will develop with the creation of provider collaboratives and place based partneships	No risks identified		Very low
		3.3.39	Produce a team structure to meet its identified role within agreed management cost envelope		Y	Laura Clare	01/11/2021	31/03/022		Amber	DoF level discussions regarding teams working closer togeher across the system commenced with various workstreams set up led by system deputies to explore options. Initial CCG structure to lift and shift into ICB but will be reviewed to develop system wide finance structure as other areas develop	Risk around capacity within existing finance team in CCG to pick up all system wide work	Structure being reveiwed across system around how can bring together existing resource across the system in a better way	Moderate
		3.3.40	Consult with NHSEI to: • agree new control totals for ICB • determine performance against previously agreed control totals		Y	Laura Clare	01/11/2021	28/04/2022		Amber	22/23 planning guidance released 24.12.21. System now working through detailed 22/23 financial plan development for final submission at end of April	Risk that system transfomation and organisational efficiencies will not be fully identified in order to meet control total	Integrated Delivery board reviewing progress against efficiency plans and system transformation projects on monthly basis	Moderate

		Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
Archive	3.3.41	Identify archive requirements and ensure that data/information is extracted and stored in an easy to access format. This also applies to all feeder systems to the ledger. Documentation should be held in accordance with guidance on retention of records.	Y		Maria Tongue	01/12/2021	31/03/2022		Green	Data is held on secure shared drive. The Finance team are working closely with IT & IG teams to ensure the appropriate records are archived securely and in accordance with guidance	No risks identified		Very low
Timetable	3.3.42	Produce a timetable for ledger close-down	Y		Maria Tongue/SB	01/03/22	31/05/22		Green	To be completed as part of SBS transition plan	No risks identified		Very low
HMRC	3.3.43	Ensure that documentation (for example, copies of the HMRC checklist) relating to off-payroll arrangements is archived and available in case of an HMRC visit. Documentation should be held in accordance with guidance on retention of records.	Y		Maria Tongue	01/03/22	31/03/22		Green	Process established. Review will be carried out in March	No risks identified		Very low
New ledger	3.3.44	ICB will be required to use ISFE and the standard chart of accounts		Y	Maria Tongue	01/11/2021	31/03/2022		Green	Cost centres provided to CCG. Code combinations will be set-up by SBS as part of transition plan	No risks identified		Very low
	3.3.45	Ensure arrangements are in place for the transfer of closing balances from the old to the new system	Y	Y	Maria Tongue	Duplicate of 3.3.17			Green				Very low
Seal	3.3.46	Destroy existing CCG seal, ascertain if need new seal	Y	Y	Alison Smith/Tracy Eggby Jones	01/07/2022	15/07/2022		Amber	Plan in place for destruction - must wait for CCG to be dissolved before the seal is destroyed. A seal will be created for the ICB.	There is a very low risk that the new seal for the ICB may be delayed dependent on manufacturer lead times	It is anticipated that there will be very few documents that require sealing - no further mitigation identified.	Very low
Functions	3.3.47	Determine the role and responsibilities of each of the new functions within the new management structure within the ICB, to include: - Corporate - Commissioning - Contracting - CHC/individual personal commissioning - Finance		Y	Alison Smith/Nicky O'Connor	01/11/2021	12/05/2022		Green	ICB CE has released a structure showing new ICB Exec Director roles and how CCG functions will sit within each portfolio.		None identified at moment.	Very low
Capital	3.3.48	Agree a framework for capital prioritisation and allocation across the system		Y	Claire Skidmore		30/06/2022		Amber	Governance proposal going to IDB/Sust cttee in March with a view to establishing a capital governance and process that sits alongside the revenue process (closely linked and not operating in isolation) with a view to then evolving into a single process over time. Aim to have that up and running in April.	No risks identified		Very low
CEfF	3.3.49	Consider arrangements for CEfF (Controlled Environment for Finance) to review detail on invoices https://www.england.nhs.uk/wp-content/uploads/2019/01/ccg-CEfF-compliance-statement-v1-4.pdf		Y	Maria Tongue/ ML CSU					Currently in operation through MLCSU			Very low
Costs	3.3.50	Keep track of all costs associated with the transition e.g. interim support costs, website etc	Y	Y	Mark Ward	01/09/2021	30/06/2022		Green	All costs are being recorded against a separate cost centre	No risks identified		Very low
P2P	3.3.51	Purchase to Pay: - Supplier template - NHS supplies - Locations template - Purchasing Positions template - Catalogue template - Non PO rules template - Payment configuration form - Vendor notifications		Y	Maria Tongue/MLCSU/ SBS	01/11/2021	30/06/2022		Green		No risks identified		Very low
O2C	3.3.52	Order to Cash: - Customer data - Receivable items - Receivable activities - Sales Person template		Y	Maria Tongue/MLCSU/ SBS	01/11/2021	30/06/2022		Green		No risks identified		Very low

3.4 FINANCIAL DUE DILIGENCE CHECKLIST: Banking Arrangements

The CCG should look to close all bank accounts and open a new Government Banking Service Account for the new organisation

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
	Bank Accounts	3.4.1	Ensure plans are in place to list and close all CCG bank accounts and set up new account for ICB. Obtain closing of bank account in writing. Write to RBS/Government Banking Service (GBS). Arrange for redirections to be in place.	Y	Y	Maria Tongue	01/12/2021	30/04/2022		Green	Existing CCG bank account will be renamed and become ICB bank account. Letter sent to GBS 24/03/22 in line with national deadline	No risks identified		Very low
		3.4.2	Identify all GBS accounts and list authorised signatories. Ensure that arrangements in place to manage transfer. Complete new bank mandates.		Y	Maria Tongue	01/12/2021	31/07/2022		Green	(see above) Bank mandates have been reviewed & updated where applicable.	No risks identified		Very low
V4		3.4.3	The issue of all cheques from CCG accounts to cease no later than 30 June 2022 (agree treatment of outstanding cheques, POs etc)	Y		Maria Tongue	01/03/2022	30/06/2022		Green	Will be covered in SBS transition plan	No risks identified		Very low
		3.4.4	Ensure continuity of existing BACS and transition to new BACS arrangements - identify payment run dates (especially GP payments)	Y	Y	Maria Tongue	01/01/2022	30/06/2022		Green		No risks identified		Very low
		3.4.5	Inform any non-NHS bodies which pay electronically of the new bank details		Y	Maria Tongue	01/01/2022	30/06/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
		3.4.6	Inform suppliers of change in organisational structure and new payment arrangements (experience shows that this process should be started early and at least two letters should be sent). Inform suppliers that any debts will be pursued by the new organisations and balances will be paid by the new organisation		Y	Maria Tongue	01/01/2022	30/06/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
		3.4.7	Inform suppliers of the final date for sending invoices to the CCG(s)	Y		Maria Tongue	01/01/2022	30/04/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
		3.4.8	Contact customers who pay by standing order to request pay to new bank account	Y		Maria Tongue	01/01/2022	31/05/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
		3.4.9	Check for any payments which currently interact directly into the ledgers, such as Personal Health Budgets (PHB) payments, and flag to SBS	Y		Maria Tongue	01/01/2022	31/05/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
		3.4.10	Contact suppliers submitting invoices electronically via Tradeshift to ensure connections are made to the new organisation. Liaise with SBS e-invoicing team - SBS-W.e-invoicingqueries@nhs.net to ensure a smooth transition	Y	Y	Maria Tongue	01/01/2022	31/05/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
		3.4.11	Agree a final date for paying invoices from the 'old' CCG(s) bank accounts	Y		Maria Tongue	01/01/2022	30/04/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
		3.4.12	Check any direct debits are set up for the new bank account and also any standing orders. Cancel existing direct debits the existing bank account and reissue for the new bank account.		Y	Maria Tongue	01/01/2022	30/04/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
		3.4.13	Ensure any payments driven by systems have been changed to the new bank account. For example AP, the faster payments and CHAPS in the Oracle system.		Y	Maria Tongue	01/01/2022	30/04/2022		Green	Will be covered in work with SBS/CSU	No risks identified		Very low
V4	Petty Cash	3.4.14	Ensure arrangements are in place to bank all petty cash by 3o June 2022 and close accounts where relevant. Determine petty cash floats for the new organisation & make arrangements	Y	Y	N/A				Green	N/A - no petty cash held			Very low
	Payment Cards	3.4.15	Identify all payment cards held by the organisation - close down payment cards for the old organisation - identify requirements for payment cards in the new organisation - identify categories and spending limits for payment cards - set up payment cards in the new organisation	Y	Y	Maria Tongue	01/12/2021	30/04/2022		Green	Existing payment cards will be novated/transferred to the ICB. Allpay to be contacted to formally confirm.	No risks identified		Very low
V3	Stationery	3.4.16	Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes. [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Y		Maria Tongue/MLCSU	01/04/2022	31/07/2022		Green		No risks identified		Very low
		3.4.17	Ensure new stationery (e.g. payable orders (POs) and cheques) is ordered and received with name of the ICB and safe arrangements for storage made. To include new VAT number and GBS / bank account details		Y	Maria Tongue	01/04/2022	31/05/2022		Green				Very low

3.5 FINANCIAL DUE DILIGENCE CHECKLIST: Contracts

The organisation should identify all clinical and non-clinical contracts, the date that the contract is due to end and, where necessary, review the terms. The organisation should assess the potential cost to the NHS of contract termination and develop plans that minimise these.

		Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
Contracts	3.5.1	Core tab outlines the requirements for the contracts register, ensure that the following are included (where appropriate): - Primary care contracts - CHC contracts - Placement contracts - PHB contracts - NHS contracts for healthcare services - independent sector, NHS organisations, D2A beds, patient transport, Medical support to assessment beds, etc - Non healthcare service contracts, e.g., IT contracts	Y	Y	Kay Holland	31/10/2021	31/01/2022		Green	Contract register is in place and updated regularly.	Oversight of contracts not held/managed by the Contract Management Team (e.g. Medicines Management contracts) needs to be stronger	Procurement Oversight Group invitation sent to Goods & Services contract holders, so contract issues can be discussed and risks escalated as required	Very low
	3.5.2	Identify any other material matters relating to contracts and commercial agreements, including: - Open contract management actions - Open contract notices - Open contractual financial incentive schemes (eg revenue sharing for outsourced pharmacy provision)	Y		Kay Holland	31/10/2021	31/01/2022		Green	Directors and Senior Managers contacted	28 rebate contracts to be updated to new organisaton	Medicines Management liaisng with each individual company	Very low
	3.5.3	Ensure that the review of contracts in place includes negotiation with suppliers so the ICB is able to buy at the best price given to the CCG(s)	Y	Y	Kay Holland	31/10/2021	31/01/2022		Green	Directors and Senior Managers contacted	28 rebate contracts to be updated to new organisaton	Medicines Management liaisng with each individual company	Very low
	3.5.4	Outline any PFI agreement, NHS LIFT or other Public Private Partnership arrangements or equivalent DHSC initiative in place	N/A	N/A	N/A	31/10/2021	31/01/2022		N/A	Not applicable no PFI, NHS LIFT or other Public Private Partnership arrangements in place			Very low
	3.5.5	Agree approach to contracts in ICB, payment mechanism, aligned incentive, risk share etc.	N/A	Y	Kay Holland	31/10/2021	31/01/2022		Green	Task & Finish Group in place chaired by Jill Robinson and reporting to Directors of Finance to develop an Intelligent Fixed Payment contracting model with SaTH, RJAH and SCHT; Paper submitted to Directors of Finance in December; Discussions on-going			Very low
	3.5.6	Develop new s75/s256/s76 agreements for the ICB (and arrange for the appropriate governance/sign off) or revise existing ones for ICB		Y	Claire Parker/Tracey Jones	31/10/2021	31/01/2022		Green	Awaiting final confirmation from LA colleagues and that this expected to be able to be confirmed as our statement by the 4th MAY deadline 1) We have a current signed section 75 in place regarding BCF budgets with both Shropshire and Telford LA 2) That these arrangements can transfer over into the ICB under the wordings of successor organisations as was confirmed when we moved from two CCGs into one CCG 3) We have a process for agreeing the updates to the BCF that may be required on release of national planning guidance for BCF expected end of quarter 1 22/23			Very low
Provisions	3.5.7	Ensure appropriate provisions have been made for any early contract termination penalties (if applicable).	Y		Kay Holland	31/10/2021	31/01/2022		Green	Directors and Senior Managers contacted to date no early contract termination penalties identified			Very low
Disputes	3.5.8	Ensure that all contractual disputes are documented and have appropriate ownership prior to the establishment of the ICB (determine the arrangements in the ICB for resolving all disputes, including those carried forward from the CCG(s)	Y	Y	Kay Holland	31/10/2021	31/01/2022		Green	No contractual disputes identified			Very low
Risk share	3.5.9	Identify all risk share / gain share arrangements which are in place prior to the establishment of the ICB to ensure that they are either terminated or continued	Y	Y	Kay Holland	31/10/2021	31/01/2022		Green	Any risk/gain share arrangements will be continued			Very low
Joint working	3.5.10	Identify all joint working arrangements - ensure that they have been appropriately accounted for	Y	Y	Kay Holland	31/10/2021	31/01/2022	27/05/2022	Green	Directors and Senior Managers contacted			Very low
Grants	3.5.11	Identify and charitable or government grants	Y	Y	Kay Holland	31/10/2021	31/01/2022		Green	Grants are listed on the contract register			Very low

3.6 FINANCIAL DUE DILIGENCE CHECKLIST - Assets

The organisation should put itself into a position to identify all assets and make arrangements for each asset to be transferred to the new organisation with comprehensive backing information.

		Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
Assets	3.6.1	Establish baseline audit of existing state of the fixed asset register (FAR)	N	N					N/A	The CCG does not hold fixed assets			N/A
	3.6.2	Reconciliation of inventory (if applicable) and establish any write offs. Review of any inventory below the capitalisation limit	N	N					N/A	The CCG does not hold fixed assets			N/A
	3.6.3	Reconciliation of FAR (where possible, physically verify all plant and equipment. Where this is not possible, consider whether write- offs are required). Assets include those 'non accountable' assets below the capitalisation threshold	N	N					N/A	The CCG does not hold fixed assets			N/A
	3.6.4	Intangible assets - review with ICT team to ensure that asset is in use, functional and will be transferred new organisation	N	N					N/A	The CCG does not hold fixed assets			N/A
	3.6.5	Determine which equipment is under warranty or has a service contract and ensure that the necessary documentation is identified and appropriately filed or archived	N	N					N/A	The CCG does not hold fixed assets			N/A
	3.6.6	Ensure that if the asset register is not integrated, it interfaces with the ledger system		Y	Maria Tongue	01/11/2021	31/03/2022		Green	The CCG does not currently hold fixed assets but does have access to a fully integrated asset system provided by SBS if required.			N/A
	3.6.7	If different asset registers are maintained, agree a date when they will be merged onto one system	Y	Y					N/A	The CCG does not hold fixed assets			N/A
	3.6.8	Review capitalisation policies, particularly around IT equipment and staff costs, and determine approach	Y	Y	Maria Tongue	01/01/2022	31/03/2022		Green		No risks identified		Very low
Working Capital	3.6.9	Working capital • Establish, if not in place already, an internal escalation framework to resolve disputes based on the age and size of the balance. Where disputes can not be resolved via normal payment or debt collection processes, disputes should be escalated to the Deputy Director of Finance (DDoF). If the dispute can not be resolved at DDoF level, it should be escalated to the Director of Finance and if they are unable to resolve the dispute, to the Chief Executive to engage with their counterparts. • Report balances over 90 days old to the Audit Committee and Transition Board (or equivalent) to ensure senior leadership is aware of the issues and can provide oversight of the process. Executives should be engaged in resolving disputes. • Encourage budget-holders to review and resolve queries with greater frequency and haste. • Ensure the finance team regularly report on and discuss aged balances with budget-holders. • Ensure settling balances is a high priority and monitored regularly by the Director of Finance and Senior Management Team. • Build and maintain relationships with key contacts within counter-party organisations in order to facilitate resolution of contentious issues. • Balances under 30 days should be resolved primarily through normal dispute and approval processes. Any disputed or unapproved items over 30 days should be reviewed by Finance and discussed with budget-holders. • The Finance team should contact their counterparts to resolve disputes.	Y		Maria Tongue/MLCSU/SBS	01/12/2021	31/03/2022		Green	Process already well established and will continue in ICB	No risks identified		Very low
Invoicing	3.6.10	Do not delay in raising sales ledger invoices relating to 2022/23		Y	Maria Tongue	01/11/2021	31/03/2022	Raised between 18/04/22 to 20/05/22	Green	Action noted & built into M12/M1 planning			Very low
Offices	3.6.11	Determine office requirements for the new organisation, including the need to assess impact on current office space, end lease / continue lease etc. Where a new accommodation is commissioned, ensure that NHS digital access is in place.		Y	Sam Tilley/Alison Smith	01/11/2021	28/02/2022		Green	CCG merger has already undertaken a consolidation of accommodation so no further changes will be forthcoming. **COMPLETED**	No risks identified	N/A	Very low
Debtors	3.6.12	Review and, where appropriate, write off irrecoverable debts. This should be done in detail on a balance by balance basis. If the debt cannot be written off, consider whether any impairment is necessary. Ensure that any write offs are documented in the losses and special payments register.	Y		Maria Tongue	01/03/2022	30/06/2022		Green	Aged debtors will be reviewed regularly as part of transition plan with SBS/CSU	No risks identified		Very low
	3.6.13	Agree post-ICB establishment debt recovery service if via more than one external supplier		Y	N/A					N/A			N/A
	3.6.14	Review debtor balances and manage down so that no debts remain at year end that are over 1 month	Y		Maria Tongue/MLCSU/SBS	01/01/2022	30/06/2022		Green	Aged debtors will be reviewed regularly as part of transition plan with SBS/CSU	No risks identified		Very low
	3.6.15	Clear unallocated cash balances where possible. Applying to sales invoices, AP refunds or coding direct cash payments to I&E	Y		Maria Tongue/MLCSU/SBS	01/01/2022	30/06/2022		Green	Included within SBS transition plan	No risks identified		Very low
Policy	3.6.16	Prepare new receivables policy for credit terms, recovery, legal action, write-off, de minimis levels etc		Y	Maria Tongue	01/02/2022	30/06/2022		Green	Existing CCG policy will be utilised with name change since well established process			Very low
Leases	3.6.17	Consider IFRS16 finance leases (the standard is effective from 1 April 2022 as adapted and interpreted by the FReM)	Y	Y	Maria Tongue	01/01/2022	31/03/2022		Green	Leases identified - core data passed to SBS for inclusion in FMIS system which will be utilised from 1/7/22	No risks identified		Very low
	3.6.18	Identify all contracts with NHS Property Services Ltd and Community Health Partnerships.	Y		Wendy Wood/Alison Smith	01/10/2021	30/06/2022		Green	Process already well established. **COMPLETED**	N/A	N/A	Very low
	3.6.19	Identify any leases which are held at a peppercorn rent	Y		N/A				Green	N/A			N/A
	3.6.20	Ensure that all lease documentation is properly filed and archived. Inform lessors of equipment of the transfer to ICB. Review all existing leases and terminate/ renegotiate as necessary (including mobile phones / pagers, photocopiers, lease cars)	Y	Y	Kay Holland	01/11/2021	31/06/2022		Amber	Not Finance - contracts register does contain some lease information but more work to be undertaken. All lease/contract owners contacted and asked to update register			Very low

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

3.7 FINANCIAL DUE DILIGENCE CHECKLIST: Liabilities

The organisation should put itself into a position to ensure that any balances remaining at 30 June 2022 are minimal and disputes have been resolved with both NHS and non-NHS organisations. The organisation should ensure arrangements are in place for each liability to either be approved for payment or have a clear route to authorisation (including those to be transferred to the new organisation with comprehensive backing information).
All creditor control accounts will be fully reconciled with no balances awaiting clearance unless they are longer term transactions.

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
	Working Files	3.7.1	Ensure that all liabilities can be analysed by the ICB with appropriate working files	Y	Y	Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
V4	Invoices	3.7.2	Ensure communication and ordering arrangements are in place to minimise the chance of invoices arriving late (i.e. post 30 June 2022)	Y		Maria Tongue/MLCSU/SBS	01/12/2021	31/05/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
	Disputes	3.7.3	Prioritise and resolve any outstanding disputes	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
V4	Expenses	3.7.4	Establish arrangements to manage staff expenses down so only claims relating to the end of June 2022 remain	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Not material - minimal claims being made	No risks identified		Very low
	Credit Notes	3.7.5	Review all outstanding credit notes and monitor resolution	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.6	Ensure all credit notes are applied. If appropriate re-raise but as a debtor	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
V4	Suppliers	3.7.7	Ensure supplier list up to date. Suppliers in respect of those with balances will need to be transferred to new organisation post 1 July 2022	Y	Y	Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.8	Write to inform suppliers of changes	Y		Maria Tongue/MLCSU/SBS	01/04/2022	31/05/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
	Authorisations	3.7.9	Clear lines of authorisation and availability of authorising officers • Keep scheme of delegation under regular review to ensure any staff departures are recognised and addressed appropriately. • Ensure sufficient cover to address staff leaving. • Continually review authorisation processes to ensure proper processes are in place. • Ensure that authorising officers are at the correct seniority. • Ensure Governing Body approval for any changes	Y		Maria Tongue/MLCSU/SBS	01/03/2022	30/06/2022		Green	Financial scheme of delegation to be reviewed as part of transition	No risks identified		Very low
	Working Capital	3.7.10	Working capital • Aim to settle all invoices within 30 days in line with the better payment practice code. Ensure all Non PO & PO invoices are validated and paid where possible. • Establish, if not in place already, an internal escalation framework to resolve disputes based on the age and size of the balance. Where disputes can not be resolved via normal payment or debt collection processes, disputes should be escalated to the Deputy Director of Finance (DDoF). If the dispute can not be resolved at DDoF level, it should be escalated to the Director of Finance and if they are unable to resolve the dispute, to the Chief Executive to engage with their counterparts (or equivalent). • Report balances over 90 days old to the audit committee and transition board (or equivalent) to ensure senior leadership is aware of the issues and can provide oversight of the process. Executives should be engaged in resolving disputes. • Encourage budget-holders to review and resolve queries with greater frequency and haste. • Ensure the finance team regularly report on and discuss aged balances with budget-holders. • Ensure settling balances is a high priority and monitored regularly by the Director of Finance and Senior Management Team. • Build and maintain relationships with key contacts within counter-party organisations in order to facilitate resolution of contentious issues. • Balances under 30 days should be resolved primarily through normal dispute and approval processes. Any disputed or unapproved items over 30 days should be reviewed by Finance and discussed with budget-holders. • The finance team should contact their counterparts to resolve disputes. • Following a concentrated effort during Quarter Three to resolve aged debt, balances approaching 60 days should be escalated to the DDoFs of both parties for resolution and beyond.	Y		Maria Tongue/MLCSU/SBS	01/04/2021	30/06/2022		Green	Process already well established and will continue in ICB	No risks identified		Very low
	GRNI	3.7.11	Clear all goods received not invoiced balances (GRNI) as soon as the invoice is paid. Investigate any outstanding balances. Contact suppliers to issue invoices where GRNI balances are being accrued	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
V4	Payments	3.7.12	Determine frequency of payments and establish timetable to operate from 1 July 2022. Harmonise payment dates if operating with two or more systems	Y	Y	Maria Tongue/MLCSU/SBS	01/02/2022	31/05/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.13	Determine how any payables carried forward from CCG(s) are going to be cleared in the ICB's accounts		Y	Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.14	Review payables, decide on reference methodology and eliminate redundant/duplicated references	Y	Y	Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.15	Specify requirements for payments and determine if time constraints will force a period of dual running	Y	Y	Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.16	Ensure bank details are obtained and reviewed for payables paid by BACS		Y	Maria Tongue/MLCSU/SBS	01/03/2022	30/04/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.17	Ensure compatibility with ordering and goods received systems		Y	Maria Tongue/MLCSU/SBS				N/A	No work required - continuation of existing ISFE system			Very low
		3.7.18	Ensure payables payment system interfaces with ledger accounting		Y	Maria Tongue/MLCSU/SBS				N/A	No work required - continuation of existing ISFE system			Very low

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
		3.7.19	The CCG(s) should ensure it has established who has responsibility for the settlement of balances and communication with creditors	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/04/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
V2		3.7.20	Non PO invoices on hold to be released and paid where possible once verified as appropriate	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
V2		3.7.21	PO Notifications to be actioned and holds released to ensure invoices can be paid once verified as appropriate	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.22	Clear Prepayment Status Report Invoices	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
		3.7.23	Ensure every effort is taken to recover any outstanding incorrect or duplicate supplier payments	Y		Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
	Staff	3.7.24	Identify key purchasing staff and ensure that they can continue to order supplies during the transition period	Y	Y	Maria Tongue/MLCSU/SBS	01/12/2021	30/06/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified		Very low
	Other contracts	3.7.25	Identify ongoing service contracts (small contracts such as milk delivery, window cleaning as well as the more obvious such as servicing of medical equipment) and decide whether these contracts need to be terminated/extended	Y	Y	Kay Holland	01/12/2021	31/03/2022		Green	These contracts were reviewed and update by the Contract owner on the merger of Shropshire and Telford & Wrekin CCGs - contract owners to confirm and take necessary steps for new organisation			Very low
		3.7.26	Review services provided and see if there are consolidation opportunities. Ensure that processes for tender/quotation for services are followed (combined services may change the required procedure under SFIs). Agree / confirm ICB's new tender / quotes limits	Y	Y	Kay Holland	01/12/2021	31/03/2022		Green	These contracts were reviewed and update by the Contract owner on the merger of Shropshire and Telford & Wrekin CCGs - contract owners to confirm and take necessary steps for new organisation			Very low
	Processes	3.7.27	Review supplies team processes and ensure they are amended as required	Y	Y	Kay Holland	01/12/2021	31/03/2021		Green	Supplies team processes reviewed			Very low
	Insurance	3.7.28	Determine insurance requirements for the ICB and ensure portfolio of required cover is in place, contact NHS Protect to inform them of NHS body affected by reorganisation so that all insurance cover and claims can be amalgamated and new reference numbers allocated		Y	Maria Tongue	01/04/2022	31/05/2022		Green	NHS Protect will be contacted to inform them of change	No risks identified		Very low
V2	Legal	3.7.29	Ensure that the ICB has access to all of the CCG(s) claims history (see also core tab 1 - section 1.5)	Y	Y	Alison Smith	01/11//2021	30/05/2022		Green	Claims and litigation information is held.	No risks identified	N/A	Very low
V2		3.7.30	Identify any ongoing legal cases, clear working files for new entity (see also core tab 1 - section 1.5)	Y	Y	Alison Smith	01/11//2021	30/05/2022		Green	Held and updated monthly.	No risks identified	N/A	Very low
	Pension/Ill Health Provisions	3.7.31	Consider any need for a redundancy provision, early retirement provisions or ill health retirement provisions - this should include any clinicians covered by the 2019/20 pension annual allowance charge compensation policy	Y	Y	Duplicate of 3.3.14				Green				Very low

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

4.0 IT ASSETS, IT AND RECORDS MANAGEMENT CHECKLIST

The organisation puts arrangements in place for the effective management of financial data transfer between the CCG and the ICB and that access to systems will be maintained post 30 June 2022. This should cover the annual accounts production and audit process and also any post June 2022 reporting requirements.

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
V4	Licensing	4.1	System and software licensing arrangements are reviewed to ensure that financial data can be accessed after 30 June 2022. Licences for existing systems should be extended (pending a national decision on historic data archiving)	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	List of systems suppliers collected, software to continue to be in place post 30/06/2022	No risk identified	No mitigation needed	Very low
		4.2	Identify all software licences held are transferred to the ICB, identify any early termination penalty clauses, rationalise licences	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	All software licences can be transferred to the ICB, no penalty clauses of rationalisation of licences	No risk identified	No mitigation needed	Very low
	Access	4.3	Access to buildings for legacy staff is enabled in whatever way is most appropriate. It is not sensible to exit data centres for example without a clear transition plan in place for data and records archiving.	Y	Y	Tracy Eggby-Jones	N/A	N/A		N/A	Access to buildings needs to be removed from the tab and assigned to the right person No data centres will be exited as a result of the ICB	No risk identified	No mitigation needed	N/A
		4.4	Key business security systems are maintained and regularly checked (e.g. back up procedures and business continuity arrangements) to protect management and audit trails	Y		Sara Spencer	01/11/2021	30/06/2022		Green	Back-up process in place for all data storage servers as part of the CSU contract for IT.	No risk identified	No mitigation needed	Very low
V3		4.5	Single prompt replaced by new suite of prompts 4.23 to 4.34 inclusive - see version control log. Prompt number retained but not reused to prevent renumbering confusion		Y	Sara Spencer	01/11/2021	31/03/2022						Very low
	Security	4.6	Ensure all hardware is identified and staff holder mapped	Y		Sara Spencer	01/11/2021	31/03/2022		Green	Asset lists available from the MLCSU IT department	No risk identified	No mitigation needed	Very low
		4.7	Evaluate and compare existing systems against ICB's requirements. Compare to other systems if appropriate	Y	Y	Sara Spencer	01/11/2021	30/06/2022		Green	All systems meet with the ICBs requirements, the ICB transition will not affect the systems or software	No risk identified	No mitigation needed	Very low
		4.8	Review the spine end points (e.g. EMIS) which may have Spine endpoints affected	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	Spine endpoints have been reviewed no actions reported	No risk identified	No mitigation needed	Very low
V3	Risk	4.9	Prompt moved to 4.29 and wording revised - see version control log. Prompt number retained but not reused to prevent renumbering confusion	Y		Sara Spencer	01/11/2021	31/03/2022						Very low
	Policy	4.10	Develop a policy on use of work computers and communicate the new policy to employees		Y	Sara Spencer	01/11/2021	30/06/2022		Green	Review of policies to identify if this is in place. New draft to be adopted by the new ICB	No risk identified	No mitigation needed	Very low
	Hardware/Software	4.11	Identify and dispose of surplus equipment securely (risk of old IT kit not being wiped properly)	Y		Sara Spencer	01/11/2021	31/03/2022		Green	There is a contract in place for the safe disposal of IT equipment with MLCSU; This is complete, all old IT equipment is returned to the CSU IT Team and is securely destroyed.	No risk identified	No mitigation needed	Very low
		4.12	Identify hardware needs, standardise and purchase new equipment		Y	Sara Spencer	01/11/2021	30/06/2022		Green	Hardware needs identified, standard hardware offer has been agreed for the future ICB	No risk identified	No mitigation needed	Very low
	Dual Running	4.13	Specify requirements for each material system and determine if time constraints will force a period of dual running after establishment of the ICB		Y	Sara Spencer	01/11/2021	31/03/2022		Green	All systems will not require dual running for the ICB transition, all systems in place and delivering to ICB requirements	No risk identified	No mitigation needed	Very low
	Smart Card	4.14	Review the smart card users. Take action to reconcile the smart card list with the Care Identity Service	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	Smartcard / RA service has been contacted to identify if a process of transfer is needed, the ODS code is not changing, just a name change is expected	No risk identified	No mitigation needed	Very low
V3	Records Retention	4.15	Single prompt replaced by new suite of prompts 4.23 to 4.34 inclusive - see version control log. Prompt number retained but not reused to prevent renumbering confusion	Y	Y	Sara Spencer	01/11/2021	31/03/2022						Very low
V3		4.16	Single prompt replaced by new suite of prompts 4.23 to 4.34 inclusive - see version control log. Prompt number retained but not reused to prevent renumbering confusion	Y	Y	Sara Spencer	01/11/2021	31/03/2022						Very low
V3		4.17	Ensure that records management transition plans are in place [repeated on tab 1.0 - prompt 1.7.11]	Y	Y	Sara Spencer	01/11/2021	31/05/2022		Green	All departments have a migration date in May to transfer records to the new shared drive except one service.	One team is behind in the data transfer, risk of not meeting the May deadline.	Working with the team to gather information for the migration of the shared drive information.	Very low
V3		4.18	Ensure that records management transition plans for historical financial records are in place	Y	Y	Sara Spencer	01/11/2021	31/05/2022		Green	Historical records identified and saved electronically in the correct folders on the shared drive.	One team still to complete this work.	Working with the team to ensure that the assets are transferred to the new organisation	Very low
V3		4.19i	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for Inquiries, including the forthcoming Covid Inquiry [repeated on tab 1.0 - prompt 1.7.12]	Y	Y	Sara Spencer	01/11/2021	30/06/2022		Green	All data has been cleansed and mapped to Uassure ready for transfer to the new organisation. Paper records audits have been updated from the information collected for the single commissioner work completed last year.	No risk identified	No mitigation needed	Very low
V3		4.20	Identify archive requirements and ensure that data / information is extracted and stored in an easy to access format. This also applies to all feeder systems to the ledger [repeated on tab 3.3 - prompt 3.3.41]	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	The data retention schedule and naming convention for all records has been circulated to all departments IAAs and IAOs.	No risk identified	No mitigation needed	Very low
		4.21	Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes [elements repeated on tab 3.4 - prompt 3.4.16]	Y	Y	Alison Smith / Maria Tongue								
V3		4.22	Ensure all appropriate records are kept, and emails are retained for any key staff that may leave during the transition period [repeated on tab 3.2 - prompt 3.2.16]	Y	Y	Sara Spencer	01/11/2021	30/06/2022		Green	The data retention of staff that leave will be worked through to ensure no data or emails are lost	No risk identified	No mitigation needed	Very low
V3		4.23	Establish ongoing records management processes as set out in the Records Management Code of Practice including the requirement in the following rows:	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	Records management process in place and implemented with department IAAs and IAOs. Complete	No risk identified	No mitigation needed	Very low
V3		4.24	Responsibility and accountability for the Records Management requirements assigned to a suitably qualified or experienced person	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	Each department has a named IAA and IAO for the records management process. Also IG operational manager in post to ensure records management is maintained. Workshops are in place to maintain progress. Complete	No risk identified	No mitigation needed	Very low
V3		4.25	Records management policies and procedures are put in place - covering both corporate and clinical records	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	All polices are in place and will be adopted to the ICB. Complete			Very low
V3		4.26	A network or shared repository for the storage of records and an electronic records management file structure	Y	Y	Sara Spencer	01/11/2021	31/05/2022		Green	All data is stored electronically on a shared drive.	No risk identified	No mitigation needed	Very low
V3	Records Management	4.27	Arrangements for physical records storage - both onsite and offsite storage (where applicable), including inventories detailing records in store	Y	Y	Sara Spencer	01/11/2021	30/06/2022		Green	Template on shared drive, this has been circulated to all departments to detail where the files stored.	No risk identified	No mitigation needed	Very low
V3		4.28	All Information Asset Registers and Records of Processing Activity are kept up to date (links to 5.30)	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	The process for maintain information asset registers is in place with all IAAs and IAOs ensuring the assets are recorded. Policies are in place supporting this and a monthly workshop to support departments.	No risk identified	No mitigation needed	Very low

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
V3		4.29	A procedure to deal with the increased risk to records that result from a re-organisation (such as potential loss or accidental disclosure)	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	The process for reporting breaches has been circulated to all staff in the CCG newsletter. The process is held on the website with all CCG IG policies.	No risk identified	No mitigation needed	Very low
V3		4.30	Ensure there is a record of any actions taken in relation to records e.g. transferred to the local Place of Deposit. Certificates of disposal should be obtained where necessary.	Y	Y	Sara Spencer	01/11/2021	30/06/2022		Green	A certificate will be collected with disposal of records or records that are moved to archive. Records disposal has director sign off to prevent the deletion of assets	No risk identified	No mitigation needed	Very low
V3		4.31	Check all boxes of paper records that have been transferred are accounted for and all electronic records have transferred and can be opened	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	Paper record audit has been completed, and data cleanse of all electronic documents. Complete	No risk identified	No mitigation needed	Very low
V3		4.32	Ensure there is clarity about which records the ICB is taking where there is a boundary change taking place / a "split" CCG (if applicable)	Y	Y	Sara Spencer	01/11/2021	31/03/2022		Green	There is no boundary change for the ICB transition. Complete	No risk identified	No mitigation needed	Very low
V3		4.33	Ensure that any records which are subject (or may become subject) to an Inquiry, investigation or request for information continue to be retained and can be accessed. This includes records which are subject (or may become subject) to any current Public Inquiry	Y	Y	Sara Spencer	01/11/2021	30/06/2022		Green	All documents that are subject to a stop notice or investigation will be retained for the public inquiry	No risk identified	No mitigation needed	Very low
V3		4.34	Ensure adequate file plans are in place for digital repositories to be transferred	Y	Y	Sara Spencer	01/11/2021	30/06/2022		Green	Naming conventions in place for all documents to be stored in an approved format	No risk identified	No mitigation needed	Very low
V5		4.35	- IT provision agreed (in-housing or externally provided)		Y	Laura Clare/Sara Spencer	14/04/2022	15/05/2022		Green	IT services are provided by Midlands and Lancashire CSU. Contract in place will be transferred to the ICB	No risk identified	No mitigation needed	Very low
V5		4.36	- Service separation, data migration, off-boarding completed (if applicable)	Y		Laura Clare/Sara Spencer	14/04/2022	15/05/2022		Green	Footprint is not changing therefore no data or services being transferred or off boarding requirements	No risk identified	No mitigation needed	Very low
V5		4.37	- Email address closedown, transfer activities, including mailboxes (if applicable)	Y		Laura Clare / Sara Spencer	14/04/2022	30/06/2022		Green	Working with NHSmail Team at the CSU to progress through the planned name change of the organisation. This is nationally led, regular updates	No risk identified	No mitigation needed	Very low
V5		4.38	- Review of access controls for all systems, with amendments actioned accordingly	Y		Laura Clare / Sara Spencer	14/04/2022	30/06/2022		Green	Access controls are in place with all systems, these will not change with the ICB transition.	No risk identified	No mitigation needed	Very low
V5		4.39	- Review and consolidation of auditing procedures	Y		Laura Clare / Sara Spencer	14/04/2022	30/06/2022		Green	Auditing procedures are in place and will be transferred to the ICB	No risk identified	No mitigation needed	Very low
V5		4.40	- Contract, agreement updated and signed		Y	Laura Clare / Sara Spencer	14/04/2022	30/06/2022		Green	All contracts will be transferred to the new organisations	No risk identified	No mitigation needed	Very low

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

5.0. DATA SECURITY AND PROTECTION TOOLKIT (DSPT)

The DSP Toolkit has been reviewed and released. Please follow the link below to the briefing and DSP toolkit:
https://www.dsptoolkit.nhs.uk/News/CCG-ICB-DSP-Toolkit

V2/3/4 **CCGs are required to complete and publish the DSP Toolkit for 2021-22 before they are abolished and by the deadline of 30 June 2022. NHS Digital will exempt the requirement for a DSP Toolkit audit for CCGs for 2021-22.**

			Suggested Actions *A number of due diligence activities which relate to the set up of the ICBs are included and shaded in grey*	CCG close down	ICB setup	Person Responsible	RAG	Comments	Guidance Notes and Link to DSPT
	IG Appointments	5.1	Job descriptions reviewed and updated as needed		Y		Green	Existing job description extracts will be transferred into new post JDs	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security.
		5.2	Board appointment of Senior Information Risk Owner (And deputy if applicable)		Y		Amber	DPO continues in place with CSU (Hayley Gidman), SIRO and CG roles to be confirmed shortly – discussions with executives underway re job profiles /portfolios	See DPST 1.3.3 which requires the assignment of SIRO responsibility for data security
		5.3	Board appointment of Caldicott Guardian (Deputy if applicable)		Y		Amber	DPO continues in place with CSU (Hayley Gidman), SIRO and CG roles to be confirmed shortly – discussions with executives underway re job profiles /portfolios	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security.
		5.4	Data Protection Officer - Information Commissioner's Office updated with contact details		Y		Green	CSU arrangement continues with Hayley Gidman	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security. Also consider GP DPO Support if relevant.
		5.5	Appointment Information Asset Owners - Form submitted by SIRO to NHS Digital		Y		Green	all existing IAOs/IAAs will transfer to new organisation as lift and shift	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security.
		5.6	IG Lead(s)		Y		Amber	DPO continues in place with CSU (Hayley Gidman), SIRO and CG roles to be confirmed shortly – discussions with executives underway re job profiles /portfolios	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security.
		5.7	Head of IT or equivalent		Y		Green	The Operational IT & IG Manager role will lift and shift to the new organisation	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security.
		5.8	Cyber Security Specialist – Cyber Associates Network (CAN) Member		Y		Amber	cyber specialist continues to be brought in from CSU	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security.
		5.9	Subject Access Request (SAR) Lead		Y		Amber	All SARs are requested through Patient Services Team, - Action for Alison Smith to confirm the lead	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security. See also 1.3.17 on core tab.
		5.10	Freedom of Information (FOI) Lead		Y		Amber	All FOIs are requested through the Corporate Services Team, Action for Alison Smith to confirm the lead	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security. See also 1.3.18 on core tab.
		5.11	Information Asset Administrators		Y		Green	all existing IAOs/IAAs will transfer to new organisation as lift and shift	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security.
		5.12	IG team structure designed and approved by SMT or Board		Y		Amber	CSU IG team lift and shift, IG lead and SIRO TBC	See DSPT 1.1.5 which requires a list of the names and job titles of your key staff with responsibility for data protection and data security.
	IG Governance	5.13	IG governance process established (in shadow form until ICB established) - Structure agreed - Terms of Reference agreed - Meetings scheduled		Y		Green	existing governance arrangements will transfer – IG working group, quarterly IG steering group feeding into audit committee	See DSPT 1.3.4 which requires clear lines of responsibility and accountability to named individuals for data security and data protection.
	IG Processes Mapped	5.14	Current IG processes mapped (for all CCGs if multiple going into ICB), decisions made to stop or continue for ICB	Y	Y		Green	This is in place, the process will be adopted by the new ICB.	
		5.15	- Data Protection Impact Assessments processes mapped	Y	Y		Green	This is in place, the process will be adopted by the new ICB.	See DSPT 1.3.8 which requires a process for Data Protection Impact Assessments.
		5.16	- Subject access requests processes mapped	Y	Y		Green	This is in place, the process will be adopted by the new ICB.	See DSPT 1.2.2 for requirement to have a process for subject access requests and also refer to core checklist tab (1.3.17) for the need to transfer individual subject access requests.
		5.17	- National data opt-out processes mapped	Y	Y		Green	This is in place, the process will be adopted by the new ICB.	See DSPT 1.2.4 which requires compliance with national data opt-out.
		5.18	- Data subject rights requests processes mapped	Y	Y		Green	This is in place, the process will be adopted by the new ICB.	
		5.19	- Freedom of information requests processes mapped	Y	Y		Green	This is in place, the process will be adopted by the new ICB.	Also refer to core checklist tab (1.3.17) for the need to transfer individual freedom of information requests which would need to transfer to the ICB.
		5.20	- Data breaches processes mapped	Y	Y		Green	This is in place, the process will be adopted by the new ICB.	See DSPT 6.1.1. which requires a policy/procedure is in place to ensure data security and protection incidents are managed / reported appropriately.
		5.21	- Contract reviews	Y			Green	All contracts reviewed and transferred to the ICB	See DSPT 10.2.1 which requires that suppliers of IT have the appropriate certification. Also refer to core checklist tab (1.6.1) - contracts register and tab 3.5.
		5.22	- Confidentiality Advisory Group (CAG) approvals	Y			Green	Risk Stratratification Assurance approval to be rebranded and agreed at Audit Committee	
		5.23	- Data sharing framework (e.g. shared care record, individual or direct care, and population health data	Y			Green	IG Team to update the name of the organisation on the Information Sharing Gateway	
		5.24	- Continuing Health Care processes mapped	Y	Y		Green	CHC to be contacted to confirm and map the processes	
		5.25	- Complaints processes mapped	Y			Green	Corporate services to be contacted to detail if there is a new complaints proceedure	See also 1.4.2 on core tab.
Rows 7 to 48 added in		5.26	- Information risk registers	Y	Y		Green	Uassure records will be transferred to the ICB	See DSPT 1.3.5 which requires you to check if your organisation operates and maintains a data security risk register.

V5	IG Policies and procedures drafted and agreed covering	5.27	- Confidentiality - Data protection - Data breaches - Subject access requests - Data protection impact assessment (DPIA) - Data subject rights - Freedom of Information (FOI) - IG framework - Information management - Records management - Data quality - Information security - IT and cyber policies - Training needs analysis - Procurement and contracting policies (IG input) - Complaints		Y		Green	IG policies recently reviewed for the new CCG. These will be rebranded to ICB	See DSPT 1.3.1 which requires that there are board-approved data security and protection policies in place.
	Business intelligence (BI) provision	5.28	- BI provision agreed (to remain the same, be in-housed or externally provided) - Service separation, data migration and off-boarding	Y			Amber	BI will be contacted to review this.	
	Identification, review and replacement of agreements	5.29	- Contracts - Service level agreements - Memoranda of understanding - Data sharing agreements - Data processing agreements - Data processing deeds - Joint controller agreements - Data Access Request Service applications	Y	Y		Amber	All documents reviewed recently, for the new CCG - rebranding for the ICB transition	See DSPT 10.1.1 which requires the organisation have a list of its suppliers that handle personal information, the products and services they deliver, their contact details and the contract duration. Also refer to core due diligence 1.6.1 - contracts register and tab 3.5.
	Identification of existing information and projects	5.30	- Review and update of Information asset register and records of proce		Y		Green	This is ongoing and completed every year.	See DSPT 1.1.2 which requires your organisation to have documented what personal data you hold, where it came from, who you share it with and what you do with it. See also 4.28 on tab 4.0.
		5.31	- Review and update of Data Protection Impact Assessment log		Y		Green	This is ongoing and completed every year.	See DSPT 1.3.8 which requires your organisation to have a process for Data Protection Impact Assessments.
		5.32	- Identification and review of COPI notice registers of data processing to ensure that data flows have a legal basis	Y			Amber	IG team are reviewing these.	
		5.33	- Privacy notices updated or drafted for any new processing		Y		Green	IG team are in the process of reviewing the privacy notice and rebranding.	See DSPT 1.2.1 which requires you to have transparency information.
		5.34	- Archiving of documents where needed	Y			Amber	In progress - data cleanse to identify assests and mapping to Uassure has been completed for teams.	See tab 4.0 and several prompts re archiving.
	Information Commissioner's Office (ICO)	5.35	- Registration of ICB - Removal of previous CCG registration(s)	Y	Y		Red	Registration of the ICB with the ICO will need the details of SIRO, Caldicott Guardian and DPO. Once these are decided this will be actioned	See DSPT 1.1.1 which requires ICO registration.
	Publication scheme activities	5.36	- Agree publication scheme		Y		Green	All IG policies are agreed at the Audit Committee	
		5.37	- Privacy notices published		Y		Green	IG team are in the process of reviewing the privacy notice and rebranding.	See DSPT 1.2.1 which requires you to have transparency information.
		5.38	- IG policies and processes published		Y		Green	The policies are in the process of being rebranded	
		5.39	- Data Protection Impact Assessment summary published		Y		Amber	The DPIA will be rebranded to reflect the ICB changes	DSPT 1.3.8 which requires your organisation to have a process for Data Protection Impact Assessments.
		5.40	Statement of contract transfer or replacement from previou	Y	Y		Amber	All contracts will be transferred to the ICB, this will be reviewed with the Contracts Team	
	IG training completed	5.41	- Senior Information Risk Owner - Caldicott Guardian - Information Asset Owners and Information Asset Administrators		Y		Amber	Once roles decided IG training will be offered	DSPT 3.3.1 requires you to provide details of any specialist data security and protection training undertaken.
	Intranet activities (see ICB Website Guidance for Systems)	5.42	- Closedown of previous CCGs intranet sites (if applicable) - Set up of new intranet site - Publish IG policies, procedures, guidance, forms for staff - Social media channels, sites, profiles identified and decision taken to close down or continue	Y	Y		Green	There is no intranet at the CCG - the website will be updated	See ICB Website Guidance for Systems - Released via FutureNHS.

DELIVERY PLAN							ASSURANCE								
Standard	**Assertion**	**2021/22 Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IG Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**	
1. Personal Confidential Data	**The organisation has a framework in place to support Lawfulness, Fairness and Transparency**	1.1.1	What is your organisation's Information Commissioner's Office (ICO) registration number?	IG Lead/DPO - Ensure renewal of ICO registration.	G		Check ICO register and record registration number. Provide link to CCGs registration page on ICO's register.	G		None		No Action	No Action	MS - ICO Registrations have been checked and are up to date, screenshot is in evidence folder (DSPT Updated)	

1.1.2	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	SIRO - CCG to ensure IAAs and IAOs are in place for all teams. IAAs and IAOs to log/ review assets and dataflow s on Uassure.	G		Support the CCG with asset logging and data flows. To complete spreadshe et to cover Article 30.	G		None.		No Action	No Action	MS - GDPR Audit Spreadsh eets x 2 saved in evidence folder MS - Screensh ot of Assets & Data Flows saved in evidence folder DSPT Updated	
1.1.3	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Submit and complete system question naires and nominate system owners.	G		Work alongside CCG to complete system and software questionn aires.	G		None.	Work in progress, need to engage with IG	No Action	No Action	MS Evidence in place: Systems Questionn aire Final STW CW Audit Teammat ePJ - 16.07.21 Screensh ot of STW Systems & Software Register from UAssure STW Systems Spreadsh eet DSPT Updated	
1.1.4	When did your organisation last review both the list of all systems/information assets holding or sharing personal information and data flows?	SIRO/IG Lead - review and formally sign off Informati on Asset Register and Data Flows	G		Provide sign off documentation on Informatio n Assets and Data Flows	G		None.		No Action	No Action	MS - SIRO report approved by Claire Skidmore 03/11/21 (Evidence in Folder)	
1.1.5	List the names and job titles of your key staff with responsibility for data protection and/or security.	CCG - Confirm names and job descripti ons of SIRO/Ca ldicott/IG Lead /DPO	G		Review all job specificati ons for inclusion of data security responsibi lity clause.	G		Review Cybersec urity team roles and individual leadership areas of Cyber	Complete in review folder	G		MS - All key contacts have been checked on the DSPT and these are up to date (DSPT Updated) MS - Job Descriptio ns / Statement s of Responsi bility are correct and up to date & saved in the evidence folders	

	1.1.7	Was the scope of the last data quality audit in line with guidelines.	IG Lead/SIRO/IAOs - Identify teams which process PID at source and ensure regular data quality audits are undertaken.	G		Support CCG with identifying teams which process PID and provide audit template and recommended actions.	G		None.		No Action	No Action	Email from OB - Refreshed /Updated Information received from Tony Payne's Team (11/02/22) Evidence saved in folder Completed GDPR Spreadsheet which includes the retention periods column completed Email from Sara Spencer Report for the shared drive data	
Individuals' rights are respected and supported	1.2.1	How is transparency information (e.g. your privacy notice) published and available to the public?	IG Lead/DPO/Comms - Ensure Public and Staff Privacy Notices are available and easily accesible on public website and staff intranet.	G		Compile/review Public Privacy Notice and Staff Privacy Notice.	G		None.		No Action	No Action	The Privacy Notice is in place for the CCG. MLCSU will review once ICB's are closer to transition	
	1.2.2	Your organisation has a process to recognise and respond to individuals' requests to access their personal data.	CCG in house SAR service to develop and formalise a SAR process and ensure staff are fully trained.	G		Where SAR service is provided, develop and formalise SAR process and provide relevant training and advise to CCGs with an in-house SAR service.	G		None.		No Action	No Action	MS - STW SAR Process in evidence folder (DSPT Updated)	
	1.2.4	Is your organisation compliant with the national data opt-out policy?	IG Lead/DPO/IAOs - To identify any areas where national data opt-out applys. If no areas, a statement must be provided to confirm this.	G		To support the CCG's IAO's in identifying where the CCG processes personal data and the National Data Opt out may apply. To amend Privacy Notice to reflect processing activities	G		None.		No Action	No Action	The Privacy Notice is in place for the CCG. MLCSU will review once ICB's are closer to transition	

Accountability and Governance in place for data protection and data security	1.3.1	Are there board-approved data security and protection policies in place that follow relevant guidance?	CCG Board - Provide minutes of Board meeting where policies have been ratified.	G		Review the IG Policy and IG Handbook.	G		None.		G	No Action	MS - IG Policy, IG Handbook and IG Code of Conduct were approved at STW Quarterly Meeting on 30.09.21 and these have been saved into the evidence folder (DSPT Updated) MS - Copy of Minutes showing approval of Policies saved into the evidence folder MS -	
	1.3.2	Your organisation monitors your own compliance with data protection policies and regularly reviews the effectiveness of data handling and security controls.	IG Lead/DPO - To provide minutes of meetings where formal testing on Data Protection and/or Confidentiality has been discussed and actions taken.	G		To undertake formal testing on Data Protection and/or Confidentiality a quarterly basis and report findings and actions as summary report to the relevant IG group.	G		None.		G	No Action	Spot check undertaken by the CCG at Ptarmigan House. Copy of completed spot check in the CCG Evidence Folder	
	1.3.3	Has SIRO responsibility for data security been assigned?	SIRO - To assign SIRO & ensure paperwork is signed by Accountable Officer	G		Check NHS digital register is up to date, and provide CCG with SIRO registration paperwork when necessary	G		None.		No Action	No Action	MS - SIRO & Caldicott Guardians are on the Registers, screenshots in evidence folder (DSPT Updated)	
	1.3.4	Are there clear lines of responsibility and accountability to named individuals for data security and data protection?	CCG Board - Provide Minutes of Board meeting where IG framework was ratified.	G		Review the IG framework.	G		None		No Action	No Action	MS - IG Policy, IG Handbook and IG Code of Conduct were approved at STW Quarterly Meeting on 30.09.21 and these have been saved into the evidence folder (DSPT Updated) MS - Copy of Minutes showing approval of Policies saved into the evidence folder MS -	

1.3.5	Does your organisation operate and maintain a data security risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility?	IG Lead/SIRO - Risk management process in place to receive(including from IT), review (at appropriate group), action or accept any data security risks and link in to Corp risk register. IG Lead/SIRO - Provide evidence of						Relates to vulnerability management, patch process and penetration testing	From a Cyber perspective: Created a risk register in review folder: Document actions to mitigate the risks. Can relate to Patch management. (KD) Relates to vulnerability managemenet, patch process and penetration testing. (HD)	G	BAU	Copy of the IG & IT Risk Registers received from Sara - these have been saved into the evidence folder	
1.3.6	What are your top three data security and protection risks?	IG Lead/SIRO - Ensuring there is a process in place which will identify what risks are and how they are dealt with. SIRO - Identify top three data security and protection risks. Provide evidence of report/meeting minutes where	G		Work with the CCG to identify risks. Document discussions with SIRO in SIRO report section of bimonthly/any feedback on risks from committee they are reported to also documented. Ensure top three risks are approved by SIRO prior to submission.	G		IT Provider to support CCG in this assertion including working with the CCG to identify risks. IT can provide top three security vulnerabilities across the estate				Copy of the IG & IT Risk Registers received from Sara - these have been saved into the evidence folder The Top 3 Data Security & Protection Risks for the CCG are: 1.STW do not implement the required digital work programme/actions due to lack of	
1.3.7	Your organisation has implemented appropriate technical and organisational measures to integrate data protection into your processing activities.	IG lead/SIRO - Consideration to strengthening the inclusion of principles in wider strategies that make reference to the data protection principles, and / or examples of risk management and project methodologies	G		Review the IG Handbook ensuring that a pseudonymisation procedure is updated if necessary.	G		None.			No Action	No Action	MS - IG Handbook including Psuedonomysation (Page 30) approved at STW Quarterly Meeting on 30.09.21 and these have been saved into the evidence folder (DSPT Updated) MS - Copy of Minutes showing approval of Policies saved into the evidence folder MS - Document	

		1.3.8	Your organisation understands when you must conduct a Data Protection Impact Assessment and has processes in place, which links to your existing risk management and project management, to action this.	CCG to ensure staff are trained following any TNA results which identify staff who require DPIA training. CCG Board - Provide Minutes of Boards meeting where IG policies and procedures were ratified.	G		IG team to ensure staff are trained and TNA is followed up. Ensure that DPIA materials and processes are up to date and reviewed bi-annually.	G		None.		No Action	No Action	MS - IG Handbook referencing DPIA section, DPIA templates, evidence of DPIA Training, DPIA Briefing, CCG Newsletter Nov 2021 inc DPIAs & Minutes where Policies were ratified	
		1.3.9	Is data security direction set at board level and translated into effective organisational practices?	CCG Board - Provide Minutes of Boards meeting where IG policies and handbook were ratified.	G		Review the IG framework.	G		None.		No Action	No Action	MS - IG Policy, IG Handbook and IG Code of Conduct were approved at STW Quarterly Meeting on 30.09.21 and these have been saved into the evidence folder (DSPT Updated) MS - Copy of Minutes showing approval of Policies saved into the evidence folder MS -	
	Records are maintained appropriately	1.4.1	The organisation has a records management policy including a records retention schedule	SIRO/IAOs - IAAs and IAOs to log information assets. Identify where localised record retention schedule are needed.	G		Support CCG with information asset logging. Compile/review localised records retention schedule.	G		None.		No Action	No Action	Records Management Policy included within the IG Policy (Pages 25-27) Records Retention Schedule in place & saved in evidence folder (Updated 07/02/22)	
			DELIVERY PLAN						**ASSURANCE**								
	Standard	**Assertion**	**Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IG Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**		

2: Staff Responsibilities	**Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards**	2.1.1	Is there a data protection and security induction in place for all new entrants to the organisation?	IG Lead/HR - To ensure that a data protection and security induction is included in the new starters process. IG Lead/SIRO - Ensure the CCG are adequately enforcing Induction for new starters within 1 month	G		To deliver monthly data protection and security induction to new starters via 'Teams'. To document when new starters undertake their IG induction training.	G		None.		No Action	No Action	MS - MLCSU Induction Presentation in evidence folder MS - MLCSU IG Induction Attendee Lists in evidence folder for the months of July, Aug, Sept, Oct, Nov, Dec, Jan & Feb CCG IG Induction Pack including supportig documents in evidence folder	
		2.1.2	Do all employment contracts contain data security requirements?	IG Lead/HR - Provide copy of data security clause included in employment contracts across all staff groups.	G		To conduct due diligence on data security clause in all employment contracts across all staff groups	G		None.		No Action	No Action	MS - Up to date copies of all contracts have been received and are saved in the CCG Evidence Folder (DSPT Updated)	
	DELIVERY PLAN						**ASSURANCE**										
Standard	**Assertion**	**Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IG Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**	
3: Training	**There has been an assessment of data security and protection training needs across the organisation.**	3.1.1	Has an approved organisation-wide data security and protection training needs analysis been completed after 1 July 2021?	SIRO - SIRO to approve training needs analysis report which identifies specialised training requirements. To present TNA report to CCG Board. CCG- To communicate with and encourage the identified staff to ensure specialist training complete	G		Conduct training needs analysis to identify specialist training and present findings to SIRO for approval of analysis and training options. Ensure actions arising from the TNA are monitored through to completion.	G		None.		No Action	No Action	MS - evidence in place: Email sent to SIRO requesting approval (07/02/22) SIRO approval email (08/02/22) Email from Laura to Sara (12/02/22) asking Comms to send out to staff Email from Laura to SMT Members (12/02/22) asking	

Staff pass the data security and protection mandatory test	3.2.1	Have at least 95% of all staff, completed their annual Data Security Awareness Training? Tooltips - Please provide your highest percentage figure for the period 1st July 2021 - 30th June 2022 in the space below with an explanation of how you have calculated the figure.	CCG Board - Ensure that all staff have completed mandatory IG training. The CCG to ensure that non compliant staff are identified and notified to complete training.	G		IG Team to provide approved training on ESR or face-to-face. Update IG training figures and supply compliance figures as part of the bi-monthly reports.	G		None.		No Action	No Action	Board Training took place on 13/10/21 - copy of attendance list from the CCG in evidence folder 95% achieved on 02/11/21 (DSPT Updated) Email from Heather 15/02/22 showing how the CCG reached the 96% compliance figure	
Staff with specialist roles receive data security and protection training suitable to their role	3.3.1	Provide details of any specialist data security and protection training undertaken.	SIRO - Ensure CCG staff attend specialist training if identified as part of their role	G		IG to provide details of specialist training available and undertaken to the CCG.	G		None.	Complete in review folder	G	No Action	MS - Specialist training spreadsheets from September 2021 onwards saved in evidence folder (Comment included on DSPT)	
	3.3.2	The organisation has appropriately-qualified technical cyber security specialist staff and/or service.	CCG Board - CCG ensure IT provider has appropriately qualified technical cyber security specialist staff and/or service.			None.			Certificates of professional qualifications attained by KD, KR and JK.	Certificates of professional qualifications attained by KD, KR and JK	Complete		(DSPT Updated)	
	3.3.3	The organisation has a nominated member of the Cyber Associates Network.	CCG Board - Ensure IT provider has a nominated member of the Cyber Associates Network.			None.			Printscreen of CAN Membership	Printscreen of CAN Membership from Cyber associates	Complete		(DSPT Updated)	
Leaders and board members receive suitable data protection and security training.	3.4.1	Have your SIRO and Caldicott Guardian received appropriate data security and protection training?	CCG Board - CCG to provide dates, content and certs if taken any external specialist training for SIRO and Caldicott Guardian.	G		To deliver face-to-face Specialist Training where agreed with SIRO and Caldicott Guardian.	G		None.		No Action	No Action	MS - SIRO Certificate in evidence folder MS - Caldicott Guardian Certificate in evidence folder DSPT Updated	

		3.4.2	**All** board members have completed appropriate data security and protection training.	CCG to ensure board members complete training annually.	G		Work with CCG to establish if board members want specialised face to face or ESR online training and deliver if face to face agreed.	G		None.		No Action	No Action	MS - Board training took place on 13/10/21 - copy of attendance list from the CCG in evidence folder (DSPT Updated)	
		DELIVERY PLAN					**ASSURANCE**										
Standard	**Assertion**	**Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IG Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**	
4. Managing Data Access	**The organisation maintains a current record of staff and their roles.**	4.1.1	Your organisation maintains a record of staff and their roles.	IG Lead/HR - CCG to inform the IG team how they maintain a record of staff and their roles. Provide the IG team with a copy of their starters and leavers procedure and how these link in to maintaining the staff record accurately.	G		To work with CCG to improve starters and leavers procedure where necessary.	G		None		No Action	No Action	CCG Leavers Process which includes the Leaver Form & Exit Interview Checklist CCGs Organisational Structures Starters & Leavers forms are completed online via the EASY system	
		4.1.2	Does the organisation understand who has access to personal and confidential data through your systems, including any systems which do not support individual logins?	SIRO/IAOs - IAAs and IAOs to provide a list of all systems they use that holds personal and confidential information. IAOs to ensure system questionnaires are completed on all systems. The CCG to undertake a risk assessment of any new			IG team to support and review all system questionnaires and update U Assure appropriately.			IT Provider to support CCG in this assertion.		G		System Level and Access Control Procedure (SLAC) v1 in evidence folder System & Software questionnaires to be identified and reviewed as part of the IAO/IAA Work Programme which is currently ongoing Email from Sara Spencer Report for the shared	

Organisation assures good management and maintenance of identity and access control for it's networks and information systems.	4.2.1	When was the last audit of user accounts held?	SIRO - CCG to formalise it's assurance/audit process and conduct audit to ensure only permitted members of staff have access to systems. SIRO to agree to the scope of the audit. Provide feedback to IT/CCG System Owner to ensure	G		Agree with the SIRO the scope of the audit and produce an audit template to support CCG.	G		AD audits are completed every quarter with the first month as Jan. Cyber team will develop a socialsed version of the audit to CCG/Systems owners for review.	AD audits are completed every quarter. Cyber team will develop a socialsed version of the audit to CCG/Systems owners for review. BAU AD reporting cycle of AD Potential SOP account auding - Investigation on how best to socialise	G		STW Account Audit document provided by MLCSU IT Dated Nov/Dec 2021	
	4.2.4	Are unnecessary user accounts removed or disabled?	IG Lead/HR - Provide the IG team with a copy of the CCGs starters and leavers procedure detailing how unnecessary user accounts are removed or disabled including more than just AD accounts, such as O365 distribution	G		Review the process of starters/leavers, ensuring that change of job role and informing the IT provider is included in the process for removing unnecessary user accounts.	G		IT will remove accounts upon completion of a leavers request form. Evidence is subject to auditor sampling	IT will remove accounts upon completion of a leavers request form. Evidence is subject to auditor sampling Monitoring and Logging Policy developed. Need evidence of logs Awaiting latest leaver list	IT will remove accounts upon completion of a leavers request form. No sample leavers have been provided as this is usually requested from auditors - this can be marked as complete 11/03/22		Leaver Form & Exit Interview Checklist in evidence folder as well as MLCSU User Accountg Management Policy in place (DSPT Updated) STW Account Audit document provided by MLCSU IT MLCSU User Account Managem	
All staff understand that their activities on IT systems will be monitored and recorded for security purposes	4.3.1	All system administrators have signed an agreement which holds them accountable to the highest standards of use.	SIRO/IAOs - CCG to identify if they maintain any systems. If the CCG maintain system/s provide a system administrator accountability statement.	G		None	G		System administrators sign and adhere to the Privileged Access Management form. Sample evidence will be provded.	PAM agreement amended for 2022 as is due for renewal	G		PAM Request Email Template & PAM export saved in evidence folder. Signed PAM Agreements received - saved in evidence folder DSPT Updated	

	4.3.2	Are users, systems and (where appropriate) devices always identified and authenticated prior to being permitted access to information or systems?	IG Lead/SIRO - Request access control Information Systems Policy and evidence from the IT provider that the policy is been followed.	G		None	G		IT Policies due for ratification in March 2022	IT Policies due for ratification in March 2022. Expect ratification before this date. Systems - refer to assest management policy users - Network security policy Group policy documentation Authentication/Access control policy Evidence is subject to auditor sampling	G		MLCSU Network Security Policy and System Level and Access Control Procedure (SLAC) v1 in evidence folder	
You closely manage privileged user access to networks and information systems supporting the essential service.	4.4.2	The organisation does not allow users with wide ranging or extensive system privilege to use their highly privileged accounts for high-risk functions, in particular email and web browsing.	IG Lead/DPO - Request statement and policy from IT provider confirming that it does not allow users with wide ranging or extensive system privilege to use their highly privileged accounts for high-risk functions, in particular reading			None			System administrators sign and adhere to the Privileged Access Management form. Sample evidence will be provded.	System administrators sign and adhere to the Privileged Access Management form. Sample evidence will be provided	G			
You ensure your passwords are suitable for the information you are protecting	4.5.1	Do you have a password policy giving staff advice on managing their passwords?	None	G	G	Review wording within IG Handbook			Password management policy	Reference to Password management policy	G		MS - This is included in the IG Handbook on Page 25 MLCSU Password Management Policy in evidence folder	
	4.5.2	Technical controls enforce password policy and mitigate against password-guessing attacks.	None	No Action	No Action	Review wording within IG Handbook			New assertion - password management policy is applicable along with MFA, account lockouts.	New assertion. Reference password policy and MFA controls. Evidence gathering pending.	G		MS - This is included in the IG Handbook on Page 25 MLCSU Password Management Policy in evidence folder	

		4.5.4	Passwords for highly privileged system accounts, social media accounts and infrastructure components shall be changed from default values and should have high strength.	IG Lead/SIRO - CCG evidence that highly privileged system accounts, social media accounts and infrastructure components are changed from default values.	G	G	None	No Action	No Action	Evidence of MLCSU password management policy and standards within domain.	Evidence of MLCSU password management policy and standards within domain	G		MLCSU Password Management Policy in evidence folder	

			DELIVERY PLAN					ASSURANCE								
Standard	**Assertion**	**Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IG Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**	
5. Process Reviews	**Process reviews are held at least once per year where data security is put at risk and following data security incidents**	5.1.1	Root cause analysis is conducted routinely as a key part of your lessons learned activities following a data security or protection incident, with findings acted upon.	IG Lead/DPO - To provide evidence that the breach SOP is followed and investigations, RCAs and Actions are completed including by IT Provider.	G		To support the CCG in breach management and recording outcomes. Maintain and review breach trend spreadhsheet, conducting further investigation as required.	G		IT RCA's should be completed and shared with CCG.	RCA will be reviewed and shared with CCG	G		MS - IG Team have reviewed the CCGs Breach Reporting SOP and this has been approved by the SIRO on 13/12/21. The CCG will take this to the IG Committee on 17/01/22 for formal approval MLCSU Breach Reporting SOP in CCGs evidence folder	

			DELIVERY PLAN					ASSURANCE								
Standard	**Assertion**	**Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IG Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**	
6. Responding to Incidents	**A confidential system for reporting data security and protection breaches and near misses is in place and actively used**	6.1.1	A policy/procedure is in place to ensure data security and protection incidents are managed/reported appropriately.	IG Lead - To work with the CSU to refine the localised breach SOP. To work with the IT Provider to a ensure that a policy/procedure is in place to ensure data IT security and protection incidents are managed/reported appropri	G		To work with the CCG to refine the localised breach SOP if required.			IT Provider to support CCG in this assertion.	Evidence will reference incident management process and network security policy. Both are due for review and renewal Cyber evidence will reference incident management process and network security policy.	G			

	6.1.3	Is the board or equivalent notified of the action plan for all data security and protection breaches?	CCG Board - CCG to ensure their breach management SOP outlines the flow of the incident from point of breach to notifying the Board. CCG Board - CCG to provide minutes of meetings where action plans have	G		To support the CCG in ensuring breach management SOP outlines the flow of the incident from point of breach to notifying the Board. Ensure IG incidents are reported via bi-monthly reports.	G		IT Provider to support CCG in this assertion by reporting on incidents and action plan to the CCG.		No Action	No Action	MS - IG Team have reviewed the CCGs Breach Reporting SOP and this has been approved by the SIRO on 13/12/21. The CCG will take this to the IG Committee on 17/01/22 for formal approval Bi monthly reports record breaches for the CCG which go	
	6.1.4.	Individuals affected by a breach are appropriately informed.	CCG Board - CCG to ensure their breach management SOP outlines the flow of the incident from point of breach to notifying the Board. Caldicott Guardian - to record breach incidents and outcomes on Caldicott log and	G		To support with the completion of Caldicott Log	G		None		No Action	No Action	MS - IG Team have reviewed the CCGs Breach Reporting SOP and this has been approved by the SIRO on 13/12/21. The CCG will take this to the IG Committee on 17/01/22 for formal approval Bi monthly reports record breaches for the CCG which go	
All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway	6.2.1	Has antivirus/anti-malware software been installed on all computers that are connected to or capable of connecting to the Internet?	CCG Board - CCG to request the evidence from the IT provider that anti-virus or malware protection software been installed on all computers that are connected to or capable of connecting to the Internet. CCG obtain regular reports	G		None	No Action	No Action	Device export of each asset and their AV status. Subject to sampling by an auditor where we need to export a full build. Also include confirmed and approved base images	Fall's within the Cyber teams reporting cycle - need to export evidence The assertion is met however, MLCSU IT need to collate evidence for assurance.	G		Cathy updated DSPT	

	6.2.3	Antivirus/anti-malware is kept continually up to date.	CCG Board - CCG to request the evidence from the IT provider that anti-malware and Anti-Virus is kept continually up to date. Obtain regular reports from the IT provider.	G		None	No Action	No Action	See 6.2.1	Fall's within the Cyber teams reporting cycle - need to export evidence The assertion is met however, MLCSU IT need to collate evidence for assurance.	G		Cathy updated DSPT	
	6.2.8	You have implemented on your email, Domain-based Message Authentication Reporting and Conformance (DMARC), Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) for your organisation's domains to make email spoofing difficult.	Not applicable if NHS mail in use. DMARC features are provided by default by NHS Mail. IG Lead/SIRO - If the CCG uses an alternative email domain other than NHS mail request assurance that the email system in use			None	No Action	No Action	IT Provider to support CCG in this assertion. Not applicable if NHS mail in use.	Exempt	Exempt		(DSPT Updated)	
	6.2.9	You have implemented spam and malware filtering, and enforce DMARC on inbound email.	Not applicable if NHS mail in use. DMARC features are provided by default by NHS Mail. If the CCG uses an alternative email domain other than NHS mail request assurance that the IT provider have implemented			None	No Action	No Action	IT Provider to support CCG in this assertion. Not applicable if NHS mail in use.	Exempt	Exempt		(DSPT Updated)	

Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses	6.3.1	If you have had a data security incident, was it caused by a known vulnerability?	CCG Board - CCG to request regular updates from the IT provider with assurance that any known vulnerabilities have been acted upon following a data security incident, and if it was caused by a known vulnerability.			None	No Action	No Action	Use PrintNightmare attack - response and remidation - as evidence	PrintNightmare example in review folder	G			
	6.3.2	The organisation acknowledges all 'high severity' cyber alerts within 48 hours using the respond to an NHS cyber alert service.	CCG Board - CCG to request regular updates from the IT provider with assurance that any known vulnerabilities have been acted upon following high severity CareCERT alerts within 48 hours over the last twelve months.			None	No Action	No Action	High severity and CareCERT process documentation along with remidation examples (subject to sampling)	High severity and CareCERT process documentation along with remidation examples (subject to sampling) New process complete	G			
	6.3.3	The organisation has a proportionate monitoring solution to detect cyber events on systems and services.	CCG Board - CCG to request regular updates from the IT provider with assurance that any known vulnerabilities have been acted upon and the organisation has a proportionate monitoring solution to detect cyber events on			None	No Action	No Action	Documented overview of monitoring solutions used and managed by MLCSU IT and Cyber.	Documented overview of monitoring solutions used and managed by MLCSU IT and Cyber. Complete	G		(DSPT Updated)	

		6.3.4	Are all new digital services that are attractive to cyber criminals (such as for fraud) implementing transactional monitoring techniques from the outset?	SIRO - CCG to provide statement confirming that all new Digital services that are attractive to cyber criminals for the purposes of fraud, implementing transactional monitoring techniques from the outset.	G		None	G	No Action	Statement of assurance from JU	Statement of assurance from JU and/or Head of IT services No known services	G		Acknowledgement of CSU IT Statement received from Claire Skidmore (SIRO) 07.03.22 **Cathy updated DSPT**	
		DELIVERY PLAN						**ASSURANCE**									
Standard	**Assertion**	**Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IC Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**	
7. Continuity Planning	**Organisations have a defined, planned and communicated response to Data security incidents that impact sensitive information or key operational services**	7.1.1	Your organisation understands the health and care services it provides.	IG Lead/BC Lead - Identify CCGs operational services along with key dependencies for each service and ensure these are referenced in CCG BCP. Request evidence of BCP from IT provider.	G		None	G	No Action	IT Provider to support CCG in this assertion.		G	No Action	Updated Business Continuity Plan received from Laura Clare - approved at Audit Committee 17/11/21. Saved in evidence folder MLCSU IT Disaster Recovery & Prevention Policy saved in evidence folder (DSPT Updated with Review	
		7.1.2	Do you have well defined processes in place to ensure the continuity of services in the event of a data security incident, failure or compromise?	IG Lead - provide the CCGs BCP which includes processes to ensure continuity in event of data security incidents. Request evidence of a BCP that includes data security incidents from the IT provider and the details of testing and	G		None	G	No Action	IT Provider to support CCG in this assertion.		G		Updated Business Continuity Plan received from Laura Clare - approved at Audit Committee 17/11/21. Saved in evidence folder MLCSU IT Disaster Recovery & Prevention Policy saved in evidence folder (DSPT Updated with Review	

There is an effective test of the continuity plan and disaster recovery plan for data security incidents.	7.2.1	Explain how your data security incident response and management plan has been tested to ensure all parties understand their roles and responsibilities as part of the plan.	IG Lead/BC Lead - CCG confirm that an incident response and management plan is in place. IG Lead/BC Lead - CCG to request assurance that 'live' and testing exercises have been conducted to validate the efficacy of data	G		Support CCG in obtaining evidence of BCP testing and response.	G	BAU	Sample evidence from business continuity exercises, incident response management, incident management process and PrintNightmare	Sample evidence from business continuity exercises, incident response management, incident management process and PrintNightmare Complete for MLCSU IT	G		Updated Business Continuity Plan received from Laura Clare - approved at Audit Committee 17/11/21. Saved in evidence folder (DSPT Updated with Review Date - October 2022) Evidence in place as follows: STW Business Continuity Plan 17.11.21	
	7.2.2	From the business continuity exercise, explain what issues and actions were documented, with names of actionees listed against each item.	IG Lead/BC Lead - CCG to confirm completion of table top exercises, how issues and actions were reported, and what actions had been taken to mitigate anomalies. Confirm with who the responsibility sits and the reporting structure.	G		None.	G	No Action	As above - incident response plan will be socialised	As above - incident response plan will be socialised. MLCSU are currently working with Gemserv to discuss BCE options for next year.	G		Updated Business Continuity Plan received from Laura Clare - approved at Audit Committee 17/11/21. Saved in evidence folder Evidence in place as follows: STW Business Continuity Plan 17.11.21 Cyber Minimum Standard #1 2021_11_18 Cyber	
You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions.	7.3.1	On discovery of an incident, mitigating measures shall be assessed and applied at the earliest opportunity, drawing on expert advice where necessary.	SIRO - Review the organisation's data security incident response plan and determine if it includes how technical (in-house or third party) resources would be deployed during an incident. Review the IT providers Data Security Incident	G		None.	G	No Action	High severity CareCERT evidence pertaining to mitigation	Cyber team to submit High severity CareCERT evidence pertaining to mitigation PrintNightmare	G			

7.3.2	All emergency contacts are kept securely, in hardcopy and are up-to-date.	IG Lead/BC Lead - Provide evidence as to where hardcopy emergency contacts including IT are stored, how regularly updated (document has version control), how do staff know how to access them. This should form part of the	G		None.	G	No Action	SMT IT On call rota evidence	SMT IT on call rota evidence obtained	G		Narrative remains the same as last year as confirmed by Laura Clare 20/12/21. Email saved in CCG evidence folder (DSPT Updated)	
7.3.4	Suitable backups of all important data and information needed to recover the essential service are made, tested, documented and routinely reviewed.	IG Lead/BC Lead - Request evidence of backup policy/procedure and evidence of this being tested from IT provider The CCG should review / approve backup policy, and confirm:- a) methodology (3-2-1 copies) b) alignmen	G		None	G	No Action	IT Provider to support CCG in this assertion. Back up policy should include include the following: • Details on how often the organisation backs up its most important data. • How long back-ups are stored for. • Steps that would be taken if the organisation has to	Pending review of procedure, agreements and restoration cycles. Evidence will demonstrate compliance and assurance with data and information appropriately being backed up. Currently engaging with 3rd parties and IT team Currently	G		Backup Process detailing how backups are made, tested, documented and routinely reviewed. MLCSU IT are primarily responsible for IT services, such as IT systems, infrastructure and AD. Please refer to associated evidence.	
7.3.5	Do you test your backups regularly to ensure you can restore the service from a backup?	IG Lead - Request evidence of date of last restore from backup and last disaster recovery date from IT Provider. Ensure reports are made available on a regular basis. Link to be made with CCG and IT provider.	G		None	G	No Action	Backup restoration procedure VM Restore example Backyp report (physical) Daily server reports	As above Due 30/30/22 Evidence is currently being collated as verbal update	G		Backup Process detailing how backups are made, tested, documented and routinely reviewed. Please refer to associated evidence for testing scheduling and restorations.	

		7.3.6	Are your backups kept securely and separate from your network ('offline'), or in a cloud service designed for this purpose?	IG Lead - Request date of last restore from IT provider. Provided evidence of any CCG specific backups. Ensure reports are made available on a regular basis. Link to be made with CCG and IT provider.	G		None	G	No Action	IT Provider to support CCG in this assertion.	As 7.3.4 Due 30/30/22 All client evidence is assessed as Amber. We need to create evidence.	G		STW: Verbal evidence: All offline backup media is stored in secondary location, away from the central infrastructure at William Farr House 11/03/22 **DSPT Updated**	
		DELIVERY PLAN					**ASSURANCE**										
Standard	**Assertion**	**Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IT Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**	
8. Unsupported Systems	**All software and hardware has been surveyed to understand if it is supported and up to date.**	8.1.1	Provide evidence of how the organisation tracks and records all software assets and their configuration.	SIRO/ IAO's - IAAs and IAOs to add software assets to Uassure and complete systems and software questionnaire.	G		Support IAAs and IAOs in adding software assets to Uassure and completing systems and software questionnaire.	G		IT to provide evidence and exports from IT Health and Certero in reference to installed applications on endpoints.	Supporting IG where necessary. Last year, IT submitted instances of installed applications but does not have visibility of IAOs congifs	G		MS Evidence in place: Screenshots of STW Systems & Software Register from UAssure Information Software Asset List – Export from UAssure Teammate Systems & Software Questionnaire MLCSU IT Asset Managem	
		8.1.2	Does the organisation track and record all end user devices and removable media assets?	IG Lead/SIRO - CCG to provide a list of end users and removable media assets.	G		None	G		Port management rules and controls set within Sophos. Evidence export of monitoring can be provded.	Port management rules and controls set within Sophos. Evidence export of monitoring can be provided. Awaiting latest export	G		**Cathy updated DSPT**	

		8.1.3	Devices that are running out-of-date unsupported software and no longer receive security updates (patches) are removed from the network, or the software in question is uninstalled. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted and signed off by the SIRO.	IG Lead/SIRO - CCG to request a list of unsupported software in criticality /risk order, including which devices are affected, risk assessment of the software and remediation plan. SIRO - SIRO to acknowledge the risks of any	G		None	G		New assertion. Further investigation is needed in determining best approach	New assertion. Further investigation is needed in determining best approach in providing assurance. Yet to run a report in IT Health and MDE All client endpoints and servers are updates/patched - evidence required for assurance.	All client endpoints and servers are updates/patched - evidence required for assurance. Percentage of endpoints patched January onwards: 91% Percentage of servers patched January onwards: 93% No known unsupported software		Acknowledgement of CSU IT Statement received from Claire Skidmore (SIRO) 12.03.22 **Cathy updated DSPT**	
	Unsupported software and hardware is categorised and documented, and data security risks are identified and managed.	8.2.1	List any unsupported software prioritised according to business risk, with remediation plan against each item.	IG Lead/SIRO - CCG to request a list of unsupported software in criticality /risk order, including which devices are affected, risk assessment of the software and remediation plan.			None	No Action	No Action	Annual and quarterly pentesting remidation plan used to supported prioritisation of unsupported systems. The use of MDE and IT Health (NDR) to identify unsupported systems and their CVE scores.	Annual and quarterly pentesting remidation plan used to supported prioritisation of unsupported systems. The use of MDE and IT Health (NDR) to identify unsupported systems and their CVE scores. Confirming if applicable No evidence	G		Following from the annual penetration test, remediation activities were agreed for unveiled vulnerabilities and unsupported software. In addition, using MDE and the associated CVE/CVVS scores, MLCSU report monthly on the top 5 vulnerabilities in	
		8.2.2	The SIRO confirms that the risks of using unsupported systems are being managed and the scale of unsupported software is reported to your board along with the plans to address.	SIRO - SIRO request information on on the risks of any unsupported software and decide whether the risks are to be treated or tolerated.	G		To add summary to SIRO report.	G		Previous evidence was an email of assurance. MLCSU IT and Cyber to refresh evidence.	Previous evidence was an email of assurance. MLCSU IT and Cyber to refresh evidence Cyber to request statement of assurance from SIRO Please refer to CareCERT examples. We are currently documenting examples.	G		Acknowledgement of CSU IT Statement received from Claire Skidmore (SIRO) 12/03/22	

Supported systems are kept up-to-date with the latest security patches.	8.3.1	How do your systems receive updates and how often?	IG Lead/SIRO - Request regular patching update reports from IT provider. Ensure assurances are made available by IT. Link to be made with CCG and IT provider.			None	No Action	No Action	Evidence can refer to MLCSU IT Vulnerability Management policy SCCM Update Cycle Overvirew, Server & Client updates and reporting and ATP reports	Evidence refer to MLCSU IT Vulnerability Management policy SCCM Update Cycle Overvirew, Server & Client updates and reporting and ATP reports. Cyber to estalbish a new SOP alongside IT Currently reviewing process for new SOP	Please refer to the MLCSU IT Vulnerability Management Policy and CareCERT process. Updates are pushed via SCCM, Certero and WSUS. Please see narrative for 8.3.2 as it relates 11/03/22			
	8.3.2	How often, in days, is automatic patching typically being pushed out to remote endpoints?	IG Lead/SIRO - Request patching policy from IT provider and statement of number of days between waves of patching. Ensure assurances are made available by IT. Link to be made with CCG and IT provider.			None	No Action	No Action	As above	As above Please refer to the MLCSU IT Vulnerability Management Policy and CareCERT process. We will document before/after examples	G		Please refer to the Patching SOP and MLCSU IT Vulnerability Management Policy associated to this assertion. We endeavour to deploy critical security patches within 14 days of its release. Patches are tested on a secure environment to ensure compatibil	
	8.3.3	There is a documented approach to applying security updates (patches) agreed by the SIRO.	IG Lead/SIRO - Request patching policy from IT provider. SIRO to approve patching policy or provide minutes of meeting where CCG have approved. Ensure assurances are made available by IT. Link to be made with CCG			None	No Action	No Action	Please refer to MLCSU IT Vulnerability Management Policy (ratification due March 2022)	Please refer to MLCSU IT Vulnerability Management Policy (ratification due March 2022) Last DSPT evidence is sufficient, however we are currently reviewing the evidence to ensure it is fit for purpose.	G		Approach is detailed in the MLCSU IT Vulnerability Management Policy, ratified by the IGRM (SIRO included). The detail is provided by infrastructure managers and MLCSU Cyber based on the NCSC and DSPT guidelines of best practice	

		8.3.4	Where a security patch has been classed as critical or high-risk vulnerability it is applied within 14 days, or the risk has been assessed, documented, accepted and signed off by the SIRO with an auditor agreeing a robust risk management process has been applied.	IG Lead/SIRO - Request patching policy from IT provider. SIRO to approve patching policy or minutes of meeting where CCG have approved. Link to be made with IT provider. CCG need to be assured that NHS Cyber Alerts			None	No Action	No Action	Please refer to High severity and CareCERT process documentation	Please refer to High severity and CareCERT process documentation	G		Details can be found in 8.3.4 MLCSU Process for dealing with High Severity CareCERT Alerts 2.0. CareCERTS that have taken over 14days include: Printnightmare, Log4J and HTTP stack. Regular reports are generated to monitor progress. (DSPT	
	You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service	8.4.1	Is all your infrastructure protected from common cyber-attacks through secure configuration and patching?	IG Lead/SIRO - Request standard operating procedure for secure configuration and patching including risk assessments. Link to be made with IT provider. CCG need to be assured on risks.			None.			Evidence will be obtained from pentesting reports and that state of patching (CVE completion) to date. Evidence in this nature will primarily be obtained by MDE and IT Health.	Evidence will be obtained from pentesting reports and that state of patching (CVE completion) to date. Evidence in this nature will primarily be obtained by MDE and IT Health. Currently reviewing process for new SOP Evidence needed for assurance	Please refer to 8.3.3 for our monitoring of services 11/03/22			
		8.4.2	All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support.	IG Lead/SIRO - Receive patching reports from IT provider.	G		None	G	No Action	Similar to above	Similar to above however we have established a reporting cycle against this New report needed after 8.3.1 and 8.4.1 Evidence needed for assurance	G		MLCSU IT endeavour to patch OS and software packages regularly. Lansweeper and MDE highlights Windows devices that are unpatched over 30, 60 and 90 days. Please see 8.4.2 evidence as current patching overview	
			DELIVERY PLAN					**ASSURANCE**									
Standard	**Assertion**	**Evidence ref**	**2021/22 Evidence**	**Action Required by CCG**	**RAG CCG**	**RAG ICB**	**Action Required by MLCSU IG Team**	**RAG CCG**	**RAG ICB**	**Action Required by IT**	**Updates from IT**	**Timescale IT**	**Timescale ICB**	**Comments**			
9. IT Protection	**All networking components have had their default passwords changed.**	9.1.1	The Head of IT, or equivalent role, confirms all networking components have had their default passwords changed to a high strength password.	IG Lead - Request password statement evidence from IT provider.	G		None	No-Action	No-Action	Evidence as email of assurance from heads of service	Evidence as email of assurance from heads of service	G					

	9.1.2	The Head of IT, or equivalent role, confirms all organisational devices have had their default passwords changed.	IG Lead/SIRO - Request password statement evidence from IT provider.	G		None	No-Action	No-Action	See 9.1.1	See 9.1.1	G			
A penetration test has been scoped and undertaken	9.2.1	Annual IT penetration testing is scoped through negotiation between the SIRO, business and testing team, and includes a vulnerability scan and a check that all networking components have had their default passwords changed.	SIRO - SIRO to be involved with and confirm and agree scope of penetration test with IT provider. SIRO to receive results. IG Lead/SIRO - Ensure that evidence is documented of SIRO discussion and approval of any testing. It	G		None	No-Action	No-Action	MLCSU IT and Cyber commit to quarterly Pentesting cycles with L-HIS and an annual Pentestration test with Dionach. Security Spec and sign-off to be socialised and provided as evidence.	Pentest is currently ongoing. Remidation plan pending, JU is aware Complete however we are currently documenting evidence that is appropraite for this assertion.	G			
	9.2.2	The date the penetration test was undertaken.	IG Lead/SIRO - Request confirmation of penetration test date from IT Provider. IG Lead/SIRO - Actions arising from pen tests should be monitored and followed through with risks mitigated	G	G	None	No-Action	No-Action	IT Provider to support CCG in this assertion.	See 9.2.1	G	TBC	PEN Test 15th February 2022	
Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities.	9.3.1	All web applications are protected and not susceptible to common security vulnerabilities, such as described in the top ten Open Web Application Security Project (OWASP) vulnerabilities.	IG Lead/SIRO - Request report from IT provider to confirm web applications are protected.	G		None	No-Action	No-Action	Evidence will include OWAPS framework email from Apps development lead and Secure Software Development Policy	Evidence will include OWAPS framework email from Apps development lead and Secure Software Development Policy Awaiting latest web check from App Dev team Not all websites are managed by MLCSU.	G	BAU		

	9.3.3	The organisation uses the UK Public Sector DNS service, or equivalent protective DNS service, to resolve Internet DNS queries.	IG Lead/SIRO - Request evidence showing use of UK Public Sector DNS Service to resolve internet DNS query items from IT provider.	G		None	No-Action	No-Action	Already in place - IT to provide evidence of assurance	Already in place - IT to provide evidence of assurance	G			
	9.3.4	The organisation ensures that changes to its authoritative DNS entries can only be made by strongly authenticated and authorised administrators.	IG Lead/SIRO - Request from IT provider evidence that changes can only be made by Domain Administrators.	G		None	No-Action	No-Action	Already in place - IT to provide evidence of assurance	Already in place - IT to provide evidence of assurance	G			
	9.3.5	The organisation understands and records all IP ranges in use across the organisation.	IG Lead/SIRO - Request evidence from IT provider of recording of IP addresses.	G		None	No-Action	No-Action	Already in place - IT to provide evidence of assurance	Already in place - IT to provide evidence of assurance	G			
	9.3.6	The organisation is protecting it's data in transit (including email) using well-configured TLS v1.2 or better.	IG Lead/SIRO - Request evidence items from IT provider confirming protecting data in transit.	G		None	No-Action	No-Action	Already in place - IT to provide evidence of assurance	Already in place - IT to provide evidence of assurance	G			
	9.3.7	The organisation has registered and uses the National Cyber Security Centre (NCSC) Web Check service, or equivalent web check service, for its publicly-visible applications.	IG Lead/SIRO - Request evidence items from IT provider of National Cyber registration for the CCG.	G		None	No-Action	No-Action	Complete NCSC web check service to serve as evidence	Complete NCSC web check service to serve as evidence Awaiting latest web check from App Dev team	G			
You have demonstrable confidence in the effectiveness of the security of your technology, people, and processes relevant to essential services.	9.4.4	Security deficiencies uncovered by assurance activities are assessed, prioritised and remedied when necessary in a timely and effective way.	IG Lead / SIRO Request report from IT provider regarding NHS Digital alerts actions.	G		None	No-Action	No-Action	Use pentesting remdiation plan as evidence	See 9.2.1	G			
	9.4.5	What level of assurance (overall risk rating & confidence level rating) did the independent audit of your Data Security and Protection Toolkit provide to your organisation?	IG Lead/ SIRO - Provide the IG Team with scope and timing of the audit as soon as agreed with internal auditors.	N/A	N/A	Support the CCG with audit of the DSPT.	N/A	N/A	N/A		N/A	N/A	Voluntary not required for CCGs this toolkit NHSD Presentation Slide 17 & Screensh ot saved into evidence folder DSPT Updated	

You securely configure the network and information systems that support the delivery of essential services.	9.5.1	All devices in your organisation have technical controls that manage the installation of software on the device.	IT Lead - To supply copy of Nessus report IG Lead / SIRO - If the CCG holds devices that are not controlled by the IT provider submit technical controls to manage software installation.	G		None	G	No-Action	Liaise with infrastrcuture managers to confirm installation procedures and AD settings to prevent unwanted and unapproved installations	Changed/ new assertion Liaise with infrastrcuture managers to confirm installation procedures and AD settings to prevent unwanted and unapproved installations No evidence to date Currently collating evidence appropriate for this assertion	G		Installation of software on devices is limited to those with administration rights only. UAC prevents installations, staff will need to request installation via the Incident Management process or if it is a new system, complete a Change request which will be reviewed by the CAB.	
	9.5.2	Confirm all data are encrypted at rest on all mobile devices and removable media and you have the ability to remotely wipe and/or revoke access from an end user device.	IG Lead/ SIRO - Request evidence from IT Provider regarding encrypted at rest on all mobile devices.	G		None	G	No-Action	Evidence from MDM service in reference to enterprise featrures such as remote wipe and encryption.	Evidence from MDM service in reference to enterprise features such as remote wipe and encryption. Cyber to take screenshots of MDE system	G		Mobile Configuration Guide in evidence folder The CCG follows the NHSmail configuration guidance when setting up mobile phones end users. Laptops are supplied by CSU IT – encryption at rest is on these. Mobile phones all have mobile device managem	
	9.5.9	You have a plan for protecting devices that are natively unable to connect to the Internet, and the risk has been assessed, documented, accepted and signed off by the SIRO.	IG Lead / SIRO - Request evidence of policy/plan in place for protecting networked connected IT equipment from IT provider.	G		None	G	No-Action	IT to provide Statement of assurance and incident management process	IT to provide Statement of assurance and incident management process Further work required New statement of assurance needed Further investigation required. Statement of assurance needs renewing.	G		MLCSU confirm that there are no known devices connected to the domain that are natively unable to connect to the internet. Devices of this nature will undergo a risk assessment and testing via the MLCSU Incident Management Process.	
The organisation is protected by a well managed firewall	9.6.1	Have one or more firewalls (or similar network device) been installed on all the boundaries of the organisation's internal network(s)?	IG Lead/ SIRO - Request evidence of confirmation of firewalls in place and screenshot from IT provider.	G		None	No-Action	No-Action	Evidence to include network diagram/topologies	Refresh evidence of network diagram and topologies	G			

DELIVERY PLAN							ASSURANCE								
Standard	Assertion	Evidence ref	2021/22 Evidence	Action Required by CCG	RAG CCG	RAG ICB	Action Required by MLCSU IG Team	RAG CCG	RAG ICB	Action Required by IT	Updates from IT	Timescale IT	Timescale ICB	Comments	
10. Accountable Suppliers	**The organisation can name its suppliers, the products and services they deliver and the contract durations**	10.1.1	The organisation has a list of its suppliers that handle personal information, the products and services they deliver, their contact details and the contract duration.	IG lead - Provide supplier management policy/process and list of IT suppliers that process personal data which includes services they deliver, contact details and the contract duration.	G		None.	G	No Action	Update Supplier contract spreadsheet as documented by Mark Westbury	Update Supplier contract spreadsheet as documented by Mark Westbury New evidence pending Requested update from IT Contracts Manager	G		Copy of IT Contracts 21-22 CCG IT software suppliers in evidence folder MLCSU IT PAM Request Email Template & PAM export in evidence folder	
	Basic due diligence has been undertaken against each supplier that handles personal information in accordance with ICO and NHS Digital guidance.	10.2.1	Your organisation ensures that any supplier of IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification.	IG Lead/SIRO - Provide evidence of IT supplier accreditations/certifications. IG Lead/SIRO - Formal process/guidance/due dilligence to be put in place for CCGS to assess suppliers certifications/accreditations.	G		Support with procurement evaluation process.	G		IT to confirm accreditations help by suppliers, such as CE, Tiger accrediation by LHIS and other parties	IT to confirm accreditations help by suppliers, such as CE, Tiger accrediation by LHIS and other parties Cyber Essentials Certificate in IT Evidence Folder	G		Cyber Essentials Certificate in IT Evidence Folder MS - Evidence moved over from last year as advised by Cathy & saved into CCG Evidence Folder	
		10.2.4	Where services are outsourced (for example by use of cloud infrastructure or services), the organisation understands and accurately records which security related responsibilities remain with the organisation and which are the supplier's responsibility.	IG Lead - Provide copies of any contracts with cloud outsourced services provider to MLCSU IG if applicable. IG Lead/SIRO - Assurance and procurement process with suppliers to be strengthened and reviewed	G		Provide due diligence on contracts where services are outsourced to ensure they accurately record security responsibilities. Support with procurement evaluation process.	G	No Action	IT Provider to support CCG in this assertion. Review the IT procurement policy (or similar) and determine if there is a requirement to document the roles and responsibilities for both parties under the relationship, particularly for technical	IT Provider to support CCG in this assertion. Review the IT procurement policy (or similar) and determine if there is a requirement to document the roles and responsibilities for both parties under the relationship, particularly for technical	G		Cathy advised this is complete MS to move evidence over - use last years not changed	

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BI

6.0. ODS RECONFIGURATION TOOLKIT

V2	The current codes used to identify STPs will be changed to identify ICBs.
V3	
V4	The ODS Reconfiguration Toolkit has been reviewed and released previously. Pleas

Please Note: this document does not contain an exhaustive list of impacts, actions or people. CCGs will need to consider fully their

Purpose of this form

Some key systems, services and reporting functions known to be impacted by ODS changes are listed below, but note this is not an impacted by a boundary change) or names within, via their own internal impact assessment. A recommended approach towards an removed or additional impacts identified added at your discretion.

No New ODS codes will be issued and Shropshire and Telford and Wrekin CCG/STP will be automatically be renamed in line with the changes below.

Integrated Care Boards (ICBs)

Current active STP codes will be renamed

A new organisation name suffix will be shown as ‘Integrated Care Board’ - e.g. 'NHS Devon Integrated Care Board'

All 42 STP codes will be retained and will remain legally active within the data infrastructure (no end dates will be applied)

The primary role against STP codes will remain unchanged, this is ‘Strategic Partnership’

Non Primary Roles

The non primary role against the 42 STP codes currently ('Sustainability and Transformation Partnership') will be end dated 31/03/2022

A new non primary role will be applied to all 42 codes, start dated 01/04/2022, to denote the point at which they became a legal entity

The new non primary role name will be '**Integrated Care Board**'

All entities currently linked to or from an STP code in ODS data will remain unchanged in the transition year (apart from those impacted by ICB Boundary changes)

Clinical Commissioning Groups (CCGs)

Renaming

Current active CCGs will be renamed

The current CCG ODS code will be displayed in the Sub ICB location name to represent the geographic area - e.g. "15N" represents Devon CCG

Using Devon as an example, the renaming will result in the following, Sub ICB Location Name: "NHS Devon ICB" and the current ODS CCG code "15N".

e.g. NHS Devon ICB - 15N.

No end dates will be applied to CCG codes during transition year 2022/23.

ODS has two concepts of organisation start/end dates - a legal view and an operational view. All current CCG codes will remain 'legally' and 'operationally' open in ODS data due to wider NHS system constraints/implications.

Non Primary Roles

A new non primary role will be applied to all active CCG codes, start dated 01/04/2022

The new non primary role name will be 'Sub ICB Location'.

The primary role (organisation type) will remain unchanged e.g. Clinical Commissioning Group (RO99)

All active Commissioning Hub codes will remain unchanged during transition year (currently coded as a CCG entity with a Commissioning Hub non primary role)

All entities currently linked to or from a CCG in ODS data will remain unchanged in the transition year (apart from those impacted by the ICB Boundary changes)

This will mean it automatically change from

CCG Code	CCG Name
M2L0M	NHS SHROPSHIRE, TELFORD AND WREKIN CCG

To

Sub ICB Location ODS Code	Sub ICB Location Name
M2L0M	NHS SHROPSHIRE, TELFORD AND WREKIN ICB - M2L0M

LL THROUGH PARLIAM

e follow the link below to the Fut
own uses for ODS codes.

exhaustive list. Organisatio
impact assessment can be

CCG Non-Primary Role Name and Code	STP Code
N/A	QOC

Sub ICB Location Non-Primary Role	ICB Code
SUB ICB LOC	QOC

ENT

ure NHS Platform:

ns affected by an organisational change must identify all systems, services and reporting platforms they utilise their current CCG codes (whe
found on the IA tab. This Reconfiguration Checklist tab may be used as a 'starting point' for identifying impacted areas; i.e. non-impacted are

Pre April 2022
STP Name
SHROPSHIRE AND TELFORD AND WREKIN STP

From April 2022
Integrated Care Board Name
NHS SHROPSHIRE, TELFORD AND WREKIN INTEGRATED CARE BOARD

ere a CCG is
eas may be

n-Primary Role Name ar	NHSE Region Code	E Region N
SUSTAINABILITY AND T	Y60	MIDLANDS COMMISSIONING REGION

ICB Non-Primary Role	Region Code	Region Name
INTEGRATED CARE BO	Y60	MIDLANDS COMMISSIONING REGION

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

7.0 QUALITY DILIGENCE CHECKLIST - ICB SET UP

The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. This tab builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.

V4

7.1 Strategic Quality - approach to maintaining quality during the transition and improving quality following the establishment of the ICB		CCG Close	ICB Set Up	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	Rag Rating	Comments	Risk	Mitigating Action/Comment	Risk RAG Rating
7.1.1	Identify the nominated executive lead for quality within the ICS		Yes	Simon Whitehouse	11/11/2021	31/2/22		Green	The Chief Nurse is the nominated lead. A susbstantive appointment has been made from June 2022.		Appointment to CNO post has been made	Very low
7.1.2	Develop a clear and credible strategy for improving quality (experience, safety and effectiveness) and reducing unwarranted variation and inequalities. This includes details on transformation and embedding of cultures to empower staff and enable sustained improvement.		Yes	Zena Young	11/11/2021	31/2/22	Jul-22	Green	We have an ICS Quality Strategy, approved by the ICS Board in June 2021. System partners have contributed to developing this and it is currently undergoing refresh in light of changing guidance and our emerging approach to system governance. It includes Quality Improvement capability and capacity. The draft is to be presented at teh System Quality Group 04/05/22		The actions relating to requirement are built into our forward quality governance plan (Quality Roadmap).	Very low
7.1.3	Ensure a defined governance and escalation process is established for quality which ensures that risks are identified, mitigated and escalated effectively through System Quality Groups (SQG) and links to Regional NHSEI quality oversight and reports to the ICB. This will link to the broader ICS risk management strategy, policy and procedures (see 3.1.13). The System Quality Group will serve as, or align with any Quality Committee (see 1.3.24).		Yes	Zena Young			Jun-22	Green	In accordance with National Quality Board (NQB) and NHSEI published guidance, we have set up our local quality governance, implementing a structure and function in accordance with the needs of our system. We are awaiting a further NQB publication which will inform the approach to Place-based quality governance. As part of our emergent system-level governance arrangements, we are reviewing how risks to quality are captured, escalated and managed effectively to ensure that our future system risk arrangements reflect our development as an ICS. We are awaiting the NQB guidance on risk escalation and will adopt this when published. We do not yet have a complete shared view of system quality risks, however providers publication of their Quality Accounts by the end of June 22 will inform this work. The system approach to risk appetite needs to be confirmed along with consideration of adopting a unified risk scoring system / matrix as a number of different ones are in use in the system. The NED chair of the QPC has yet to be announced.		The actions relating to requirement are built into our forward quality governance plan (Quality Roadmap). We are well-placed to adopt the NQB guidance on risk escalation when it is published, which should be in the next few weeks.	Moderate
7.1.4	Agree the SQG (or equivalent name) structure and develop Terms of Reference. The NQB Position Statement [located on FutureNHS] sets out guidance on suggested structure for an SQG and includes: o membership o quoracy arrangements, o guidance on managing conflicts		Yes	Zena Young	11/11/2021	31/03/2022		Green	Completed and embedded. We have received feedback from membership eg CQC that our approach is at an advanced stage and is to be commended.			Very low
7.1.5	Develop a plan to ensure that quality is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence. Includes local quality metrics and national metrics (e.g Quality Toolkit, System Oversight Framework) aligned with section 1.4 of the core checklist.		Yes	Zena Young	11/11/2021	31/03/2022	Jun-22	Green	A task & finish group with system representatives is established to finalise the format and content of reporting requirements to the various quality forums. We have a prototype report which incorporates all of the requirements of the NQB toolkit (the minimum requirement) as well as some localised priority metrics. Metrics at Place are also under development, but do exist at a population health level. Our reporting metrics report format will undergo further development over the next few months. There is system Business Intelligence Support identified for this and good system engagement to progress this work.		The actions relating to requirement are built into our forward quality governance plan (Quality Roadmap). A report is under development and the information feeds are being mapped in. There is system Business Support identified for this.	Low
7.1.6	Agreed way to transfer and systematically store and retain legacy information (following Caldicott principles) [note that this links to section 1.4.19 of the core checklist]	Yes	Yes	Zena Young	11/11/2021	31/03/2022		Green	The data cleanse exercise, securing, transfer and storing of records is completed		This is expected to be completed by the requested timeline. Migration of information storage planned for 20/04/22	Very low
7.2 Operational Quality - Ensure the ICB recognises its statutory duties for quality, setting up systems and processes to enable effective delivery and oversight (where relevant) of:		**CCG Close**	**ICB Set Up**	**Person Responsible**	**Start Date**	**End Date**	**New ICB Timeline Due Date**	**Rag Rating**	**Comments**	**Risk**	**Mitigating Action/Comment**	**Risk RAG Rating**
7.2.1	**Quality Systems and Assurance:** Independent Investigations (including Mental Health Homicides); Regulation 28 reports; Judicial reviews; Controlled Drugs Assurance and Oversight; Complaints; Whistleblowing and Freedom to Speak Up; Review of provider Quality Accounts; Learning from Deaths; Medical Examiners; Infection Prevention and Control (IPC); Antimicrobial Resistance (AMR); HealthCare Acquired Infections (HCAI).		Yes	Zena Young	11/11/2021	31/03/2022		Green	Plans are in place to enable the ICS to assess which schemes will be ongoing post transfer. The list of relevant information relating to this item is updated and changes frequently within month. A number of these requirements are also reported regionally - eg safeguarding, IPC.		An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Very low
7.2.2	**Experience:** Patient surveys and unpaid carer feedback including FFT; Embedding experience of care in improvement and transformation programmes including coproduction with people with lived experience; Enabling engagement and coproduction; Staff surveys and feedback.		Yes	Zena Young	11/11/2021	31/03/2022		Green	Plans are in place to enable the ICS to assess which schemes will be ongoing post transfer. QPC receives quarterly reports on a number of these schemes. As a system we are considering our approach to hearing and improving patient experience and will be developing a pathway and feedback route as part of our Quality Roadmap.		An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Very low
7.2.3	**Patient Safety:** Serious Incident Framework or Patient Safety Incident Response Framework processes (or Patient Safety Incident Response Framework, PSIRF, oversight if the ICB includes an Early Adopter); Incident reporting to the Learn from Patient Safety Events service (and former NRLS, StEIS); Support for the commissioning of patient safety incident investigations including arrangement for regional or national escalation as appropriate; Compliance with national patient safety alerts; supporting safety improvement programme; Identifying Patient Safety Specialists and recruiting two or more Patient Safety Partners.		Yes	Zena Young	11/11/2021	31/03/2022	Jun-22	Green	We are awaiting NHSEI to approve the timing for roll-out of the PSIRF (part of the NHS Patient Safety Strategy) to all systems including STW. STW CCG has a system Patient Safety Specialist who is leading this work with Patient Safety Specialists from our NHS providers and other experts. We have established a specific system-wide Patient Safety Forum with the brief of implementing the NHS Patient Safety Strategy and PSIRF consistently within our system and are engaged in national learning forums to ensure we are taking an aligned approach to implementing PSIRF. The CCG GB paper January 2022 provides an update on progress with implementing the Patient Safety Strategy.		The actions relating to requirement are built into our forward quality governance plan (Quality Roadmap). \\athwfhdc001\Users\dunnch\Desktop\STWCCG	Very low

7.2.4	**Effectiveness:** National Clinical Audits; NICE Health and Care guidance, Quality Standards and Technology Appraisals; Getting it Right First Time (GIRFT) reports.		Yes	Zena Young (owner)/Julie Garside				Green	This requirement is a shared responsibility and the named directors have been updated accordingly. Plans are in place to enable the ICS to assess which schemes will be ongoing post transfer.		An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. GIRFT repotts are received through the Performance route of our governance reporting.	Very low
7.2.5	**Safeguarding:** Executive accountability/ownership for the Safeguarding Accountability and Assurance Framework across their partnerships (including safeguarding children and adults system leadership; Children in Care/ Looked After Children; Child Death responsibilities and Overview Panel).		Yes	Zena Young			Jun-22	Green	All of these responsibilities are incorporated into the forward quality governance arrangements and accountabilities. We submit a separate return to regional NHSE on safeguarding readiness to operate and have received positive feedback from our submissions. We have live action plans to address learning points identified in the CCG Internal Audits for Adult and Child Safeguarding. An update will be provided to the May 22 CCG Audit Committee - at present all actions are progressing satisfactorily, with the exception of the recommendation relating to the Designated Doctor for child safeguarding. We have part funding for this post which needs to be increased and a business case has been developed. The current post-holder has resigned from this post at short notice from the provider and there is a current gap in service.		The recommendation relating to the Designated Doctor for child safeguarding is subject to on-going discussions with system partners and the developed Business Case requires approval as a cost pressure to the CCG.	Very low
7.2.6	**Transformation and Quality Improvement:** Local transformation and improvement priorities; the NHS Long Term Plan programmes (e.g. Maternity, Learning Disabilities and Autism, Screening Programmes, Continuing Healthcare, Personal Health Budgets, Infection Prevention and Control, digital transformation programmes; clinical pathways).		Yes	Zena Young (owner)/Claire Parker				Green	Transformation schemes will carry forward into the ICS, being incorporated into the wider governance architecture for our system as this is under development for the sub structure of reporting within the ICS. Transformation schemes are subject to regional NHSEI reporting requirements. There is a robust assurance and reporting mechanism for maternity - relating to recommendations arising from the Ockenden reports.		The second Ockenden report has just been published and recommendations arising from ths will be incorporated to the exisiting QA process.	Very low

VERSION CONTROL - LOG OF CHANGES

Date of Change	Version Change	Tab Number	Ref	Original Drafting	Revised Drafting	Comment Regarding Change
Version 1 released 18 August 2021						
Version 2 released 14 October 2021 - Changes shown below						
14/10/2021	V2	Introduction	Para 1 Line 7	Completion of the full checklist is not itself mandated by NHSEI	**Completion of the full checklist is not itself mandated by NHSEI**	There is no change to the wording, but the statement regarding the checklist not being mandated has been changed to blue bold type to make this important point clearer. Nb tab 2.2 is required.
14/10/2021	V2	Introduction	Line 28	N/a	Reference to a new tab - line added	The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. A new 'Quality Due Diligence Checklist' tab (tab 7.0) has been added which builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.
14/10/2021	V2	Introduction	Line 34	Version Control The current version of the Due Diligence Checklist will be made available via the Hub. Strict version control will be applied and the current version number and date of issue will be included below; and the changes made will be logged at tab 7.0	Version Control The current version of the Due Diligence Checklist is made available via the Hub / FutureNHS platform. Strict version control is being applied and the current version number and date of issue included below; any prompt changed / added is highlighted in yellow in column A on each tab, including the version in which the change took place; and the changes made logged on the version control log tab.	Added reference to the Future NHS platform. Added any prompt changed / added will be highlighted in yellow in column A on each tab, including the version in which the change took place - this is to make it easier to see the changes. The version control log tab is no longer called 'tab 7' to allow for additional tabs to be added - but will always be located at the end.
14/10/2021	V2	Introduction	Line 36 / 37	V1 18/08/21	V2 14/10/21	Latest version release
14/10/2021	V2	Introduction	Line 40	N/a	Comments Regarding Versions Released V1 was released on 18.08.21 V2 provides an update as at 14.10.21 and the change log indicates all changes made to date	Added to provide confirmation of all versions released
14/10/2021	V2	1 Core	1.4.21	Further prompts relating to the necessary arrangements to support the establishment of processes for robust quality management are being developed and will be added in a later update via version control (these prompts will be either added on the core list at this point, or as a separate tab)	Quality Checklist (relating to ICB set up) included at tab 7.0	The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. A new 'Quality Due Diligence Checklist' tab (tab 7.0) has been added which builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.
14/10/2021	V2	1 Core	1.7.12	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. **Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry**	Added reference to the Covid Inquiry.
14/10/2021	V2	2.2 HR Due Diligence Data	Line 17 - and multiple columns	N/a	Drop down functionality removed	A number of columns appeared to have a drop down option but nothing was contained in the drop down menu. These were blank as there was no intention to be prescriptive regarding the drop down options but the drop down functionality has now been removed.
14/10/2021	V2	2.2 HR Due Diligence Data	Columns G, H, I, AH, AI	N/a	Added columns for: Professional Registration Body - column G Professional Registration Unique Identifier - column H Professional Registration Expiry Date - column I Department - column AH Staff Group - column AI	Added five columns / data fields required

14/10/2021	V2	3.2 Accounts & Audit	3.2.13	Ensure that there is a Local Counter Fraud Specialist (LCFS) and an agreed plan in place. Ensure that LCFS and senior Ensure Ensure that management work plans cover the increased risk of fraud and asset loss during times of change (this is a major risk on reorganisation). Ensure that the LCFS is involved in fraud and risk assessment for the ICB	3.2.13.1 Ensure the ICB has an accredited and nominated Local Counter Fraud Specialist (LCFS) with full access to NHS Counter Fraud Authority (NHSCFA) guidance, intelligence and case management systems. 3.2.13.2 Ensure appropriate handover arrangements are in place between CCG and ICB LCFSs to ensure: -continuity and progression of reactive work; including investigations, sanctions and recoveries -the ICB LCFS receives all relevant information from the CCG LCFS to inform ICB LCFS work plan 3.2.13.3 Ensure an agreed LCFS work plan is in place which should include (not exhaustive): -consideration of proactive work both before and after the establishment of the ICB in the light of the risks that it poses and adjust the nature and timing of work accordingly. -fraud risk assessment activity considering increased risk of fraud and asset loss during times of change (this is a major risk on reorganisation). -appropriate action to ensure compliance with the NHS Requirements of the Government Functional Standard GovS013 Counter Fraud	The initial prompt included at 3.2.13 has been revised and also expanded from one to three prompts.
14/10/2021	V2	3.7 Liabilities	3.7.20	Non PO invoices on hold to be released and paid where possible	Non PO invoices on hold to be released and paid where possible once verified as appropriate	Revised wording
14/10/2021	V2	3.7 Liabilities	3.7.21	PO Notifications to be actioned and holds released to ensure invoices can be paid	PO Notifications to be actioned and holds released to ensure invoices can be paid once verified as appropriate	Revised wording
14/10/2021	V2	3.7 Liabilities	3.7.29	Ensure that the ICB has access to all of the CCG(s) claims history on the NHS Protect's extranet	Ensure that the ICB has access to all of the CCG(s) claims history (see also core tab 1 - section 1.5)	Removed reference to NHS Protect and cross referenced to the core tab and section 1.5
14/10/2021	V2	3.7 Liabilities	3.7.30	Identify any ongoing legal cases, clear working files for new entity	Identify any ongoing legal cases, clear working files for new entity (see also core tab 1 - section 1.5)	Cross referenced to the core tab and section 1.5
14/10/2021	V2	4 IT Assets, IT and Records	4.16	N/a	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. **Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry**	Added reference to the Covid Inquiry.
14/10/2021	V2	5 DSPT	Tab 5	N/a	NHS Digital is in the process of reviewing and updating the DSPT Toolkit to ensure that it is fit for purpose for the establishment of ICBs. The aim is to confirm by 31 October 2021 when the DSPT Toolkit will be released with an indicative release date of mid-November 2021.	The DSPT Toolkit is not yet available for release but a new entry has been made on tab 5.0 as outlined in column G.
14/10/2021	Vs	6 ODS Reconfiguration	Tab 6	N/a	The current codes used to identify STPs will be changed to identify ICBs. NHS Digital is in the process of reviewing and updating the ODS Reconfiguration Toolkit to ensure that it is fit for purpose for the establishment of ICBs and takes account of the use of STP codes for ICBs as opposed to an application for, and receipt of, a new ICB code. Once complete the ODS Reconfiguration Toolkit will be released by NHS Digital and also via this Due Diligence Checklist. The aim is to confirm by 31 October 2021 when the ODS Reconfiguration Toolkit will be released with an indicative release date of mid-November 2021.	The ODS Reconfiguration Toolkit is not yet available for release but a new entry has been made on tab 6.0 as outlined in column G.
14/10/2021	V2	7 Quality	Tab 7	N/a	New tab added The new tab includes a number of prompts and these are 7.1.1 to 7.1.6 and 7.2.1 to 7.2.6 (inclusive)	The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. A new 'Quality Due Diligence Checklist' tab (tab 7.0) has been added which builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.
Version 3 released 24 November 2021 - Changes shown below						
24/11/2021	V3	Introduction	Line 36 / 37	V2 14/10/21	V3 24/11/21	Latest version release
24/11/2021	V3	Introduction	Line 40	Comments Regarding Versions Released V1 was released on 18.08.21 V2 provides an update as at 14.10.21 and the change log indicates all changes made to date	Comments Regarding Versions Released V1 was released on 18.08.21 V2 provides an update as at 14.10.21 and the change log indicates all changes made to date V3 provides an update as at 24.11.21 and the change log indicates all changes made to	Latest version release
24/11/2021	V3	1 Core	1.3.7	Current investigations by the Care Quality Commission (CQC) that would transfer	Current inspections by the Care Quality Commission (CQC) that would transfer	Investigations corrected to inspections
24/11/2021	V3	1 Core	1.4.12	Open medical examiner reports that would transfer	Open mortality review reports / medical examiner referrals that would transfer – ie any cases being reviewed by the CCG, such as cases referred by a medical examiner which the CCG is following up or has an outstanding action for the CCG	A number of queries have been received about this prompt and it has therefore been updated to provide clarity

24/11/2021	V3	1 Core	1.4.20	Agree the approach to maintaining quality during the transition and improving quality following the establishment of the ICB as outlined in: Shared Commitment to Quality: https://www.england.nhs.uk/publication/national-quality-board-position-statement-on-quality-in-integrated-care-systems/ Position statement: https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/	Agree the approach to maintaining quality during the transition and improving quality following the establishment of the ICB as outlined in: Shared Commitment to Quality: https://www.england.nhs.uk/publication/national-quality-board-position-statement-on-quality-in-integrated-care-systems/ Position statement: https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/ See the Quality section on the FutureNHS platform under ICS Guidance - Quality. This includes a briefing note to support handover	Included reference to a new handover briefing note
24/11/2021	V3	1 Core 4 IT Assets, IT and Records	1.7.11 4.17	Ensure that data and records management transition plans (including a clear sub section for historic financial data) are in place	Ensure that records management transition plans are in place See briefing paper providing records management guidance located on FutureNHS [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Removed reference to data as guidance provided that the two should not be combined. Original prompt at line 1.7.11 split into two prompts on tab 4.0 - 4.17 & 4.18. Extended narrative to link to records management guidance briefing paper and to group all associated prompts into one place in the due diligence checklist
24/11/2021	V3	1 Core 4 IT Assets, IT and Records	1.7.11 4.18	Ensure that data and records management transition plans (including a clear sub section for historic financial data) are in place	Ensure that records management transition plans for historical financial records are in place	Original prompt at line 1.7.11 split into two prompts on tab 4.0 - 4.17 & 4.18.
24/11/2021	V3	1 Core	1.7.12	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry [this prompt is covered by a number of prompts on tab 4.0 to ensure that all prompts associated with records management are in one place - review tab 4.0 for full details]	Extended prompt to redirect the user to tab 4.0 which provides a more comprehensive set of prompts related to records management.
	V3	3.1 Financial	3.1.24	Change Request raised: NHS Digital for new ODS codes	~~Change Request raised: NHS Digital for new ODS codes~~	Removed as there is no need to raise a change request for new codes
24/11/2021	V3	3.1 Financial	3.1.27	Destroy old stationery. Evidence for audit purposes Inform suppliers and users of address for invoices / queries	Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes	Clearer description
24/11/2021	V3	3.2 Accounts & Audit	3.2.16	Ensure appropriate records are kept, and emails are retained for any key staff that may leave during the transition period. This is likely to include the need to review policy. Documentation should be held in accordance with guidance on retention of records.	Ensure all appropriate records are kept, and emails are retained for any key staff that may leave during the transition period.	Added the word 'all' - ie Ensure all appropriate records are kept… Second element split from this prompt as repeated. See 4.22
24/11/2021	V3	4 IT Assets, IT and Records	4.5	Devise new records management arrangements for the ICB: - electronic file structure - policy & procedures relating to records management - corporate and clinical - physical record storage arrangements: on site and archive arrangements		Single prompt replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.9	The organisation should put arrangements in place to assess and respond to the increased risk to the confidentiality, integrity and availability of data from the reorganisation. Ensure that documentation is stored on shared rather than local drives.	A procedure to deal with the increased risk to records that result from a re-organisation (such as potential loss or accidental disclosure)	Revised wording
24/11/2021	V3	4 IT Assets, IT and Records	4.15	Documentation should be held in accordance with guidance on retention of records		Single prompt replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.16	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry [note that this links to section 1.7.12 of the core checklist]	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB.	Replaced by 4.19 Plus supported by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.17		Ensure that records management transition plans are in place	Repeated prompt on tab 1.0 (1.7.11) to ensure that all records management prompts are in one place on tab 4.0
24/11/2021	V3	4 IT Assets, IT and Records	4.18		Ensure that records management transition plans for historical financial records are in place	Extended prompt above to focus on historical financial records
24/11/2021	V3	4 IT Assets, IT and Records	4.19		Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for Inquiries, including the forthcoming Covid Inquiry	Prompt originally at 4.16 - amended and new number allocated
24/11/2021	V3	4 IT Assets, IT and Records	4.20		Identify archive requirements and ensure that data / information is extracted and stored in an easy to access format. This also applies to all feeder systems to the ledger.	Repeated prompt on tab 3.3 (3.3.41) to ensure that all records management prompts are in one place on tab 4.0
24/11/2021	V3	4 IT Assets, IT and Records	4.21		Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes	Repeated prompt on tab 3.4 (3.4.16) to ensure that all records management prompts are in one place on tab 4.0

24/11/2021	V3	4 IT Assets, IT and Records	4.22		Ensure all appropriate records are kept, and emails are retained for any key staff that may leave during the transition period.	Added the word 'all' - ie Ensure all appropriate records are kept… Repeated to ensure that all records management prompts are in one place - See 3.2.16
24/11/2021	V3	4 IT Assets, IT and Records	4.23		Establish ongoing records management processes as set out in the Records Management Code of Practice including the requirement in the following rows:	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.24		Responsibility and accountability for the Records Management requirements assigned to a suitably qualified or experienced person	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.25		Records management policies and procedures are put in place - covering both corporate and clinical records	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.26		A network or shared repository for the storage of records and an electronic records management file structure	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.27		Arrangements for physical records storage - both onsite and offsite storage (where applicable), including inventories detailing records in store	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.28		All Information Asset Registers and Records of Processing Activity are kept up to date	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.29		A procedure to deal with the increased risk to records that result from a re-organisation (such as potential loss or accidental disclosure)	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.30		Ensure there is a record of any actions taken in relation to records e.g. transferred to the local Place of Deposit. Certificates of disposal should be obtained where necessary.	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.31		Check all boxes of paper records that have been transferred are accounted for and all electronic records have transferred and can be opened.	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.32		Ensure there is clarity about which records the ICB is taking where there is a boundary change taking place / a "split" CCG (if applicable).	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.33		Ensure that any records which are subject (or may become subject) to an Inquiry, investigation or request for information continue to be retained and can be accessed. This includes records which are subject (or may become subject) to any current Public Inquiry (such as Infected Blood Inquiry), and the forthcoming COVID inquiry.	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
24/11/2021	V3	4 IT Assets, IT and Records	4.34		Ensure adequate file plans are in place for digital repositories to be transferred.	Single prompt at 4.5 replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
14/10/2021	V3	5 DSPT	Tab 5	The aim is to confirm by 31 October 2021 when the DSP Toolkit will be released with an indicative release date of mid-November 2021.	The DSP Toolkit has been reviewed and released. Please follow the link below to the briefing and DSP toolkit: https://www.dsptoolkit.nhs.uk/News/CCG-ICB-DSP-Toolkit ICBs will be required to publish a DSP Toolkit by 30 June 2022. There is no requirement for a CCG to publish a toolkit assessment before it is abolished on 31 March 2022. A CCG can voluntarily publish a DSP Toolkit, however, the successor ICB would still be required to publish their toolkit by 30 June 2022.	The DSP Toolkit has been released and the link is provided on tab 5..
14/10/2021	V3	6 ODS Reconfiguration	Tab 6	The aim is to confirm by 31 October 2021 when the ODS Reconfiguration Toolkit will be released with an indicative release date of mid-November 2021.	The aim is to release the ODS Reconfiguration Toolkit by 1 December 2021.	The ODS Reconfiguration Toolkit is not yet available for release but a new entry has been made on tab 6.0 as outlined in column G.
Version 4 released 16 February 2022 - Changes shown below						
16/02/2022	V4	Introduction	Line 7	The checklist has been co-produced by NHS England & NHS Improvement (from this point referred to as NHSEI), CCGs, ICSs, the Healthcare Financial Management Association (HFMA) and other stakeholders as a practical tool for use by CCGs and existing ICSs to provide evidence of due diligence in the transition from CCGs to ICBs. In all cases CCGs and ICSs must undertake an appropriate level of due diligence and it is recommended that this comprehensive checklist is used as the basis for the exercise. It is particularly important that the property list is sufficiently detailed for 'level 3' due diligence, where potentially property and liabilities are to be allocated between ICBs. **Completion of the full checklist is not itself mandated** by NHSEI, however, the information on individual members of CCG staff must be provided by either completing the relevant tab in the checklist (ref 2.2) or in another form using the same data fields. The checklist may be used to reflect any work that has already been undertaken and adapted as necessary to suit local circumstances. It is recognised that some areas of the checklist will be more important than others - and the level of detail provided should be proportionate to local circumstances. The checklist is designed to be a live working document that can be updated as the due diligence process progresses.	The checklist has been co-produced by NHS England & NHS Improvement (from this point referred to as NHSEI), CCGs, ICSs, the Healthcare Financial Management Association (HFMA) and other stakeholders as a practical tool for use by CCGs and existing ICSs to provide evidence of due diligence in the transition from CCGs to ICBs. In all cases CCGs and ICSs must undertake an appropriate level of due diligence and it is recommended that this comprehensive checklist is used as the basis for the exercise. It is particularly important that the property list is sufficiently detailed for 'level 3' due diligence, where potentially property and liabilities are to be allocated between ICBs. **Completion of the full checklist is not itself mandated by NHSEI, however, the information on individual members of CCG staff must be provided by either completing the relevant tab in the checklist (ref 2.2) or in another form using the same data fields.** In addition, **all level 3 systems (ie where boundary changes are taking place) need to create a comprehensive 'list' of property from sending organisations to receiving organisation**s. The checklist may be used to reflect any work that has already been undertaken and adapted as necessary to suit local circumstances. It is recognised that some areas of the checklist will be more important than others - and the level of detail provided should be proportionate to local circumstances. The checklist is designed to be a live working document that can be updated as the due diligence process progresses.	To ensure that there is clarity that lists of staff need to be created by all CCGs and lists of property need to be created for all level 3 areas. Note the additions in blue.

16/02/2022	V4	Introduction	Line 10	Note: the checklist includes reference to a number of activities to establish ICBs (shaded in grey), and some of these areas are subject to NHSEI guidance which is currently under development. The checklist currently includes a number of 'placeholders' and will evolve.	Note: the checklist includes reference to a number of activities to establish ICBs (shaded in grey)	The placeholders included in the first draft that referred to guidance to be shared have since been address and the reference has been removed from the introductory section and throughout the document
16/02/2022	V4	Introduction	Line 26	Tab 5.0 - DSPT checklist - to be included at a later point	Tab 5.0 - DSPT checklist - link provided on tab 5.0	To acknowledge that links have now been provided
16/02/2022	V4	Introduction	Line 27	Tab 6.0 - ODS Reconfiguration checklist - to be included at a later point	Tab 6.0 - ODS Reconfiguration checklist - link provided on tab 6.0	To acknowledge that links have now been provided
16/02/2022	V4	1 Core	1.3.24	New Constitution agreed for ICB - Model Constitution guidance currently under development	New Constitution agreed for ICB ~~- Model Constitution guidance currently under development~~	Draft model now released
16/02/2022	V4	1 Core	1.4.11ii		Number of Looked After Children cases to be transferred	Systems have raised that this was missing and asked for it to be added
16/02/2022	V4	1 Core	1.4.11iii		Number of Deprivation of Liberty Safeguarding (DOLS) cases to be transferred	Systems have raised that this was missing and asked for it to be added
16/02/2022	V4	1 Core	1.4.17ii		Open learning points from clinical audits	New prompt
16/02/2022	V4	1 Core	1.4.18	Open learning points from complaints, incidents, quality matters, etc. that would transfer	Open learning points from complaints, incidents, clinical audits, quality matters, etc. that would transfer	Added reference to clinical audit
16/02/2022	V4	1 Core	1.4.20		Agree the approach to maintaining quality during the transition and improving quality following the establishment of the ICB as outlined in: Position statement: https://www.england.nhs.uk/publication/national-quality-board-position-statement-on-quality-in-integrated-care-systems/ Shared Commitment to Quality: https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/ National Quality Board's Publications: NHS England » National Quality Board publications for Integrated Care Systems See the Quality section on the FutureNHS platform under ICS Guidance - Quality. This includes a briefing note to support handover. It can be found at the following link: https://future.nhs.uk/ICSGuidance/view?objectID=117441221	Updated links provided
16/02/2022	V4	1 Core	1.7.11	Ensure that records management transition plans are in place - See briefing paper providing records management guidance located on FutureNHS [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place].	Ensure that records management transition plans are in place - See briefing paper providing records management guidance located on FutureNHS [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]. The link is as follows: https://future.nhs.uk/ICSGuidance/view?objectId=119899909	Link provided
16/02/2022	V4	2.1 HR	2.1.3.9	Complete the ESR IBM data collection template to identify the changes required within ESR to establish the ICS ESR VPD taking the existing CCG VPD structures into account. Submission will generate the allocation of a merge event within the IBM programme calendar from May 2022 onwards (also included on financial governance tab 3.1)	Complete the ESR IBM data collection template to identify the changes required within ESR to establish the ICS ESR VPD taking the existing CCG VPD structures into account. Submission will generate the allocation of a merge event within the IBM programme calendar from [see dates in the ICB Establishment Timeline] (also included on financial governance tab 3.1)	Referenced the ICB Establishment Timeline for applicable dates
16/02/2022	V4	3.1 Financial - Governance	Intro	The organisation needs to provide assurance to the Board and Audit Committee that appropriate arrangements are in place to closedown the accounts and financial systems of the entity by 31 March 2022. The organisation should also ensure it has robust working papers for the new body. It should also ensure appropriate arrangements for archiving of financial and accounting records for the appropriate retention period.	The organisation needs to provide assurance to the Board and Audit Committee that appropriate arrangements are in place to closedown the accounts and financial systems of the entity by 30 June 2022. The organisation should also ensure it has robust working papers for the new body. It should also ensure appropriate arrangements for archiving of financial and accounting records for the appropriate retention period.	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.1 Financial - Governance	3.1.8	Ensure that the audit committee meetings are scheduled in line with the requirements of the business, including one very close to the 31 March 2022 to provide an appropriate formal closure report. Schedule meetings for approval to submit draft and final accounts and report.	Ensure that the audit committee meetings are scheduled in line with the requirements of the business, including one very close to the 30 June 2022 to provide an appropriate formal closure report. Schedule meetings for approval to submit draft and final accounts and report.	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.1 Financial - Governance	3.1.11	Complete the ESR IBM data collection template to identify the changes required within ESR to establish the ICS ESR VPD taking the existing CCG VPD structures into account. Submission will generate the allocation of a merge event within the IBM programme calendar from May 2022 onwards (also included on HR tab 2.1)	Complete the ESR IBM data collection template to identify the changes required within ESR to establish the ICS ESR VPD taking the existing CCG VPD structures into account. Submission will generate the allocation of a merge event within the IBM programme calendar from [see dates in the ICB Establishment Timeline] (also included on HR tab 2.1)	Referenced the ICB Establishment Timeline for applicable dates
16/02/2022	V4	3.1 Financial - Governance	3.1.19	Budgets and contracts will need to be agreed for the ICB (essentially before the 1 April), agree how this will happen ensuring the required governance is in place. This should also be reflected on the risk register.	Budgets and contracts will need to be agreed for the ICB (essentially before the 1 July), agree how this will happen ensuring the required governance is in place. This should also be reflected on the risk register. [Note the need to agree budgets and contracts for the CCG before 1 April for 3 months and for the ICB before 1 July for 9 months]	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.1 Financial - Governance	3.1.20	Map all existing CCG functions - Guidance under development	Map all existing CCG functions	Guidance in place
16/02/2022	V4	3.1 Financial - Governance	3.1.21	Map all existing CCG Statutory Duties - Guidance under development	Map all existing CCG Statutory Duties	Guidance in place
16/02/2022	V4	3.1 Financial -	3.1.22	Confirm changes with HES NHSD / UNIFY arrangements	~~Confirm changes with HES NHSD / UNIFY arrangements~~	Removed as action for national team
16/02/2022	V4	3.1 Financial -	3.1.23	Change Request raised: CAPITA	~~Change Request raised: CAPITA~~	Removed as already actioned
16/02/2022	V4	3.1 Financial -	3.1.24	Change Request raised: NHS Digital for new ODS codes	~~Change Request raised: NHS Digital for new ODS codes~~	Removed as already actioned

16/02/2022	V4	3.1 Financial - Governance	3.1.28		Ensure that plans are in place to take actions in line with the guidance issued 'Impact on Apprenticeships and Apprenticeship Service Accounts'. Three documents are available on the FutureNHS platform under 'Finance' - 'Supporting Resources'.	New line added with reference to new guidance released
16/02/2022	V4	3.3 Financial - Ledger	3.3.3	For cash purposes, consider any payments that may go out on the 31/3 (rates) or on the 1/4 to ensure fully factored into transitioning arrangements	For cash purposes, consider any payments that may go out on the 30/06 or 01/07 to ensure fully factored into transitioning arrangements	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.3 Financial - Ledger	3.3.25	Budget holders: - Agree budget holders for ICB (accountability framework) - Agree format and content of budget holder reports - Agree process and timetable for establishing base budgets (both revenue and capital) - note this will need to be done ahead of 1 April 2022 - Review budgeting assumptions and consider if they are still valid following the establishment of the ICB - Ensure that budget holders are aware of their budget responsibilities and arrange training as necessary - Amend budgets to reflect any changes in activity and resources resulting from discussions with commissioners / providers - Obtain approval of base budgets from the governing body	Budget holders: - Agree budget holders for ICB (accountability framework) - Agree format and content of budget holder reports - Agree process and timetable for establishing base budgets (both revenue and capital) - note this will need to be done ahead of 1 July 2022 - Review budgeting assumptions and consider if they are still valid following the establishment of the ICB - Ensure that budget holders are aware of their budget responsibilities and arrange training as necessary - Amend budgets to reflect any changes in activity and resources resulting from discussions with commissioners / providers - Obtain approval of base budgets from the governing body [Note the need to agree budgets and contracts for the CCG before 1 April for 3 months and for the ICB before 1 July for 9 months]	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.4 Financial - Banking	3.4.3	The issue of all cheques from CCG accounts to cease no later than 31 March 2022 (agree treatment of outstanding cheques, POs etc)	The issue of all cheques from CCG accounts to cease no later than 30 June 2022 (agree treatment of outstanding cheques, POs etc)	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.4 Financial - Banking	3.4.14	Ensure arrangements are in place to bank all petty cash by 31 March 2022 and close accounts where relevant. Determine petty cash floats for the new organisation & make arrangements	Ensure arrangements are in place to bank all petty cash by 30 June 2022 and close accounts where relevant. Determine petty cash floats for the new organisation & make arrangements	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.4 Financial - Banking	Intro	The organisation should put itself into a position to ensure that any balances remaining at 31 March 2022 are minimal and disputes have been resolved with both NHS and non-NHS organisations. The organisation should ensure arrangements are in place for each liability to either be approved for payment or have a clear route to authorisation (including those to be transferred to the new organisation with comprehensive backing information). All creditor control accounts will be fully reconciled with no balances awaiting clearance unless they are longer term transactions.	The organisation should put itself into a position to ensure that any balances remaining at 30 June 2022 are minimal and disputes have been resolved with both NHS and non-NHS organisations. The organisation should ensure arrangements are in place for each liability to either be approved for payment or have a clear route to authorisation (including those to be transferred to the new organisation with comprehensive backing information). All creditor control accounts will be fully reconciled with no balances awaiting clearance unless they are longer term transactions.	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.7 Financial - Liabilities	3.7.2	Ensure communication and ordering arrangements are in place to minimise the chance of invoices arriving late (i.e. post 31 March 2022)	Ensure communication and ordering arrangements are in place to minimise the chance of invoices arriving late (ie post 30 June 2022)	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.7 Financial - Liabilities	3.7.4	Establish arrangements to manage staff expenses down so only claims relating to the end of March 2022 remain	Establish arrangements to manage staff expenses down so only claims relating to the end of June 2022 remain	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.7 Financial - Liabilities	3.7.7	Ensure supplier list up to date. Suppliers in respect of those with balances will need to be transferred to new organisation post 1 April 2022	Ensure supplier list up to date. Suppliers in respect of those with balances will need to be transferred to new organisation post 1 July 2022	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	3.7 Financial - Liabilities	3.7.12	Determine frequency of payments and establish timetable to operate from 1 April 2022. Harmonise payment dates if operating with two or more systems	Determine frequency of payments and establish timetable to operate from 1 July 2022. Harmonise payment dates if operating with two or more systems	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	4.0 Assets, IT and Records	Intro	The organisation puts arrangements in place for the effective management of financial data transfer between the CCG and the new entity and that access to systems will be maintained post March 2022. This should cover the annual accounts production and audit process until July 2022 and also any post March 2022 reporting requirements.	The organisation puts arrangements in place for the effective management of financial data transfer between the CCG and the ICB and that access to systems will be maintained post 30 June 2022. This should cover the annual accounts production and audit process and also any post June 2022 reporting requirements.	Changed date to respond to the new target date of 1 July 2022
16/02/2022	V4	4.0 Assets, IT and Records	4.1	System and software licensing arrangements are reviewed to ensure that financial data can be accessed after 31 March 2022. Licences for existing systems should be extended (pending a national decision on historic data archiving)	System and software licensing arrangements are reviewed to ensure that financial data can be accessed after 30 June 2022. Licences for existing systems should be extended (pending a national decision on historic data archiving)	Changed date to respond to the new target date of 1 July 2022

16/02/2022	V4	5.0 DSPT Checklist	Tab 5	The DSP Toolkit has been reviewed and released. Please follow the link below to the briefing and DSP toolkit: https://www.dsptoolkit.nhs.uk/News/CCG-ICB-DSP-Toolkit ICBs will be required to publish a DSP Toolkit by 30 June 2022. There is no requirement for a CCG to publish a toolkit assessment before it is abolished on 31 March 2022. A CCG can voluntarily publish a DSP Toolkit, however, the successor ICB would still be required to publish their toolkit by 30 June 2022.	The DSP Toolkit has been reviewed and released. Please follow the link below to the briefing and DSP toolkit: https://www.dsptoolkit.nhs.uk/News/CCG-ICB-DSP-Toolkit CCGs are required to complete and publish the DSP Toolkit for 2021-22 before they are abolished and by the deadline of 30 June 2022. NHS Digital will exempt the requirement for a DSP Toolkit audit for CCGs for 2021-22. In summary: CCGs are required to complete the DSP Toolkit for 2021-22, with a deadline of 30 June 2022. CCGs are not required to complete a baseline assessment for 2021-22 CCGs are not required to complete a DSP Toolkit audit for 2021-22 ICBs are not required to complete the DSP Toolkit for 2021-22 ICBs will complete the DSP Toolkit in 2022-23.	The revision responds to the new target date for the establishment of ICBs
16/02/2022	V4	6 ODS Reconfiguration	Tab 6	The current codes used to identify STPs will be changed to identify ICBs. NHS Digital is in the process of reviewing and updating the ODS Reconfiguration Toolkit to ensure that it is fit for purpose for the establishment of ICBs and takes account of the use of STP codes for ICBs as opposed to an application for, and receipt of, a new ICB code. Once complete the ODS Reconfiguration Toolkit will be released by NHS Digital and also via this Due Diligence Checklist. The aim is to release the ODS Reconfiguration Toolkit by 1 December 2021 and an update will be provided via the chat facility on teams to confirm its release.	The current codes used to identify STPs will be changed to identify ICBs. The ODS Reconfiguration Toolkit has been reviewed and released previously. Please follow the link below to the Future NHS Platform: https://future.nhs.uk/connect.ti/ICSDigitalandData/view?objectId=30787600 And the link to the ODS Reconfiguration Toolkit is as follows: https://digital.nhs.uk/services/organisation-data-service/integrated-care-boards/reconfiguration-toolkit **Now that the date that boundary changes will take effect has been confirmed, the ODS Reconfiguration Toolkit will be updated again to reflect mid-year changes. The planned release date is by 4 March 2022.**	A series of communications have already been issued to provide the link to the ODS Reconfiguration Toolkit - the link is now provided on tab 6. The revision responds to the new target date for the establishment of ICBs. **However, please note that the toolkit is currently being updated further to reflect a mid-year change and will be released by 4 March 2022.**
16/02/2022	V4	7 Quality	Tab 7	The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. This tab builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.	The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. This tab builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB. Agree the approach to maintaining quality during the transition and improving quality following the establishment of the ICB as outlined in: Position statement: https://www.england.nhs.uk/publication/national-quality-board-position-statement-on-quality-in-integrated-care-systems/ Shared Commitment to Quality: https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/ National Quality Board's Publications: NHS England » National Quality Board publications for Integrated Care Systems See the Quality section on the FutureNHS platform under ICS Guidance - Quality. This includes a briefing note to support handover. It can be found at the following link: https://future.nhs.uk/ICSGuidance/view?objectID=117441221	The links provided on the core due diligence tab at 1.4.20 have been added to this tab too
Version 5 released 13 April 2022 - Changes shown below						
13/04/2022	V5	Introduction	Line 26	Tab 5.0 - DSPT checklist - link provided on tab 5.0	Tab 5.0 - DSPT checklist and Information Governance - link provided on tab 5.0	Reference to information governance added
13/04/2022	V5	1.0 Core	1.6.1(ii)		Cross check the contract register / schedule of contracts to the CCG's payments ledger to ensure that it is complete	New prompt added
13/04/2022	V5	1.0 Core 4.0 IT	1.3.17, 1.3.18, 1.4.2, 4.2.8		Cross reference to new prompts on tab 5.0 have been added	All three prompts have a bracketed note to cross reference to the new prompts on tab 5.0
13/04/2022	V5	1.0 Core	1.11.1	Ensure that the actions outlined in the Data Security and Protection (DSPT) Toolkit have been completed - DSPT Checklist included at tab 5.0	Ensure that the actions outlined in the Data Security and Protection (DSPT) Toolkit have been completed - DSPT Checklist included at tab 5.0. Please note that the prompts relevant to the ICB set up arrangements are also included on tab 5.0	Clear reference to the additional prompts added to tab 5.0
13/04/2022	V5	4.0 IT	4.35 to 4.40		4.35 to 4.40 added	6 additional prompts have been added re IT provision
13/04/2022	V5	5.0 DSPT & IG	Line 3	5.0. DATA SECURITY AND PROTECTION TOOLKIT (DSPT)	5.0. DATA SECURITY AND PROTECTION TOOLKIT (DSPT) AND INFORMATION GOVERNANCE	Added 'Information Governance'

13/04/2022	V5	5.0 DSPT & IG	Line 4	Data Security and Protection Toolkit (DSPT) The DSP Toolkit has been reviewed and released. Please follow the link below to the briefing and DSP toolkit: https://www.dsptoolkit.nhs.uk/News/CCG-ICB-DSP-Toolkit CCGs are required to complete and publish the DSP Toolkit for 2021-22 before they are abolished and by the deadline of 30 June 2022. NHS Digital will exempt the requirement for a DSP Toolkit audit for CCGs for 2021-22. In summary: CCGs are required to complete the DSP Toolkit for 2021-22, with a deadline of 30 June 2022. CCGs are not required to complete a baseline assessment for 2021-22 CCGs are not required to complete a DSP Toolkit audit for 2021-22 ICBs are not required to complete the DSP Toolkit for 2021-22 ICBs will complete the DSP Toolkit in 2022-23.	Data Security and Protection Toolkit (DSPT) The DSP Toolkit has been reviewed and released. Please follow the link below to the briefing and DSP toolkit: https://www.dsptoolkit.nhs.uk/News/CCG-ICB-DSP-Toolkit CCGs are required to complete and publish the DSP Toolkit for 2021-22 before they are abolished and by the deadline of 30 June 2022. NHS Digital will exempt the requirement for a DSP Toolkit audit for CCGs for 2021-22. In summary: CCGs are required to complete the DSP Toolkit for 2021-22, with a deadline of 30 June 2022. CCGs are not required to complete a baseline assessment for 2021-22 CCGs are not required to complete a DSP Toolkit audit for 2021-22 ICBs are not required to complete the DSP Toolkit for 2021-22 ICBs will complete the DSP Toolkit in 2022-23. Information Governance The DSP toolkit contains a number of important information governance related prompts some of which will need to be completed at the point of ICB establishment. These prompts have been listed below and column J includes clear reference to how they align with the DSPT to assist users.	Added introduction to the IG prompts.

Action to collate inforamtion required as part oif Due Diligence process - RAG ratings

Red	not started or at risk
Amber	plans in place and/or ongoing
Green	completed
N/A	This specific action in the due diligence checklist does not apply to STW CCG
Yes	
No	

Level 1 - Single CCG to coterminous ICS and no boundary changes
Level 2 - Multiple CCGs to coterminous ICS and no boundary changes
Level 3 - Boundary changes requiring confirmation of transfer arrangements for staff and property

Property and Asset Risk to ICB - RAG ratings

Red	High or extreme risk related to identified property or asset but no mitigation in place
	High or extreme risk related to identified property or asset but mitigated or only partially mitigated but remains high or extreme
Amber	Moderate risk related to the identified property or asset and has no mitigation in place
	Moderate risk related to the property or asset identified and has mitigation in place or partial mitigation in place but remains at moderate
Green	No risks related to property and assets identified
	Low or very low risks related to the property or asset identifed but are fully or partially mitigated
N/A	This specific action in the due diligence checklist does not apply to STW CCG

RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
1 Negligible	**1 VERY LOW**	**2 VERY LOW**	**3 VERY LOW**	**4 LOW**	**5 LOW**
2 Minor	**2 VERY LOW**	**4 LOW**	**6 LOW**	**8 MODERATE**	**10 MODERATE**
3 Moderate	**3 VERY LOW**	**6 LOW**	**9 MODERATE**	**12 HIGH**	**15 HIGH**
4 Major	**4 LOW**	**8 MODERATE**	**12 HIGH**	**16 HIGH**	**20 EXTREME**
5 Catastrophic	**5 LOW**	**10 MODERATE**	**15 HIGH**	**20 EXTREME**	**25 EXTREME**

Very low	1 – 3	Very Low risk
Low	4 – 6	Low risk
Moderate	8 – 10	Moderate risk
High	12 – 16	High risk
Extreme	20 – 25	Extreme risk

	Consequence score (severity levels) and examples of descriptions				
Domains	**1. Negligible**	**2. Minor**	**3. Moderate**	**4.Major**	**5. Extreme**
Impact on the safety of patients, staff or public (physical/psychological harm).	**Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.**	**Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.**	**Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.**	**Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.**	**Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.**
Quality/complaints/audit	**Peripheral element of treatment or service suboptimal. Informal complain/injury.**	**Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.**	**Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.**	**Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.**	**totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.**

Human resources/organisational/development/staffing/competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspections	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Risk in relation to CCGs	Insignificant cost increase	1-2% over plan/target	2-5% over plan/target	5-10% over plan/target	>10% over plan/target
	On assessing impact, consideration will also be given to other key financial objectives including but not limited				
Service/business interruption/environmental impact	Loss/interruption of >1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

Tab

Shropshire, Telford & Wrekin CCG Due Diligence Checklist- Ambers and Reds

Ref	Due Diligence Area for Review *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	Comments	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Further action required (Yes / No)	Action required	Due Date for Further Action	Final RAG	Risk identified	Mitigating Action/Comments	Risk RAG
1.3.1	Details of any concerns expressed by the Secretary of State, DHSC or NHSEI in relation to CCG actions	None identified to date. Processes are in place to identify these if & when they occur and to capture in the due diligence process	Alison Smith	01/10/2021	30/06/2022		Amber	Yes	This is amber as it is a continuing action but none identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.3	Details of any disciplinary action taken by the CCG in relation to CCG Governing Body members, Directors or Officers relating to their acts or omissions relating to powers and duties of the CCG	None identified to date. Processes are in place to identify these if & when they occur.	Lisa Kelly/Alison Smith	01/11/2021	30/06/2022		Amber	Yes	This is amber as it is a continuing action but none identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.5	Details of any breach of the Code of Conduct, Code of Accountability or other equivalent guidance	None identified to date. Processes are in place to identify these if & when they occur.	Alison Smith	01/10/2021	30/06/2022		Amber	Yes	This is amber as it is a continuing action but none identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.6	Details of investigations by supervisory or regulatory bodies, statutory or government bodies, the Health and Safety Executive, the Environment Agency, the police, NHS Counter Fraud and Security Management Services (CFSMS), or any other circumstances, that would transfer	None identified for H&S, Environment Agency, Security Management Services. Processes in place to identify these if and when they occur. Counter fraud investigations are reported on regularly to CCG Audit Committee	Alison Smith/Laura Clare	01/10/2021	30/06/2022		Amber	Yes	This is amber as it is a continuing action but none identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.3.12	Open learning points from past System Oversight Framework assessments that would transfer	Reviewing open learning points of system oversight framework assessments from last 12 months	Claire Skidmore	01/11/2021	30/06/2022		Amber	Yes		30/06/2022	Green			Green
1.3.13	Open risks that would transfer (provide risk register of all risks, including HR, financial / accounting, quality risks, etc)	Risks at Board Assurance Level and Directorate level are captured in regular bi monthly risk reporting to the Audit Committee and Governing Body.	Alison Smith	01/10/2021	15/06/2022		Amber	Yes	Open risks will be reported to the CCG audit committee on the 15th June which will form the informaiton that will be transferred to the ICB.	15/06/2022	Green	No risks identified currently.	N/A	Green
1.3.17	Subject access requests (SARs) that would transfer (links to S.15)	A SARs register is held by Tracy Eggby-Jones, which identifies all SARs received, their current status with RAG rating. Any open SARs at 30.6.22 will transfer to the new ICB and requesters notified.	Tracy Eggby Jones/Alison Smith	01/10/2021	30/06/2022		Amber	Yes	This list will be kept under review and updated over the period leading up to 30 June 2022.	31/06/2022	Amber	There is a potential for some SARs not to be completed by 30 June 2022 and therefore any open requests will carry forward to the ICB. There is a low risk of the SARs are not completed within the 28 days statutory timeframe as a result of transition but this is mitigated by the same team overseeing this process being in place in the ICB on 1st July for continuity. Amber risk rating reflects the ongoing nature of the action rather than the risk around particular SARs.	The list of open SARs will be kept under review to ensure they transfer to the new ICB and requesters informed. Any areas of concern will be escalated to the Director of Corporate Affairs.	Green
1.3.18	Freedom of Information (FOIs) requests that would transfer (links to S.19)	The process for overseeing FOI requests is managed by the Midlands & Lancashire CSU. They can provide a list of open FOIs at any point and relevant parties of those that are not concluded by 30 June 2022 will be notified of the transfer to the new ICB.	Tracy Eggby Jones/Alison Smith	30/06/2022	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	31/06/2022	Amber	There is a potential for some FOIs not to be completed by 30 June 2022 and therefore any open FOIs will carry forward to the ICB. There is a low risk if the FOIs are not completed within the 20 working days statutory timeframe as a result of transition but this is mitigated by the same team in the CSU and CCG overseeing this process being in place in the ICB om 1st July for continuity. Amber risk rating reflects the ongoing nature of the action rather than the risk around particular FOIs.	The Corporate Services Manager will liaise closely with the MLCSU to ensure any open FOIs are transferred to the new ICB and requesters informed. Any areas of concern will be escalated to the Director of Corporate Affairs.	Green
1.3.19	Open learning points from Emergency Preparedness, Resilience and Response (EPRR) that would transfer	Plans are in place to ensure that learning points will transfer to ICB as appropriate	Sam Tilley	01/11/2021	30/06/2022		Amber	Yes	Plans for EPRR function for the ICB is in development with a draft being submitted to NHSEI on the 27/5/22	30/06/2022	Green			Green
1.3.25	Agree the new committee structure and develop terms of reference, as necessary. Committees may include: • Remuneration committee; • Audit & risk committee; • Quality committee (following NQB guidance); • Priorities Committee; • Primary Care Commissioning committee; • IFR; • Finance committee • Capital committee Consider other committees that are an integral part of the governance structure or that are required due to the nature of the ICB. Agree their purpose, terms of reference and appropriate duration. For example, should they be: Permanent or time limited.	Relates to ICB set up Some model terms of reference have been released by NHSE/I to use. ICS already has committees in place which will be retained and added to. New ICB Interim Designate CE is in discussions with CCG and ICS Execs on changes to the current Committee and governance structure. Work has started to review current ICS Committee TOR and align will developing thinking on new structure.	Alison Smith	01/02/2022	10/06/2022		Amber	Yes	Drafts of TOR currently being developed for submission to NHSEI on 10/6/22 however further refinement is expected upto 30/6/22.	30/06/2022	Green	Ensuring triangulation between the TOR.	Discussions to refine committee structure continue to take place.	Green
1.3.26	Agree new logo, letter head, signage, harmonise all corporate documents, standard documents and inform staff where these can be accessed - for ICB	Relates to ICB set up naming convention now agreed and we are in the process of looking at all corporate templates. New NHS STW logo has been developed. Corporate stationary is being worked up and will be ready for circulation from mid-June.	Chris Hudson/Edna Boampong	22/10/2021	30/06/2022		Amber	Yes	Plan being discharched, all actions to be ready by 30 June 2022.	01/07/2022	Green			Green
1.3.27	New website for ICB	Relates to ICB set up Move to one website, with the CCG site becoming the ICB website and the ICS site being discontinued. There will be a section on the ICB site for ICS content. The planning for this change is under way.	Chris Hudson/Edna Boampong	01/10/2021	01/07/2022	01/07/2021	Amber		Plan being discharched, all actions to be ready by 30 June 2022.		Green			Green
1.4.2	Open outstanding / ongoing complaints that would transfer (links to 1.4.2)	The CCG's Patient Services Team are able to run a report from Ulysses of all open complaints, PALS and MP letters at any point and will notify relevant parties of cases not concluded by 30 June 2022 that their case will be transferred to the new ICB.	Tracy Eggby Jones	01/10/2021	30/06/2022	30/06/2022	Amber	Yes	This is amber rated as this is a continuing action up to 30 June 2022. None identified to date.	30/06/2022	Green	No risks identified currently.		Green

1.4.4	Open whistleblowing / FTSU cases that would transfer	None identified at the moment. Annual reporting on Freedom to speak up concerns to the Audit Committee	Alison Smith	01/10/2021	30/06/222		Amber	Yes	This is amber rated as this is a continuing action up to 30 June 2022. None identified to date.	30/06/2022	Green	No risks identified currently.	N/A	Green
1.4.7	Open Individual Funding Requests or appeals that would transfer	Plans are in place to ensure that relevant information is transferred to the ICP	Clare Stallard/Claire Parker	01/11/2021	30/06/2022		Amber	Yes	Any open IFR cases will automatically transfer to the new organisation, the status of any outstanding IFR cases will not change and any required actions or panel meetings will take place as previously planned, any appeals will also transfer to the new organisation		Green			Green
1.4.8	Deferred Individual Funding Requests that would transfer	Plans are in place to ensure that relevant information is transferred to the ICP	Clare Stallard/Claire Parker	01/11/2021	30/06/2022		Amber	Yes	Any IFR cases awaiting further information to support the application will continue as per policy, a 28 day deadline will still apply for the provision of further information to be provided and this will be continually reviewed in old and new organisation to ensure the policy is correctly applied.		Green			Green
1.5.1	Outstanding claims / litigation that would transfer	The CCG has some current litigation in the Court of Protection which is likely to transfer to the ICB	Alison Smith	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022. Live cases are recorded for reporting purposes if required.	30/06/2022	Green	Financial and reputational risk with one case which has accrued significant legal costs	Legal advice is being taken to minimise reputational risk. Director of Planning oversees cost approval with legal firm.	Amber
1.5.2	Pending claims / litigation (including any incidents that may become claims) that would transfer	No pending litigation identified for the purposes of reporting to NHS resolution. This will be kept under review up to 30/6/22.	Alison Smith	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Green	No risks identified currently.		Green
1.5.4	Outstanding and pending claims / litigation under Data Protection Act (DPA) or General Data Protection Regulation (GDPR) that would transfer	None identified at moment. Regular reporting via NHS Resolution and CCG solicitors allows capture of data.	Alison Smith/Laura Clare	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Green	No risks identified currently.	N/A	Green
1.5.6	Open learning points from litigation and claims that would transfer	None identified at moment. Regular reporting via NHS Resolution and CCG solicitors allows capture of data.	Alison Smith	01/01/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Green	No risks identified currently.	N/A	Green
1.6.2	Ensure that all leases are listed to assist with work associated with IFRS 16 (this could be addressed by including all leases in the contracts register or by holding a separate list of all leases) - to include all lease terms, start dates, end dates, break dates, parties to lease, CCG lead or on behalf of, etc.	All contract owners will be contacted to identify leases held independently or within contracts. Once identified these will be added to the contract register workbook as a separate tab.	Kay Holland/Julie Garside	30/10/2021	31/03/2022		Amber	Yes	As per I.3.14 - Lease and Contract owners contacted to provide information/update register, email reminders scheduled	31/03/2022	Green	Oversight of leases not held/managed by the Contract Management Team needs to be stronger	Procurement Oversight Group now covers the Goods & Services contract holders, so contract issues can be discussed and risks escalated as required	Green
1.6.3	Agreements / service agreements in place	Currently no clinical agreements/service agreements in place Contract leads will be asked to confirm for Goods & Services.	Kay Holland/Julie Garside	30/10/2021	31/03/2022		Amber	Yes	Lease and Contract owners contacted to ensure provide information on register is up to date	31/03/2022	Green	Oversight of agreements not held/managed by the Contract Management Team needs to be stronger	Procurement Oversight Group now covers the Goods & Services contract holders, so contract issues can be discussed and risks escalated as required	Green
1.6.4	Confirm which contracts are expiring at point of transfer or due for renewal in first quarter of 2022/23 and a clear plan in place to take forward each one	The contract register details expiry dates of contracts, the monthly procurement oversight group receives and discusses a expiring contracts log for clinical services which details all contracts expiring within the next 12 months and plans for each contract discussed, actions agreed and ultimately papers for approval of plans for each one taken to Strategic Commissioning Committee. Contract leads for Goods & service contracts will be asked to confirm the process	Kay Holland/Julie Garside	30/01/2021	31/01/2022		Amber	Yes	Expiring contracts for clinical services discussed at Procurement Oversight Group on 19th May , next steps identified and paper drafted for Strategic Commissioning Committee to discuss and approve	31/01/2022	Green	4 clinical contracts/agreements expire within first three months of the ICB	Discussion at Procurement Oversight Group on 19th May , paper to Strategic Commissioning Committee/Governing Body for agreement of next steps/recommendations in June 2022	Green
1.6.6	Confirm contact with counterparties to contracts and clarify transfer of contracts / continuation of contracts if required (noting that this is likely to involve more than one contact to ensure that there is clarity)	Counterparties will be identified and contacted as appropriate and record of contact made noted in the comments section of the contract register.	Kay Holland/Julie Garside	30/01/2021	31/03/2022		Amber	Yes	On-going - will be reviewed and updated over the period to 30/06/2022	30/06/2022	Green	Counterparties to contracts and clarify of the transfer of contracts is not recorded on the contract register.	Contract Register updated to now include details of countparties to the contact	Green
1.6.7	Consider if there are any 'hard to replace' services provided by independent sector providers that are not yet designated as Commissioner Requested Services. Further information via link below: https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/information-for-commissioners/	Contracting team will work with commissioning team to consider if any action needs to be taken.	Kay Holland/Julie Garside	30/01/2021	31/03/2022		Amber	Yes	On-going - will be reviewed and updated over the period to 30/06/2022	30/06/2022	Green	No 'hard to replace' services have currently been identified that are provided by independent providers	N/A	Green
1.8.2	Open requests for information under Environmental Information Regulations (EIR)	None received to date.	Alison Smith	01/11/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Amber	No risks currently identified	N/A	Green
1.8.3	Details of any enforcement notices related to Environmental Information Regulations (EIR) served in the last 24 months	None received to date.	Alison Smith	01/11/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Amber	No risks currently identified	N/A	Green
1.8.4	Open environmental problems or potential liabilities that would transfer (e.g. relating to disposal of clinical waste, substances buried underground, spillage / leakage, potential water pollution, health hazards, etc)	None received to date.	Alison Smith	01/11/2021	30/06/2022		Amber	Yes	This will need to be reviewed and updated over the period leading up to June 2022	30/06/2022	Amber	No risks currently identified	N/A	Green
1.9.1	Details of intellectual property used, enjoyed, exploited or held	Plans are in place to ensure that relevant information is transferred to the ICP	Kay Holland/Julie Garside				Amber	Yes			Green			Green
2.1.3.7	Establish arrangements for the identification, transfer and retention of staff records in line with the NHS Records Management Code of Practice		CCG	01/10/2021	30/06/2022		Amber	Work has started with a communications out to line managers w/c 28/02/2022. Plan to have this completed by end of June 2022	Risk is that capacity of line managers is limited	Arrangements established and work well underway to identify, transfer and retain staff records with more than half completed and planned to be finalised by mid June.	Very low			

Accounts	3.1.13	If key staff leave before the CCG(s) close, robust exit management arrangements should be employed to retain and manage vital business knowledge in relation to accounts preparation and assets and liabilities.	Maria Tongue	01/11/2021	30/06/2022		Amber	All staff will TUPE over to the new organisation on 1st April 2022 so risk is minimal. Any changes in staffing outside of this process will need to be addressed if & when they arise	2 members of FA team leaving Nov 21. Risk to month 9 & year-end accounts process.	Additional resources being sourced and internal cover used where possible. Interim Financial Accountant appointed Dec 21 and previous member of FA team remains within wider finance team so	Moderate			
Risk Management	3.1.16	Review, revise and agree a risk management strategy, policy and procedures. This must include an approach to setting an agreed risk appetite and identifying, evaluating and managing risks. Mechanism for risk share across organisations to be agreed.	Alison Smith	01/11/2021	22/07/2022		Amber	Discussion on approach has been agreed with Governance Leads from ICS partner organisations in February. A draft Risk Strategy will be drafted based on this approach. Good Governance Institute has been commissioned to run workshops to develop risk appetite and initial ICS BAF	There is a risk around timeframes and capacity	Agreed CCG Director of Corporate Affairs will take work forward with support from the good governance institute.	Moderate			
Declarations	3.1.17	Establish transparent arrangements for declarations, including: - register of gifts and hospitality - register of interests	Alison Smith/Tracey Eggby Jones	01/10/2021	12/05/2022		Amber	A register of interests for the ICS Board has already been developed and is presented to their Board meetings and publically available on their website. A Conflicts of Interest Policy and Standards of Business Conduct Policy have been developed, setting out the ICS approach to managing conflicts of interest and gifts hospitality and sponsorship. The draft policies are currently with Internal Audit and Counter Fraud Team for comment/feedback.	There is a risk that register of interests for staff will not be fully completed with some individual members of staff conflicts needing to change. However the CCG has an upto date register of interests for its staff which has recently been audited.	By using existing CCG registers as the basis for the ICB, this will mean staff can restate their interests where they have not changed and a focus can be put on new staff or staff who have changing interests to ensure these are captured.	Very low			
Business Plan	3.1.18	Assess the financial impact of the strategic objectives and business plan for the new ICB	Claire Skidmore	01/11/2021	28/04/2022		Green	22/23 system financial plan submitted on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years	Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG	Regular system discussions around plan development through DoFs, CEOs and system sustainability committee. IDB overseeing delivery of efficiency and system transformation	High			
	3.3.19	Develop procedures and policy for: - travel expenses - training expenses - relocation - excess travel - lease cars - telephones incl mobiles - long service awards	Alison Smith for existing CCG policies	01/11/2021	30/06/2022		Amber	Many of these policies will be inherited by the ICB from the CCG as this is a requirement as part of equivalent TUPE transfer of staff - Training expenses - The CCG have a learning and development policy which covers training expenses - Travel expenses- STW CCG Excess Mileage and Additional Travel Guidance for Managers in place - STW CCG Excess Mileage and Additional Travel Guidance for Managers in place - long service awards - STW CCG Long Service Award policy in place - telephones and mobiles - In draft form (IT) - Relocation - Not a HR policy in place for this but will use the national rate determined by HMRC - Lease cars - Not offered at the moment, decision on whether we offer lease cars has not been confirmed. CS & SW discussing at the moment.	Where policies do not exist - lease cars there is a risk that a decisio is not made to create one prior to the 1/7/22.	Discussions on lease car policy being taken forward at the meeting for the ICB. CCG does not have one in place.	Moderate			
	3.3.35	Prepare and agree an ICB financial plan	Claire Skidmore		17/3/22 (draft), 28/4/22 (final)		Green	22/23 system financial plan submitted on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years	Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG	Regular system discussions around plan development through DoFs, CEOs and system sustainability committee. IDB overseeing delivery of efficiency and system transformation	High			

	3.3.36	Prepare and agree place based budgets	Laura Clare		31/03/2022		Red	Action is dependent on place partnership set up and delegation agreed - unlikely to have budgets delegated at place level until 23/24	Risk that place will not be sufficiently developed for place level budget delegation to operate in 22/23	Place discussions continue across the system	Very low			
Plans	3.3.37	Review the cost improvement programmes and determine a new programme for the ICB	Kate Owen	01/11/2021	20/01/2022		Amber	22/23 efficiency programme included as part of 22/23 financial plan submission. At point of submission £1m of plans unidentified and £0.7m running cost efficiency badged as high risk. System transformation plan savings also inlcuded within system plan submission with £2.9m unidentified gap currently held in CCG position.	Risk that full efficiency programmes and system transformation savings will not be identified which will contribute to financial deficit of organisation and system	Integrated Delivery board reviewing progress against both internal organisation efficiency plans and system transformation plans on a monthly basis	Moderate			
	3.3.39	Produce a team structure to meet its identified role within agreed management cost envelope	Laura Clare	01/11/2021	31/03/022		Amber	DoF level discussions regarding teams working closer togeher across the system commenced with various workstreams set up led by system deputies to explore options. Initial CCG structure to lift and shift into ICB but will be reviewed to develop system wide finance structure as other areas develop	Risk around capacity within existing finance team in CCG to pick up all system wide work	Structure being reveiwed across system around how can bring together existing resource across the system in a better way	Moderate			
	3.3.40	Consult with NHSEI to: • agree new control totals for ICB • determine performance against previously agreed control totals	Laura Clare	01/11/2021	28/04/2022		Amber	22/23 planning guidance released 24.12.21. System now working through detailed 22/23 financial plan development for final submission at end of April	Risk that system transfomation and organisational efficiencies will not be fully identified in order to meet control total	Integrated Delivery board reviewing progress against efficiency plans and system transformation projects on monthly basis	Moderate			
Seal	3.3.46	Destroy existing CCG seal, ascertain if need new seal	Alison Smith/Tracy Eggby Jones	01/07/2022	15/07/2022		Amber	Plan in place for destruction - must wait for CCG to be dissolved before the seal is destroyed. A seal will be created for the ICB.	There is a very low risk that the new seal for the ICB may be delayed dependent on manufacturer lead times	It is anticipated that there will be very few documents that require sealing - no further mitigation identified.	Very low			
Capital	3.3.48	Agree a framework for capital prioritisation and allocation across the system	Claire Skidmore		30/06/2022		Amber	Governance proposal going to IDB/Sust cttee in March with a view to establishing a capital governance and process that sits alongside the revenue process (closely linked and not operating in isolation) with a view to then evolving into a single process over time. Aim to have that up and running in April.	No risks identified		Very low			
Leases	3.6.20	Ensure that all lease documentation is properly filed and archived. Inform lessors of equipment of the transfer to ICB. Review all existing leases and terminate/ renegotiate as necessary (including mobile phones / pagers, photocopiers, lease cars)	Kay Holland	01/11/2021	31/06/2022		Amber	Not Finance - contracts register does contain some lease information but more work to be undertaken. All lease/contract owners contacted and asked to update register			Very low			

7.1.3	Ensure a defined governance and escalation process is established for quality which ensures that risks are identified, mitigated and escalated effectively through System Quality Groups (SQG) and links to Regional NHSEI quality oversight and reports to the ICB. This will link to the broader ICS risk management strategy, policy and procedures (see 3.1.13). The System Quality Group will serve as, or align with any Quality Committee (see 1.3.24).	Zena Young			Jun-22	Green	In accordance with National Quality Board (NQB) and NHSEI published guidance, we have set up our local quality governance, implementing a structure and function in accordance with the needs of our system. We are awaiting a further NQB publication which will inform the approach to Place-based quality governance. As part of our emergent system-level governance arrangements, we are reviewing how risks to quality are captured, escalated and managed effectively to ensure that our future system risk arrangements reflect our development as an ICS. We are awaiting the NQB guidance on risk escalation and will adopt this when published. We do not yet have a complete shared view of system quality risks, however providers publication of their Quality Accounts by the end of June 22 will inform this work. The system approach to risk appetite needs to be confirmed along with consideration of adopting a unified risk scoring system / matrix as a number of different ones are in use in the system. The NED chair of the QPC has yet to be announced.	The actions relating to requirement are built into our forward quality governance plan (Quality Roadmap). We are well-placed to adopt the NQB guidance on risk escalation when it is published, which should be in the next few weeks.	Moderate

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body meeting on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.056	Board Assurance Framework 2022/23

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	

Action Required (please select):									
A=Approval	X	R=Ratification		S=Assurance	X	D=Discussion		I=Information	

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
This has been presented to the Audit Committee	20 May 2022	S&D

Executive Summary (key points in the report):

1. Introduction

The purpose of the report is to present to the Governing Body the latest iteration of the Board Assurance Framework (BAF) as presented to the Audit Committee at its May meeting to provide; assurance that the principal risks of the CCG not meetings its strategic priorities have been captured and are actively being managed and to allow the Governing Body to review the detail of the risks set out in the document.

2. Risk Management Framework

The CCG has in place a Board Assurance Framework (BAF), supported by the Directorate Risk Register (DRR) which are the mechanisms used to record high level strategic and directorate level risks and opportunities across all functions of the CCG, including delegated co-commissioning of primary care.
The BAF and DRR are linked to the defined objectives of the CCG, the Primary Care Commissioning Risk Register is linked to the defined objectives of the Primary Care Strategy and together reflect the risk appetite of the organisation.

3. BAF 2022/23

The attached BAF is shown in appendix A and with appendix B outlining the CCG's risk matrix criteria.

The BAF was updated by the strategic risk owners during April and May 2022 as part of the routine bi-monthly review cycle.

The following report highlights the changes and updates to the BAF which are shown in more detail as tracked changed text in red on the BAF appended to this report. This was presented to the Audit Committee for assurance purposes at its meeting on 20th May 2022 and the Committee recommended the BAF with the highlighted changes as attached and described below.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication? The BAF and DRR appropriately capture and report the strategic and operational risks of financial and other resource implications.	Yes
3.	Is there a risk to financial and clinical sustainability? The BAF appropriately captures and reports the strategic and operational risks to financial and clinical sustainability.	Yes
4.	Is there a legal impact to the organisation? Sound risk management systems are an essential component of internal control processes. NHS organisations are required to sign an annual governance statement to provide reasonable assurance that they have been properly informed about the totality of their risks and can evidence that they have identified the organisational objectives and managed the principal risks to them. There is a mandatory annual internal audit review into aspects of risk management and the BAF.	Yes
5.	Are there human rights, equality and diversity requirements? An Equality Impact Assessment is not required for this process.	No
6.	Is there a clinical engagement requirement? This is an internal process and clinical engagement is not required for the process itself.	No
7.	Is there a patient and public engagement requirement? This is an internal process and patient engagement is not required for the process itself.	No

Recommendations/Actions Required:

The Governing Body is recommended to:

- Review the BAF and consider if any additional assurances are necessary that the risks to the strategic objectives are being properly managed.

- Approve removal of risk 1 – Public and Patient Engagement from the BAF to the DRR as new risk 18.
- Accept assurance from the CCG Audit Committee that the principal risks of the CCG not achieving its strategic and operational priorities and have been accurately identified and actions taken to manage them.

Report: Board Assurance Framework and Directorate Risk Register 2022/23

Governing Body: 8th June 2022

Author: Alison Smith, Director of Corporate Affairs

This report highlights by exception changes to the BAF. Changes are shown in red text on the BAF.

Board Assurance Framework (BAF)

All reference to Julie Davies have been changed to Julie Garside, to reflect her recent name change.

Risk 1 – Public and Patient Involvement – The risk has been reviewed by the Director of Communications and Engagement and it is proposed this risk be removed from BAF onto the DRR (new risk 18) due to the risk level being reduced to below 10 to Moderate 9 risk score. The Director of Communications and Engagement is undertaking discussion with Assuring Involvement Committee (AIC) members to help inform the purpose and role of the AIC in the ICB. The Audit Committee supports this recommendation.

Risk 2 – ICS Transition – updates on actions and controls but no change on risk score

Risk 3 – CCG Workforce – updates on actions and controls but no change on risk score

Risk 4 – Financial sustainability – updates on actions and controls but no change on risk score. A further update was provided after Audit Committee on 20th May which has been included in their version of the BAF.

Risk 5 – Inability to delivery long term sustainability plan – updates on actions and controls and an increase from 16 to 20 extreme on target risk score due to planning guidance now released.

Risk 6 – Quality and Safety - – updates on actions and controls but no change on risk score. Audit Committee asked the Deputy Director of Nursing and Quality to review the content of this risk in light of the recent internal audit review of Serious Incident reporting. This reviewed risk will be presented to the Audit Committee at its meeting on 15th June.

Risk 8 – Health inequalities – updates on actions and controls but no change on risk score

Risk 9 – Safeguarding/Looked after children capacity to carry out statutory functions – at the March meeting the Audit Committee declined to approve the recommendation that this risk be removed from BAF onto the DRR (new risk 12) as a result of the risk score being reduced from 20 to 9 moderate due to the recent investment in the team which has significantly reduced the risk. This was based upon feedback from the Internal Audit of the BAF that safeguarding, as a key patient safety risk, would attract a high inherent risk impact score and therefore should remain on the BAF. This was further supported by members of the Committee who highlighted that given the committee had received a limited and moderate assurance level internal audit report on childrens' and adult safeguarding respectively, earlier

in the year removal would not be appropriate until an update showing improved position had been presented.

The Committee at its meeting on 20th May, in discussion with the Deputy Director of Nursing and Quality, acknowledged that capacity issues had been addressed, but acknowledged that the actions arising from the internal audits undertaken this year for Childrens' and Adult Safeguarding functions, although put in place, had not yet been fully embedded and therefore the risk should remain on the BAF until the CCG/ICB is confident that the actions have been fully enacted.

Risk 10 – UEC Pressures - updates on actions and controls but no change on risk score.

A risk had initially been added to the BAF with regard to Paediatric ophthalmology, however following review this has now been moved to the Directorate Risk Register to reflect the level of strategic risk to the organisation.

Recommendation

The Governing Body is recommended to:

- Review the BAF and consider if any additional assurances are necessary that the risks to the strategic objectives are being properly managed.
- Approve removal of risk 1 – Public and Patient Engagement from the BAF to the DRR as new risk 18.
- Accept assurance from the CCG Audit Committee that the principal risks of the CCG not achieving its strategic and operational priorities and have been accurately identified and actions taken to manage them.

STW CCG - Board Assurance Framework (BAF) 2022/23 - May 2022

Appendix A

CCG Strategic Priorities:

1. To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities.
2. To identify and improve **health outcomes** for our local population
3. To ensure the health services we commission are **high quality**, safe, sustainable and value for money.
4. To achieve **financial balance** by working more efficiently.
5. To improve **joint working** with our local partners, leading the way as we become an Integrated Care System.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Risk ID	Strategic Priority	Opened / added by	Risk and description	Opportunity	Existing key controls	Existing sources of assurance	Gaps in controls or assurances	Risk score (consequences x likelihood)	Risk score trend	Action plan / cost / action lead /(target date) /sufficient mitigation	Target risk score for end of financial year	Director or Risk Owner	Risk Owner	Committee/ GB Oversight	Amendments/review: name and date
1	1 and 3	A Smith	Patient and Public Involvement There is a risk that the CCG fails to meet its statutory duty to involve patients and the public in planning commissioning arrangements, in development and consideration of proposals to change existing services or to cease existing services resulting in judicial review and services not meeting peoples needs. There is also a risk that the transition of the statutory duty to consult and engage from the CCG to the ICS may not be done without disruption to engagement on any consultation/engagement activity and/or reputational damage to the CCG/ICS	To ensure that service redesign and transformation is informed by consistent and robust involvement of patients and the public	1. Interim Communications and Engagement Strategy for STW CCG approved by Governing Body 2. Communications and Engagement teams working jointly across CCG, ICS and Providers providing more capacity and expertise in planning and delivery 3. Reports to Governing bodies/Committees require section completing on Patient involvement 4. Substantive ICS Director of Comms and Engagement now appointed and overseeing both ICS and CCG functions 5. Presence of Healthwatch for both areas at Governing Body meetings and Quality Committee 6. Lay Member for PPI and Lay Member for PPI - EDI in place on Governing Body to act as specific check and balance with regard to patient involvement 7. Assuring Involvement Committee as part of CCG Governance 8. Communications and Engagement teams are working jointly across the CCG, ICS and system partners providing more capacity and expertise in planning and delivery. 9. ICS board meetings are now held in public and board papers published to the ICS website to increase transparency. Clarity on where AIC will sit in new ICB governance structure. A system wide Engagement and involvement network recently established An involving people and communities strategy and toolkit is being developed with partners (LA, VCSE, providers) and the public	IAF Engagement Rating of Outstanding for T&W and Good for Shropshire retained for 2019/20 Reporting to Assuring Involvement Committee Reporting on Engagement as part of wider reporting and decision making at SCC and Q&P Committee Updates on ICS Pledge to ICS Board Health and Overview Scrutiny Committees (HOSC) AIC now receiving comms and engagement plans from commissioners and providing Chair reports to the Governing Body The CCG is managing the challenges around engagement effectively and due diligence work is ongoing around the transfer of CCG functions to the ICS for 1 April 2021 CCG has a communications and engagement strategy. Secured a source of advice on best practice process in relation to consultation statutory duty.	Gaps in controls: 1) Forward plan and key processes to be developed. 2) Clarity is needed from the emerging ICB about where the CCG AIC functions will sit in the ICB governance. Gaps in assurance: None	**Possible 3 x Moderate 3 = Moderate 9**	↓	1a) Communications and Engagement Director overseeing the production of a Comms and Engagement Forward Plan to cover the period to the end of the financial year. The forward plan will then be used as a basis to formulate a more formal C&E Strategy for the ICS. 1 b)The Interim Director and Assistant Director have established processes with their new-look team and are now developing a forward plan of activity. 2) Directors of Communications and Engagement is undertaking discussion with AIC members to help inform the purpose and role of the AIC in the ICB. May/June 2022	**Possible 3 x Minor 2 = Low 6**	E Boampong	C Hudson	AIC	AS 24.05.21 AS 21.06.21 CH 30.06.21 EB 02.09.21 EB 09.11.21 MB 07.02.22 EB 29.04.22 Recommend this is moved to the DRR risk 18 as risk level has reduced to below a score of 10.
2	5	A Smith	Transition to a statutory ICB There is a risk that the CCG does not have sufficient capacity and capability to undertake the transition to the ICS satisfactorily, which results in the ICB being unable to discharge its new statutory duties.	The CCGs to support all ICS partners to plan and deliver improved services for the population.	Governing Body members taking lead roles in ICS governance and delivery functions. CCG Directors have dual roles with CCG and ICS Joint CCG/ICS management team meetings Transition meetings taking place with CCG AO ICS Director, ICS Workforce, CCG Director of CA ICS has been authorised by NHSE/I Project lead identified by ICS National guidance has now been released ICS and CCG have now appointed an interim CEO for ICS Transition group overseeing transition plan and due diligence via fortnightly meetings. Work is being shared between ICS/CCG and providers, with key leads being identified CS Transition Group involves CCG ED for F, ED for Quality and Nursing, D of Partnerships and Director of CA Transition plan in place with PMO support. Due Diligence plan approved and work is ongoing with identified PMO lead.	ICS Board. Regular reports to CCG Governing Bodies. Programme Boards of the ICS reporting to the ICS Board. Fortnightly reporting on Readiness to operate and due diligence to ICS Transition Steering Group which reports into the ICS CEO Group Reporting on Due Diligence assurance to ICS Audit and Risk Committee and CCG Audit Committee Due Diligence Assurance Panels held in December to assess progress of due diligence and highlight risks and mitigating actions. NHSE/I attend the ICS Transition Steering Group meetings ROS and Due Diligence progress was presented at CCG Governing Body informal to be held in February 2022.	Gaps in controls: None Gaps in assurance: 1. ICB Governance structure and reporting requirements still being defined	**Possible 3 x Major 4 = High 12**	↔	1. (a)Guidance on model constitution and place and ICB structures have been released. and ICB is leading more work on place based arrangement for 1st July. Jan - May 22 1 (b) Governance structure has been agreed and terms of reference and scheme of reservation and delegation are being developed 30 May 2022	**Unlikely 2 x Major4 = Moderate 8**	C Skidmore Deputy AO	A Smith	GB/Audit	AS 24.05.21 AS 21.06.21 AS 02.09.21 AS 10.01.22 MB 07.02.22 AS 27.04.22

3	All priorities	A Smith	CCG Workforce capacity There is a risk that due to the number of secondments, staff vacancies, recruitment freeze and staff sickness levels that the capacity, capability and resilience of our workforce is unable to meet the demands of ongoing secondment/redeployment requirements of the Covid pandemic and the ongoing need to service both CCG and ICS operational functions running in parallel which will result in the CCG being unable to meet its strategic priorities.	Ensure our workforce is focussed on the CCG/ICS priority areas, effective planning processes, adoption of technology, remote working	Work has been done to ensure that there a no duplication between the CCG and ICB meetings. A reduced rhythm of CCG governance meetings has been agreed with the CCG Governing Body. HR are continuing to collect information on secondments/ temporary staffing as part of due diligence process to provide an overview. Effective prioritisation of workload to system Big 6 priorities and other quality and safety priorities. ongoing CCG is participating in collective mutual aid with system to support level 4 incident management Jan - Mar 2022 through an internal coordination overseen by ED of Quality and D of CA. December - Mar 2022	Directors sharing directorate risk at Exec meeting weekly audit of training compliance, ICB has advertised for NEDS and Executive Directors. Staff health and wellbeing group overseeing staff support mechanisms. Ability to report Covid related sickness from EASY system for CCG staff overseen by HR and reported to Director of Corporate Affairs who escalates where appropriate to weekly Exec meeting	Gaps in controls: None Gaps in Assurance 1. Some gaps remain that need adding to the DRR for reporting purposes.	**Possible 3 x Catastrophic 5 = 15 high**	⇔	1 Capacity issues in directorates to be captured in DRR May 2022	**Possible 3 x Moderate 3 = Moderate 9**	A Smith	A Smith	Audit/GB	AS 24.05.21 AS 02.09.21 AS 09.11.21 AS 10.01.22 MB/AS 07.02.22 AS 27.04.22
4	3 and 4	Laura Clare	Financial Sustainability Failure to deliver the CCG element of the system financial sustainability plan The underlying financial position of the CCG and the system as a whole is currently in a significant deficit. The system is therefore in a recovery process and unable to make investment decisions without being through the 'triple lock' process of organisation, system and NHSEI approval. As part of the system sustainability plan and the 22/23 operational planning process the CCG has been set an expenditure envelope to deliver in 22/23. ~~which includes 21/22 which stabilises spend over the year.~~ ~~The CCG will also need to be able to demonstrate an agreed level of efficiency savings delivered on a recurrent full year basis by the end of 21/22. For 22/23 the CCG needs to deliver~~ The system has set itself an efficiency target equivalent to 1.6% which the CCG will need to deliver its share from its out of system expenditure. In addition to this, the system transformation programme is also expected to deliver efficiency. This plan will be handed over to the ICB from 1st July 2022.	This offers the CCG/ICB the opportunity to fully assess commissioned services to ensure best clinical value as well as financial efficiencies.	Detailed YTD and forecasting information provided at both organisation and system level Regular CCG/ICB budget holder meetings and budget holder training programme in place PMO function set up within CCG Finance directorate to help leads to develop efficiency programme and accurately monitor progress and delivery.	Regular CCG/ICB and System level financial reporting to CCG directors, finance committee and Governing Body. Sustainability working group within CCG chaired by Deputy Director of Finance to ensure efficiency programme is mature and realistic. Detailed efficiency programme reporting to CCG finance committee from Finance directorate. Integrated Delivery Board set up as system committee to oversee efficiency delivery across the system. CCG is an active member of the ICB Sustainability Committee.	Gaps in Controls: 1) Full CCG/ICB recurrent efficiency target of 1.6% for 22/23 not yet identified and needs to be urgently addressed. 2) CCG/ICB staff resource issue to deliver all plans 3) No contingency in plan to mitigate emerging risks - particular risks in CCG/ICB plan flagged around Individual Commissioning pricing, community beds/discharge and elective recovery. ~~around the increase to FNC pricing being discussed nationally.~~ Would need increased efficiency plans to mitigate. Gaps in assurances: 1) Minimal business cases for 2022/23 lodged and signed off so far within the CCG.	**Almost Certain 5 x Catastrophic 5 = Extreme 25**	⇔	Controls: 1)~~Sustainability~~ working group action plan updated in April to focus on 5 key themes to address the gap with assigned leads to be invited to present deep dives. Actions being monitored through the group and reported to finance committee. Progress on development of Efficiency programmes across organisations to be reported through to the Integrated Delivery Board from January 2022 (CS/KO Jan 22). Risk score following mitigation increased to reflect lack of progress with efficiency programme. 2) CCG finance team actively engaged in discussions and monitoring potential risks and cost pressures. Issues discussed at regular system finance group meeetings and pressures considered at Investment Panel. ~~involved in NHSEI discussions regarding FNC national negotiations and other emerging pressures.~~ [LC May 21]. Assurance: 1) Business case documentation has been requested from all leads by the end of February. (Efficiency programme leads Feb 22). Delivery Monitoring to commence in April '22	**almost certain x major = Extreme 20**	Claire Skidmore	Claire Skidmore/ Laura Clare ~~Julie Davies~~/Kate Owen	Finance	Laura Clare 26.5.21 28.6.21 Kate Owen 20.08.21 Laura Clare 21.10.21 Laura Clare 10/12/21 Laura Clare 19.01.22 MB 07.02.22 Claire Skidmore 14.02.22 Laura Clare 13.04.22 Laura Clare 13.05.22
5	3 and 4	Laura Clare	System failure to deliver overall long term sustainability plan. The underlying financial position of the CCG and the system as a whole is currently a significant deficit. The system is therefore in a recovery process and unable to make investment decisions without being through the 'triple lock' process of organisation, system and NHSEI approval. As well as delivering the CCG element of the sustainability plan, the CCG will also play a key part in the whole system delivering the longer term sustainability plan and the c£30m transformational saving required each ~~every~~ year for a number of years	There is huge opportunity in working together across the healthcare system on transformational projects. The COVID19 situation also presents opportunity to reset to a 'new normal' which may assist in driving out inefficiency in the cost base of the system.	Risk management framework in place across the system as part of development of system sustainability plan. System governance arrangements in place through sustainability committee and investment panel to ensure that new investments are not made unless recurrent resource is available.	Regular CCG and System level financial reporting to CCG finance committee and Governing Body. Regular system level financial reporting to system sustainability committee and Integrated Care Board Integrated Delivery Board set up across the system to oversee efficiency and transformation programme delivery	Gaps in controls: 1)- Long term plan developed with high level assumptions. ~~Final~~ April 22/23 plan submission made with a £38.1m planned system deficit. Next steps currently being worked through, signifcant gap to break even to be addressed and likely plan resubmission due June 2022. 2) System transformational projects ('big ticket 6') currently in development stage and firm plans need to be in place. Resource needs to be assigned to projects to ensure delivery Gaps in assurance: 3) Risk management framework has been drafted and agreed across the system to ensure collective ownership of risk and mitigation. This needs to be refined as plans develop.	**Almost Certain 5 x Catastrophic 5 = Extreme 25**	⇔	1) Significant work underway across system to model long term plan. Modelling task and finish group assembled and reviewing system wide financial model available from NHSEI. Future years of plan presented to the system in September- this included a ten year plan showing agreed high level assumptions. This was supported by system partners. System to organisation challenge meetings delivered improved planned deficit position for 22/23 but work still underway to work through next steps ahead of a resubmission in June 2022. Action plan held by ICB CFO for delivery in May and SROs to be assigned to programmes of work to deliver current gaps in transformation programmes and cost reduction targets. ~~improve 22/23 planned deficit position . System finance summit meetings in place.~~ Long term plan to be refreshed following submission of final 22/23 plan. (CS May 22) 2) System wide development of 'big 6' underway with SRO assigned to each, further work on modelling underway to align to system financial plan. Operational delivery group meetings now in place fortnightly with SRO, programme lead and finance leads to ensure progress: [Cherry West May '22] 3) System risk management framework to be adopted by the new ICB	**almost certain x major = Extreme 20**	Claire Skidmore	Claire Skidmore/ Laura Clare	Finance	Laura Clare 26.5.21 28.6.21 20.8.21 Steve Trenchard 26.8.21 C Skidmore 09/11/21 Laura Clare 10/12/21 Claire Skidmore 14/02/22 Laura Clare 13/4/22 Laura Clare 13/5/22

6	1, 3 and 5	Z Young	Quality and Safety Without a robust quality governance framework in place, the system will not be able to monitor quality and safety and mitigate risks in a timely manner. Patients may experience poorer outcomes and experience.	There is opportunity for the CCG to lead the development of our system quality governance approach, aligned to NQB and NHSEI guidance, adopting a distributive leadership approach to harness the talents and strengths within our system.	1. Development of an ICS Quality and Safety Strategy, co-produced with system health and social care partners and patient representative groups. Approved by ICS Board June 2021. 2. Establishment of our ICS governance structure including Quality & Safety Committee (a sub-committee of the ICS Board) and System Quality Group (SQG) which provides quality surveillance and improvement. 3. STW LMNS function is developing to encompass the new responsibilities for PNQSG and ToR and risk register have been revised in light of this requirement. 4. SaTH Safety Oversight and Assurance Group (SOAG) in place, co-chaired by NHSE/ICS lead and with system membership. 5. SI reporting in accordance with NHS SI Framework, monthly SI review meetings between commissioner/provider in place. 6. Patient Safety Group in place with remit to ensure the NHS Patient Safety strategy is delivered across system. 7. System-wide IPC forum in place providing oversight and peer support. 8. Vaccination quality governance forum in place to oversee C-19 delivery programme. 9. CCG/ICS quality and safety monitoring and reporting arrangements will run in parallel during 2021/22. 10. The model for system governance is confirmed. 11. There as aprogramme for monthly quality assurance vsitis including for maternity MVP and LMNS representatives are included in the Maternity and Neonatal Safety Champion quality visits monthly. 12. SaTH real-time (unvalidated) data submissions to MBRRACE-UK accessible through speciliste midwife and preinatla mortality tool. 13. All women now on badgernet platform. Meday now read only (May 22). 14. Regional escalation tool in place for maternity closures (May 22) 15. Quality metrics agreed adn included in System Quality metrics from June 22 for oversight.	1. Good attendance from system partners at the SQG. 2. Distributive leadership approach in evidence through leadership of quality improvement groups. 3. Number of overdue SI reports is reducing and quality of investigatory reports and action plans improving for acute provider. 4. Information sharing and benchmarking via LMNS and MatNeo Clinical Network. Maternity & Neonatal network independently review maternity position for SBLCB v2 bi-monthly. LMNS receives a Perinatal Quality Surveillance report and updates on progress with implementing the recommendations arising from the Ockenden review of maternity services 2020 and the 2nd Ockenden report 2022. Staffing levels funded to Birthrate plus recommendations. 5. Recent QA visit to SaTH demonstrated person-centred care and adherence to safeguarding policy requirements for CYP/MH cases. 6. CQC inspection of SaTH November 2021 shows underlying improvement including in individual service ratings and a reduction in number of conditions applied. 7. External Audit (Grant Thornton) report July 2021 details 'good level of assurance' on the CCG's actions to ensure patient protection and safety, especially in relation to maternity services; A&E; and SI learning. 8. Executive Chief Nurse for ICB appointed. 9. Undertake themed reviews for individual providers and system quality concerns and issues. Ongoing development of system dashboard for Quality Indicators for SQG members peer review and mutual accountability. Oct 21 10. Provider organisations have their own quality governance arrangements which provide a line of sight of any emerging concerns. CCG are engaged in these.	**Gaps in Control:** 1. Backlog in key performance areas impacted on by continued C-19 pandemic response, leading to poorer patient experience and possible harms due to delay in access for diagnostics and treatment. 2. Quality governance processes in SaTH not fully formed and embedded; reliant upon external support. 3. SaTH vacancy and staff turnover for skilled workers. Necessary workforce is not in place/do not have capacity/capability, or is achieved with temporary staffing solutions or external support. **Gaps in assurance:** 4. Triangulated information indicates areas of concern within providers. o SaTH in NHSEI Quality Special Measures - rated by CQC as inadequate for 'safe and well-led' domains and CQC regulatory action iremains in 3 areas ~~and warning notices applied in a range of areas, recently~~ including CYP MH provision and associated safeguarding assurances. o SaTH Maternity Transformation schemes (Continuity of Carer/SBLCBv2) and Ockenden (1&2) Maternity Review recommendations not yet fully implemented. o MPFT access to services for CYP MH and suicide prevention strategy. 5. Unvalidated SaTH provider metrics/data quality issues - particularly for maternity services. 6. Time lag of 2 years for MBRRACE-UK nationally validated and published comparative perinatal mortality data. 7. Closure/divert of some maternity birthing services at SaTH due to staff shortages as a result of vacancy (Maternity Led Services). 9. Establishment of system approaches to quality governance at early stages and not fully developed or embedded. In particular the quality governance at 'place' is yet to be defined.	**Possible 3 x catastrophic 3 = High 12**		1. Further develop and embed the system-wide revised approach to quality governance during 2021/22, including quality governance at 'place'. Identify senior resource (DDoN) to lead this work. Q3 2. Continue to monitor quality risks and workforce plans at provider level through existing mechanisms including a presence at SaTH internal quality governance fora. (nb Workforce reported to ICS People Board which has agreed key priority areas for action). Ongoing ~~3. Maintain a schedule of quality assurance visits, with triangulation of data from a variety of sources, including increased inclusion of patient experience elements.~~ 4. SaTH undertaking a programme of Quality Improvement ~~with UHB as their Improvement Alliance partner –~~ Getting to Good Programme - reported monthly to SOAG for oversight & scrutiny. SOAG is co-chaired by ICS and NHSE/I directors. 5. Further develop the maternity metrics dashboard at LMNS level - developments made with LMNS dashboard working with SaTH and CSU to establish validated metrics. Data Quality position report received to LMNS board March 22, improvement expected by July 22. ~~6. Negotiate access to SaTH real-time (unvalidated) data submissions to MBRRACE-UK~~ 7. Support to SaTH to further develop the content and accuracy of their internal maternity dashboard and improve exception reporting. ~~8. SaTH implementing the 'Badgernet' electronic maternity records system from in a phased roll-out programme which over time will improve confidence in audit information. Aug 2021 onwards.~~ ~~9. CCG Quality Lead to join SaTH Maternity Safety Champion programme of clinical quality assurance.~~ 10. Continue to monitor Maternity service closure and impact, ensuring appropriate escalation process are followed in each occurrence. 11. Targeted quality improvement work relating to CYP MH in progress 12. Oversight of Safeguarding and LAC risks via system safeguarding assurance mechanisms. 13. Continue to monitor LAC standards (which are improving), supporting with revised referral processes. 14. Implement recommendations of CCG internal audit of Safeguarding Adult and Child processes. Oct 21 (June 22 completion) 15. Implement new statutory requirements for Liberty Protection Safeguards when national timelines and details are published. GB development event Oct 21. 16. Review CCG Quality Team staffing plans as part of budget setting. May 2022	**Possible 3 x Major 4 = High 12**	Z Young EDoN&Q	T Slater	QPC	Z Young 03/09/21 Z Young 24/02/22 Risk score reduced due to increasing levels of system quality governance V Whatley 11/05/22 Control updated to include closed actions Assurance updated to update appointment of ICS CNO Gaps updated to revise specific maternity services closed Actions updated to reflect recent completion.
7	1, 2	Julie Garside	Restoration of Services Post Covid 19 There is a risk that the restoration of health services following the Covid19 pandemic will not keep pace with patient need resulting in patients suffering harm.	Opportunity to develop innovative and more effective approaches to patient care Opportunity to develop a system approaches to patient pathways and care	Demand and Capacity Modelling System Clinical prioritisation and approach to harm policy in place Development of digital and virtual capabilities Developing system infrastructure 2022/23 operational plan People Plan and workforce planning	Demand and Capacity Groups Covid19 Management Group System Planned Care Operational Group (Elective & Cancer recovery) and System Planned Care Board Regular updates to CCG Board and ICS Board	Gaps in controls: 1) Balance of workforce gaps, overseas recruitment impact of Covid19 and management of staff health & wellbeing will impact on the ability to produce the workforce needed to recover at the necessary rate 2) Estate limitations 3) Equipment limitations	**Almost certain 5 x Major 4 = Extreme 20**		1a)Elective Recovery trajectories set out in 2022/23 plan. Big 6 item re outpatient transformation and MSK addressing elements of sustainability and transformation 1b) Demand and capacity and performance monitoring ongoing to track progress and allow for early mitigation if deviation from plan is evident. 1c) Work ongoing on implementation of People Plan 2 &3) Ongoing dialogue with NHSE regarding equipment and estate	**Likely 4 x Major 4 = High 16**	Julie Davies, Sam Tilley,	Julie Davies	QPC/GB	J Davies 30.08.21 J Davies 11.01.22 J Garside 10.05.22
8	1,2	Sam Tilley	Population Health Needs There is a risk that the CCG fails to understand its population health needs and how this contributes to health inequalities across the footprint resulting in widening health inequalities.	To develop stronger partnerships with Local Authorities, public health and other stakeholders to develop a system strategy for health inequalities and population needs To tailor health and wellbeing services more accurately to population need ensuring they have a greater impact	Inequalities sits within the portfolio for Director of Planning and Partnerships and Population Health Management sits within the portfolio of the Director of Planning. JSNA work lead by Councils.	Health Inequalities outline strategy and bid. Personalisation agenda to meet population needs supported by regional funding and bid. New partnership arrangements for SEND with both local authority groups. Shropshire CCtH board and TWIPP working towards a place based delivery model on the needs of the populations. Health inequalities uptake approach to system vaccination programme ICB Population Health Board	1) lack of specific PHM expertise within the CCGs (recruitment to 2 x joint PHM posts with Councils not yet complete) 2) System infrastructure and agreed reporting lines to support impact assessments, BI outputs and resultant plan to be finalised 3) Need to co-ordinate system BI platforms to enable and support the development of a system approach to BI and PHM 4) Comprehensive engagement and communication strategy required for the public patient engagement exercise (SCCtH & TWIPP) 5) Lack of recurrent funding to ensure capacity in workforce to deliver needs of populations both internally and with providers.	**Likely 4 x Major 4= High 16**		1) First phase review of capacity and capacility completed. Anaylist network in place to support sharing skills and expertise and supporting a system approach. 2 x PHM posts (joint with LAs) recruited to. Refresh of PH Strategy completed to ensure system BI capacity is wrapping around the correct priorities. Further maping of progress of work programmes needed by end of May 22 2/3) PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. Need for appropriate data sharing arrangements to be finalised to support this work by end of May 22. Further mometum needed in relation to digital developments 4) Engagement strategies being developed with the SCCtH and TWIPP boards. Joint posts with Local Authority to develop partnership and place based working to deliver the needs of the population PHM SRO within ICS structure but reporting lines and working group arrangements to be developed 5) Funding requirement linked to output of the CSU Strategy Unit review	**Possible 3 x Moderate 3 = Moderate 9**	Claire Parker/ Sam Tilley	Claire Parker/ Sam Tilley	SCC/GB	S Tilley 28.02.22 C Parker 11.01.22 MB 07.02.22 S Tilley 08.05.22 C Parker 10.05.22

9	1,2,3,5	Zena Young	Safeguarding / Looked After Child (LAC) There may be insufficient capacity to carry out statutory safeguarding responsibilities for Adults and Children within our system with the increase in safeguarding activity associated with C-19 pandemic. Lessons may not be learned quickly enough to fully protect our population from avoidable harm.	To ensure all safeguarding statutory duties and improvement / oversight activities are carried out in an integrated manner between system partners. There is also opportunity to take a collaborative approach to support care home providers to avoid escalation of care needs and crisis presentation.	1. Robust safeguarding governance infrastructures for the two system Local Authorities, which is well attended by all statutory partners. 2. Regional safeguarding governance infrastructure which is well attended by CCG. 3. Experienced team members and good professional links between providers and commissioners of services across STW. 4. There is a Designated Doctor for LAC in post.	1. The safeguarding and LAC governance infrastructure is well attended by all statutory partners. 2. The GP forum is well attended. 3. STW Designate professionals are networked at regional and national level, contributing to a variety of expert groups. 4. A quality assurance visit to SaTH regarding s31 found a good level of safeguarding assurance. 5. Investment in SG LAC team wte. Team was fully recruited as of September 2021, however some turnover which is being recruited to.	Gaps in controls 1. The volume of rapid reviews and Safeguarding Governance assurance meetings requiring inputs has increased post C-19 lockdown. 2. A high number of children from Out of Area are placed in Shropshire Children's care homes; frequently their escalating or specialist needs are unable to be met by those care homes and they become 'stranded' in ED in crisis. This is beyond the control of STW system, being the responsibility of the placing organisation and private care homes. 3. A shortage nationally of NHSEI commissioned Tier 4 specialist beds, particularly for eating disorder specialist placements. 4. A delay in mental health assessment for persons presenting in ED due to a local shortage of MH assessors. 5. For Shropshire LA, LAC notifications not received/not timely which impacts on achievement of Health Assessments being conducted in a timely manner. Gaps in assurance: 6. Increased level of safeguarding concerns and associated volume of work generated post-lockdown within system. 7. On occasion there are some CYP solely with mental health needs at SaTH which breaches the CQC s31 notice issued in February 2021. 8. On occasion older YP are cared for on adult MH wards or for long periods in the s136 suite.	**Possible 3 x Moderate 3 = Moderate 9**	↓	1. Maintain attendance of designated and named professionals at safeguarding and LAC governance fora. 2. Continue to triangulate information and outcomes and address areas of concern. 3. Continue to undertake quality assurance visits. 4. Scope out development of a proactive/reactive support offer to CYP care homes with system partners. 5. Continue to support commissioners and providers in implementing new models of care.	**Possible 3 x Minor 2 = Low 6**	Zena Young	Maria Hadley	QPC	Z Young updated 24/02 - there has been investment in to the SG and LAC team which has reduced the risk to a manageable level. Recommend the risk is downgraded for monitoring on DRR risk 12 V Whatley 11/05/22 Update to controls, DD in place for LAC.
10	2,3	S Tilley	Risk of sustained UEC pressure There is a risk that demand for urgent and emergency care consistently outstrips capacity and that this will result in patients suffering harm.	Opportunity to transform UEC pathways	Daily Silver Call Weekly Gold Call UEC Improvement Plan in place	UEC Group UEC Board UEC Sub Groups Reporting to CCG Board	Workforce pressures and covid prevalence is putting significant pressure on service delivery. CCG to appoint a senior lead.	**Almost certain 5 x Major 4 = Extreme 20**	↔	Several improvement workstreams in place but capacity to deliver change has been limited due to the level of system pressure. There are signs that this is now beginning to ease. Learning from our current UEC improvement Plan and the approach to recent pressures has been consolidated and mapped into a refreshed UEC Improvement Plan which has been approved by the UEC Board. Work to finalise sub-work programmes to be completed by the end of May22 Significant collaboration between partners agencies, including our LAs in addressing current pressures has show benefits Winter Comms plan in place, Winter Plan and specific winter schemes in place. Winter scheme evaluation to be completed by end of May22 to inform planning for winter 22/23 which will commence in June 22 CCG UEC staffing resurce structure developed and ageed. Recruitment to commence in May 22 Specific development in place regarding discharge and attendance avoidance	**Likely 4 x Major 4 = High 16**	S Tilley	S Tilley	UEC Board All CCG Committees	S Tilley 28.02.22 MB 07.02.22 S Tilley 08.05.22

Audit Committee Meeting - Appendix B

RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
1 Negligible	**1 VERY LOW**	**2 VERY LOW**	**3 VERY LOW**	**4 LOW**	**5 LOW**
2 Minor	**2 VERY LOW**	**4 LOW**	**6 LOW**	**8 MODERATE**	**10 MODERATE**
3 Moderate	**3 VERY LOW**	**6 LOW**	**9 MODERATE**	**12 HIGH**	**15 HIGH**
4 Major	**4 LOW**	**8 MODERATE**	**12 HIGH**	**16 HIGH**	**20 EXTREME**
5 Catastrophic	**5 LOW**	**10 MODERATE**	**15 HIGH**	**20 EXTREME**	**25 EXTREME**

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

	Consequence score (severity levels) and examples of descriptions				
Domains	**1. Negligible**	**2. Minor**	**3. Moderate**	**4.Major**	**5. Extreme**
Impact on the safety of patients, staff or public (physical/psychological harm).	**Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.**	**Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.**	**Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.**	**Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.**	**Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.**
Quality/complaints/audit	**Peripheral element of treatment or service suboptimal. Informal complain/injury.**	**Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.**	**Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.**	**Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.**	**totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.**

Human resources/organisational /development/staffing/ competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspections	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Risk in relation to CCGs	Insignificant cost increase	1-2% over plan/target	2-5% over plan/target	5-10% over plan/target	>10% over plan/target
	On assessing impact, consideration will also be given to other key financial objectives including but not limited to cash management and receivables/payables control				

Service/business interruption/environmental impact	**Loss/interruption of >1 hour.** **Minimal or no impact on the environment.**	**Loss/interruption of >8 hours.** **Minor impact on environment.**	**Loss/interruption of >1 day.** **Moderate impact on environment.**	**Loss/interruption of >1 week.** **Major impact on environment.**	**Permanent loss of service or facility.** **Catastrophic impact on environment.**

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 8 June 2022**

Item Number:	Agenda Item:
GB-22-06.057	Patient Services Complaints and Enquiries Update

Executive Lead (s):	Author(s):	
Alison Smith Director of Corporate Affairs	Tracy Eggby-Jones Corporate Affairs Manager	Angela Porter Corporate Affairs Officer

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Not applicable		

Executive Summary (key points in the report):

NHS Shropshire, Telford and Wrekin CCG Patient Services Team, manage the Complaints and Patient Advice and Liaison Service (PALS) enquiries for the CCG.

Background

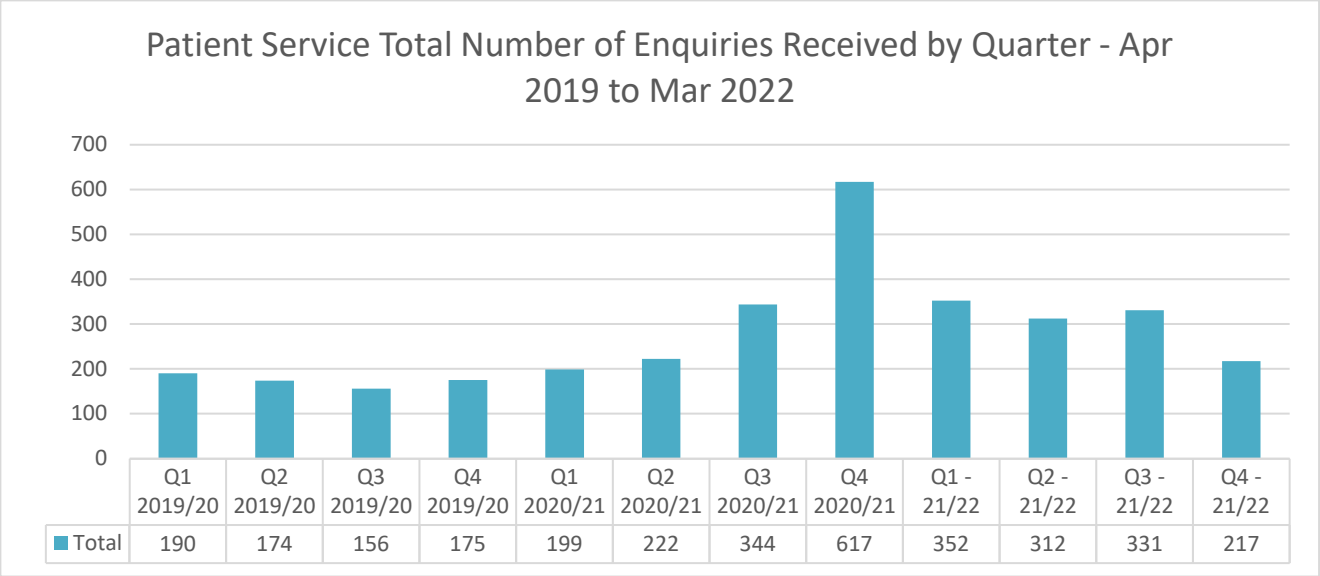
Prior to September 2019, NHS Shropshire and NHS Telford and Wrekin CCGs' Patient Services Teams were working separately. At this time SCCG Patient Services Team operated with 1.4wte, with the Corporate Services Officer offering some support. SCCG had a backlog of cases. TWCCG Patient Services Team operated with 1.0wte Patient Experience Lead, with a 1.0wte admin team member who supported both this service and the engagement function. There were no backlogs within TWCCG Patient Service Team function.

In October 2019, SCCG and TWCCG Patient Services Teams started to work together, to assist with backlogs in SCCG and in readiness for the move to the new joint NHS Shropshire, Telford and Wrekin CCG. The backlog had started to be addressed and improvements seen, with systems and processes being streamlined.

In March 2020, the team were then required to work as one team, with T&WCCG Patient Experience Lead taking on day to day line management responsibilities in order to free up the Corporate Affairs Manager to support CCGs efforts towards the Covid 19 pandemic, like all other staff within the CCG, the Patient Services Team were working from home, so staff also had to learn new ways of working.

At this time there was still a backlog of cases and there were then several other factors that impacted on the Patient Services Team workload:

- April 2020 – A new case management system was implemented – unfortunately there were some teething problems with the new system and since implementation other issues have been identified that have impacted on reporting and subsequently on the team's workload.
- April – June 2020 – NHS Complaints Teams were advised that they could put complaints processes on hold, so that clinical staff could concentrate on providing care due to the Covid 19 pandemic.
- May – September 2020 – The backlog had started to be addressed and improvements were being seen.
- September – December 2020 – NHS Shropshire and NHS Telford and Wrekin CCGs undertook a management of change process which led to further changes within the team
- January – August 2020 - As a consequence of the management of change process and some long term sickness the team was under resourced.
- During Q3 and Q4 of 2020 the service saw a significant increase in the number of enquiries, due to Covid 19 and especially around the vaccination roll out at the end of 2020 and start of 2021. Information around the number of enquiries received per quarter is detailed below.



	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 - 21/22	Q2 - 21/22	Q3 - 21/22	Q4 - 21/22
Total	190	174	156	175	199	222	344	617	352	312	331	217

In September 2019 a report showed there were some 140 cases open, 72 of which were complaints, 41 were MP enquiries and 27 were PALS enquiries. The majority of these were overdue responses, with the oldest of these cases originally being received in November 2019.

Due to the backlog and capacity, the team were advising complainants that there would be a 6 month timescale for all complaint cases.

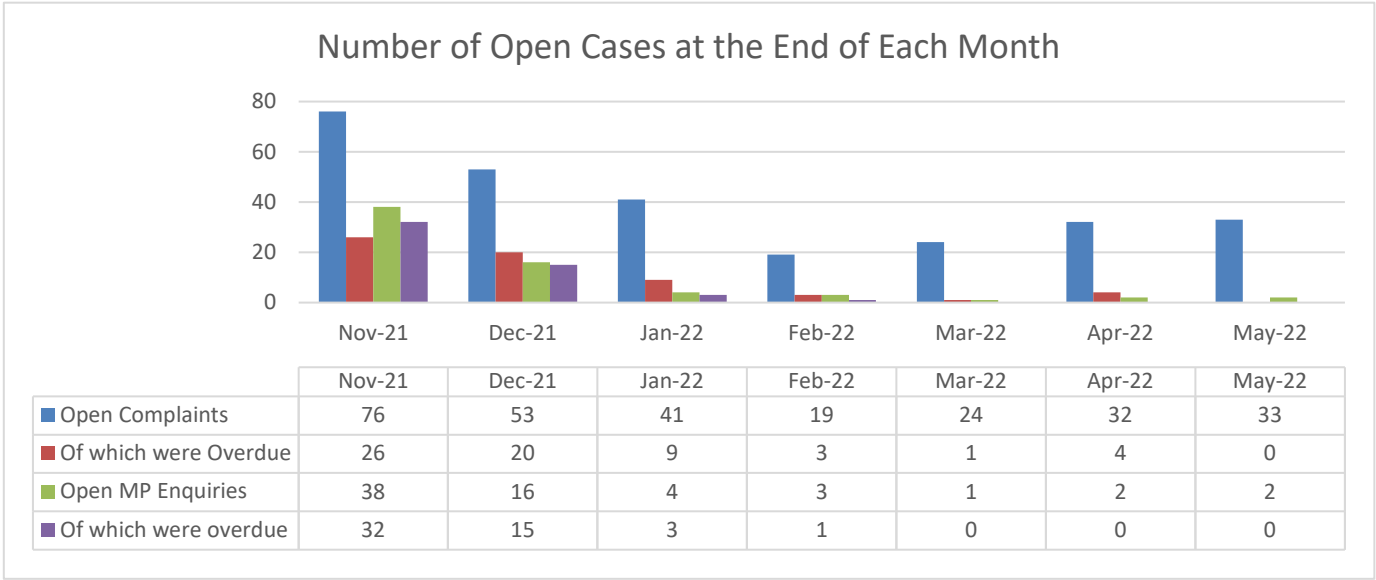
Actions Taken to Address Situation
In order to address the situation, the following actions were taken:

- An additional staff member has been employed to cover long term sickness. Reception staff capacity has been used to support the team with administrative functions.
- January 2022 - The complaints function was audited, in order to understand if any processes could be changed that would streamline the complaints handling process. Although overall the audit provided a moderate level of assurance, it was concluded that the CCG's complaints process was effective and fit for purpose. The auditors recognised the impact of the capacity issues and system problems that had been experienced within the team. The hard work and dedication of the Patient Services Team was acknowledged. Good progress has been made against the audit action plan with the remaining recommendations due to be implemented by 30 June 2022.

- The Interim Accountable Officer, reiterated internally to all CCG staff members about the need to ensure that enquiries are dealt with quickly and that responses are provided back to the patient services team within timescales requested. He has also supported the team ensuring a focus on the timeliness and quality of responses.
- Issues with the Patient Services case management system have been addressed and reporting is now more accurate and straight forward.
- A weekly report is provided to the Interim Accountable Officer and Director of Corporate Affairs outlining the current position in relation to all open enquiries, highlighting any that are overdue and including the number of new enquiries being received to ensure a new backlog is not created whilst clearing the existing backlog.
- A process is in place to escalate cases where there are delays with response to the Director of Corporate Affairs and the Interim Accountable Officer.
- A diary management process has been put in place for the team to chase up on existing cases and to update complainants in relation to progress.
- All responses are now reviewed at Director level before being sent to the Interim Accountable Officer for final sign off.

Current Position

The below table illustrates the number of complaints and MP enquiries that have been open since November 2021 to date and shows the significant improvement in performance.



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Open Complaints	76	53	41	19	24	32	33
Of which were Overdue	26	20	9	3	1	4	0
Open MP Enquiries	38	16	4	3	1	2	2
Of which were overdue	32	15	3	1	0	0	0

As at the 20 May 2022, when this report was prepared, the CCG had 33 open complaints and 2 open MP enquiries, none of these enquiries were overdue. The table below indicates the position of open enquiries.

Position of open complaints and MP Enquiries	
Investigation in Progress (Awaiting Response from provider/CCG department)	15
Awaiting Consent / Contact from Complainant	12
Re-Opened Cases (following responses being sent)	3
Response letter under review	4
Ombudsman Case	1

Recommendations/Actions Required:

The Governing Body is asked to:

- receive the report; and
- note the backlog of complaints and enquiries that the CCG had been experiencing has now been resolved.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).* Having a clear complaints process and policy in place allows patients to share their experiences of accessing and using our services. This is used to help inform future service developments and take account of different needs of our population and reduce health inequalities.	Yes
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).* Learning outcomes from complaints are used to identify and inform future service developments and improve health outcomes for our population.	Yes
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	Yes

	Learning outcomes from complaints are used to identify and inform future service developments and ensure that the services we commission are high quality, safe, sustainable and value for money.	
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).* Linking with partner organisations to align complaint processes and procedures will support the development of an Integrated Care System and joint working.	Yes
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).* Linking with partner organisations to align complaint processes and procedures will support the development of an Integrated Care System and allow for more efficient working.	Yes

Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: Governing Body Meeting held on 8th June 2022

Item Number:	Agenda Item:
GB-22-06.058	Primary Care Appointments - Shropshire, Telford & Wrekin

Executive Lead (s):	Author(s):
Claire Parker Director of Partnerships	Emma Pyrah – Associate Director of Primary Care Berni Williams – Contracting and Delegated Commissioning Lead

Action Required (please select):										
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	X

History of the Report (where has the paper been presented:		
Committee	**Date**	**Purpose (A,R,S,D,I)**
First presentation		

Executive Summary (key points in the report):

The purpose of this report is to provide Governing Body with the latest position on the restoration of access to primary care.

As with the majority of other NHS services, the pandemic required GP practices to rapidly modify the way patients access services to ensure they met national guidelines issued by NHS England to help manage the spread of Covid 19 infection amongst the primary care workforce and their patients and protect the most vulnerable.

Planned restoration of services began across the NHS in spring 2021 with the lifting of 'lock down' in March 2021. However, it was recognised that full restoration would only be achieved over time as the pandemic, the vaccination programme and subsequent surges in infection rates, which culminated in the vaccination booster programme in December 2021, continued to impact.

This report provides an analysis of the key primary care access indicators comparing the latest data in March 2022 with pre covid 2019.

General practice has worked tirelessly throughout the pandemic to maintain service provision and keep patients safe. There has been some media criticism of primary care that they are not working as hard as the rest of the NHS and are providing less capacity than before the pandemic. The data in this report provides evidence that this is not the case locally.

However, this achievement in part is offset by an increase in demand. Managing covid has become business as usual in 2022 but it leaves primary care with a legacy of additional demands on their resources, not least managing the impact on patients from the significant elective backlog and managing the backlog from within the practice from routine work which was paused during the pandemic to concentrate on urgent primary care.

The CCG is acutely aware that some patients continue to experience issues accessing their GP practice. Long waits to get through on the telephone and to an appointment are not acceptable.

All practices identified with access issues are targeted by the team for a practice visit and offered support to improve.

Recommendations/Actions Required:
The Committee are asked to note the report.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).* *Some patients continue to experience issues with timely access to their practice,*	Yes
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).* *Health outcomes are adversely impacted where there are access issues to General Practice*	Yes
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	Yes
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	No

	Functional Sign off MATRIX			
	Function	Relevance to Paper	Sign Off/Comments	
1.	Finance	N/a	For information item	
2.	Quality		Quality team aware of any practice with access issues and are supporting	
3.	Contracting	N/a	For information item	
4.	Performance	N/a		
5.	Medicines Management	N/a	For information item	

6.	Primary Care	N/a	Primary Care report
7.	Programme/Commissioning	N/a	For information item

Primary Care Appointments - Shropshire, Telford and Wrekin

Purpose of the Report
The purpose of this report is to provide Governing Body with the latest position on the restoration of access to primary care.

Background
As with the majority of other NHS services, the pandemic required practices to rapidly modify the way patients access services to ensure they met national guidelines issued by NHS England to help manage the spread of Covid 19 infection amongst the primary care workforce and their patients and protect the most vulnerable.

Practices introduced telephone clinical triage and telephone consultations to ensure only those that required face to face appointments based on clinical need attended the practice premises and promoted alternative access options such as online consultations. Same day/urgent needs were prioritised with routine and long term condition management largely stood down from 2020. Planned restoration of services began across the NHS in spring 2021 with the lifting of 'lock down' in March 2021. However, it was recognised that full restoration would only be achieved over time as the pandemic, the vaccination programme and subsequent surges in infection rates which culminated in the vaccination booster programme in December 2021 continued to impact on primary care's ability to return to a new 'normal'.

The information below provides an analysis of the key primary care access indicators comparing the latest available data in March 2022 with pre covid March 2019. The report concludes with a summary of the ongoing challenges facing primary care.

General practice has worked tirelessly throughout the pandemic to maintain service provision and keep patients safe. There has been some media criticism of primary care that they are not working as hard as the rest of the NHS and are providing less capacity than before the pandemic. The data in this report provides evidence that this is not the case locally.

Appointment capacity
The most recent available data[1] on general practice appointments for March 2022 across all Shropshire Telford & Wrekin (STW) CCG practices shows:-

- the STW population accessed 256,176 appointments compared to 220,544 appointments in April 2019 (pre-pandemic) (Figure 1).

- This is 35,632 more appointments in March 2022 (+13.91%).

- The above significant achievement should be viewed in the context that March 2022 was the month that the Government lifted all covid restrictions and this resulted in a spike in covid cases across the country. The GP workforce did not escape being impacted and a number of practices had to enact their business continuity plans and operate on skeleton workforce due to covid sickness/isolation rates amongst staff. Despite this primary care still increased appointment availability.

[1] Source is NHS Digital GPAD - https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/appointments-in-general-practice

- 92.3% of the total number of appointments made were attended by patients. This is is slightly higher than both the regional (91.02%) and national rate (91.8%). (Figure 2)

Figure 1 – April 2019 to March 2022 - Total All Appointments

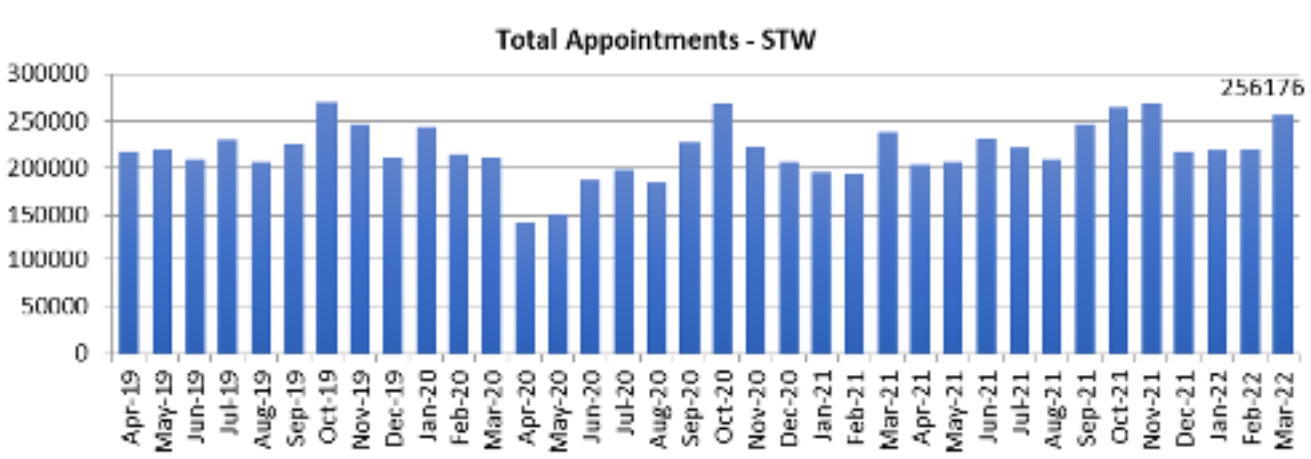
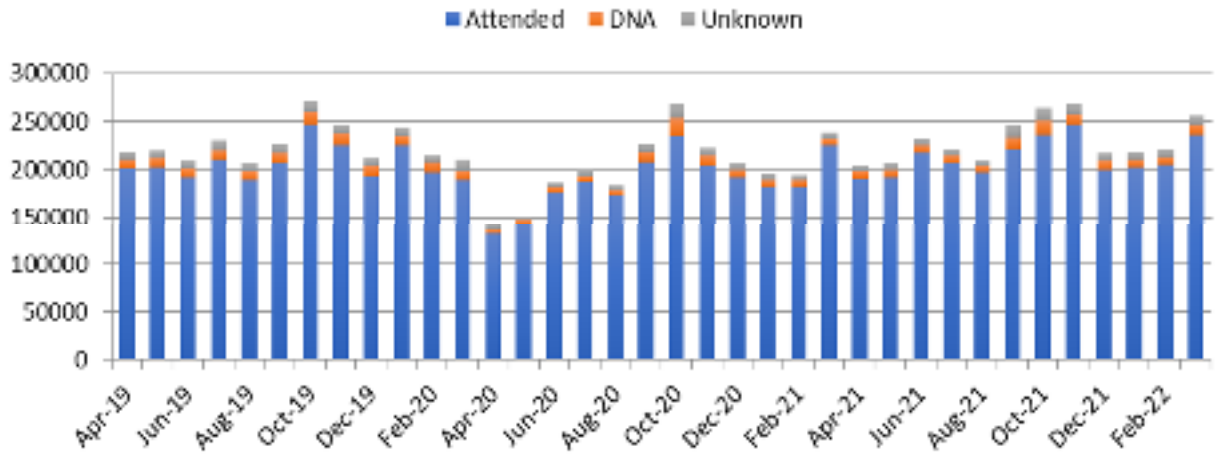


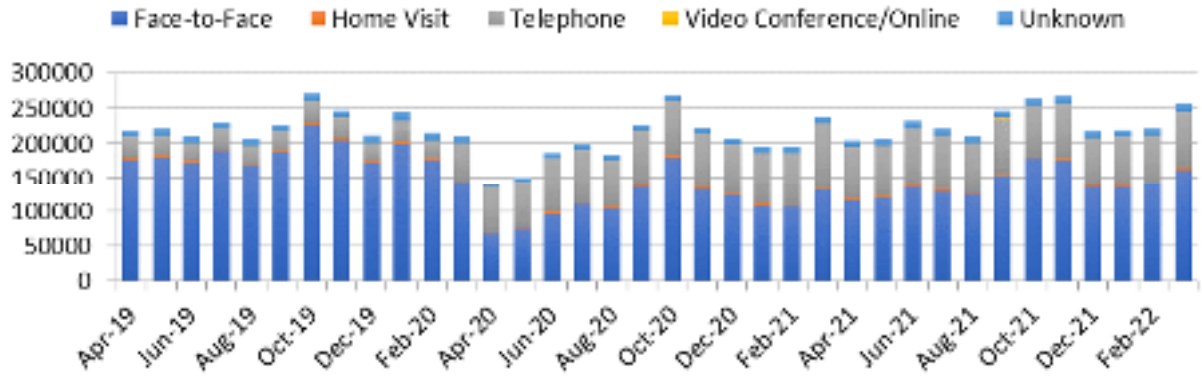
Figure 2 – April 2019 – March 2022 Attendance outcome



Appointment Types

As mentioned previously, one of the key changes resulting from the pandemic has been the mode by which patient consultations are undertaken where there has been a small reduction in face to face appointments, more than offset by the use of telephone and other modalities, to deliver an overall increase in the number of appointments of all types. Figure 3 below shows the proportional split and trend for appointments by type from April 2019 to March 2022.

Figure 3 – April 2019-March 2022 All appointments by Appointment Type



Key points from the data are:-

Telephone

- 80,366 telephone appointments were delivered in March 2022 compared to 29,643 in April 2019 (+171%)

Face to Face

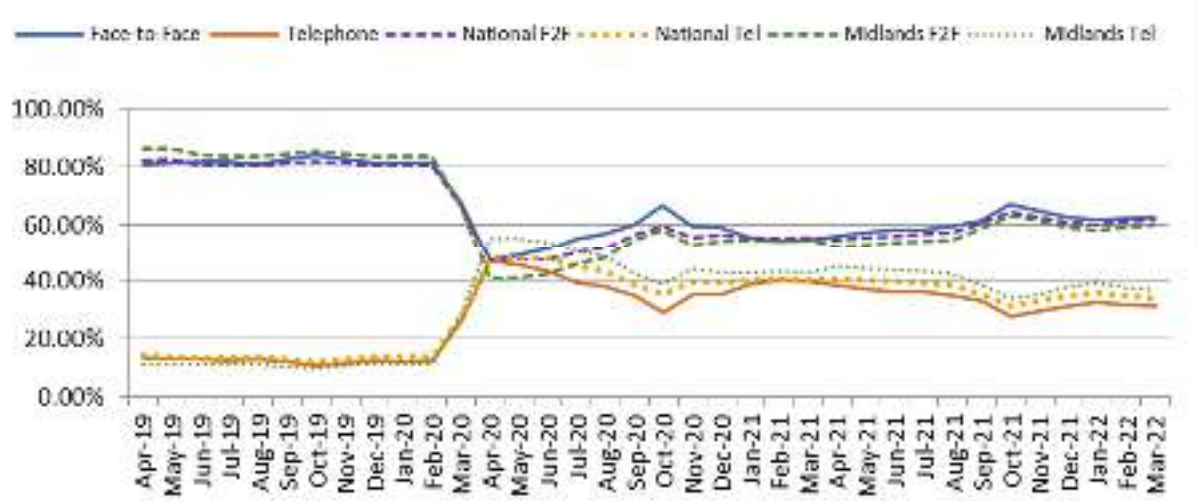
- From April 20 – Dec 21 57% of appointments were face to face.

- In March 2022, 161,391 face to face appointments were delivered compared to 176,657 in April 2019 (-9%). In STW 6 out of 10 patients are being seen face to face (63%), this is slightly higher than the Midlands regional average of 60%. (Figure 4)

Home Visits

- Home visits have remained stable over the period with an average of 2,700 (1.24%) each month.

Figure 4 - Plotted against the national average seen by F2F and Telephone



Online consultations

This mode enables patients to access an online triage service that allows them to easily seek support and self- help advice. It is accessed via the practice website. Patients can use

the service to request a sick/fit note and are able to access resources that can help them manage and understand their own health.

This mode of consultation is underutilised as STW usage is 1.8 per 1,000 patients, currently the lowest in the West Midlands region compared to the highest area in the region which is 18.3 per 1,000 patients. NHS England regional digital team will be working with STW Primary Care Team to support improvement in these ratios.

The NHS Long-term plan states; *a digital-first primary care will become a new option for every patient improving fast access to convenient primary care. In other walks of life mobile phones and apps have already transformed services.*

The aim with digital access solutions is to provide patients with a menu of options for accessing their practice as face to face is not always clinically required or convenient to the patient. It is acknowledged however that for some patients face to face is their preferred way of accessing their GP and this will only change over time as patient confidence in and experience of other modes of accessing services develops. Practices are aware that for some STW populations over reliance on digital solutions poses the risk of digital exclusion for patients where access to mobile network coverage/wifi is limited.

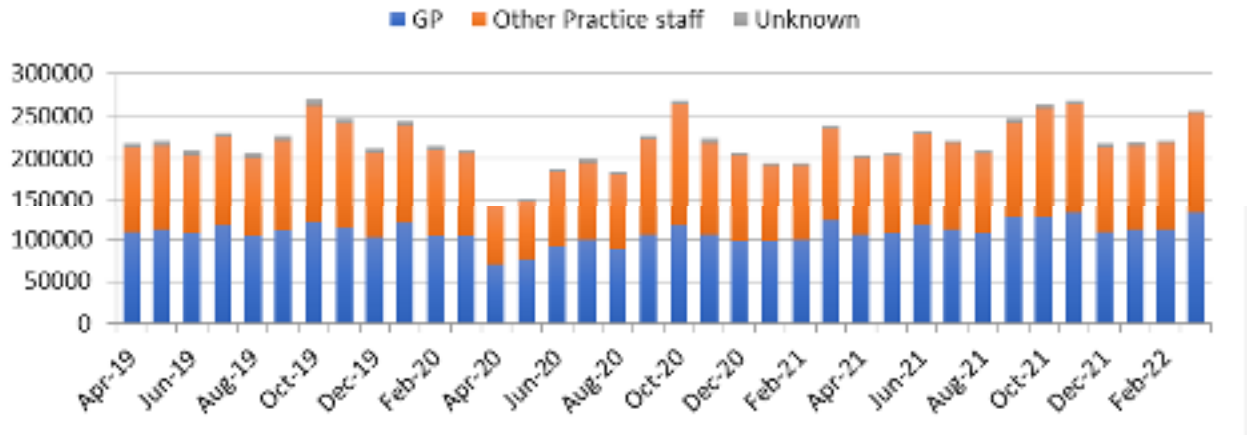
Appointment professional
The range of staff available within GP practices to manage patient needs has increased in recent years, particularly with the introduction of Primary Care Network Additional Roles Reimbursement Scheme (ARRS). Alongside GPs there are other practice staff including, Advanced Nurse Practitioners (ANPs), Health Care Assistants (HCAs) and PCN ARRS roles including mental health practitioners, clinical pharmacists, paramedics, care co-ordinators, social prescribers and health and wellbeing coaches.

ARRS are centrally-funded roles which allow Primary Care Networks (PCNs) to establish multi-disciplinary teams (MDT) to provide more integrated health and social care services locally. They enable patients to access preventative care such as health and wellbeing support and medication reviews more easily, while reducing pressure on GPs. At the end of April 2022 there are 126 ARRS staff across the 8 PCNs in STW.

- 131,049 GP appointments were delivered in March 2022 compared with 109,453 in April 2019. (figure 5) This is a 20% increase.

- In March 2022, 47% of primary care appointments were delivered by a GP.

Figure 5 - Appointment professional

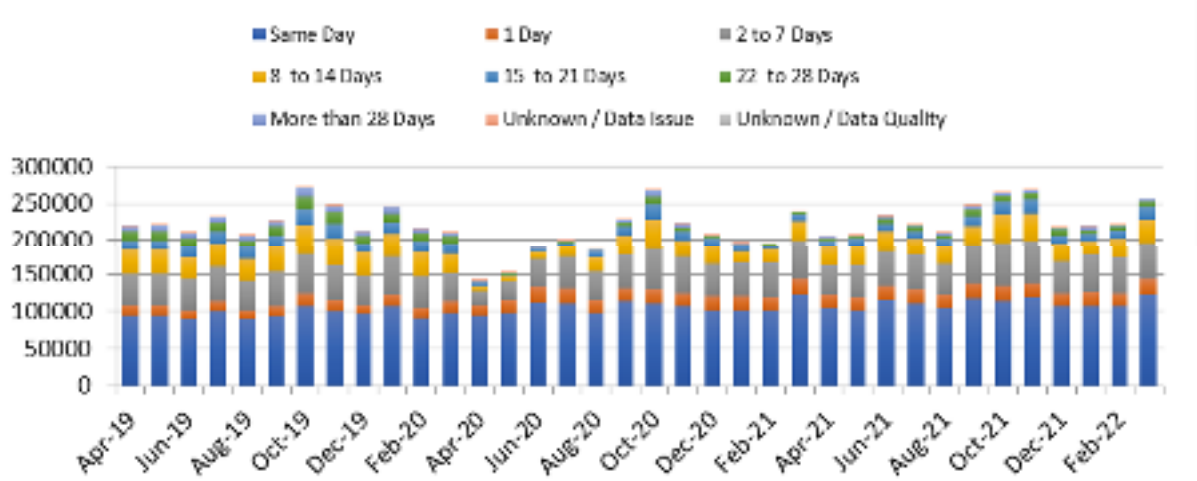


Appointment Waits
Analysis of average waiting times for appointment indicates:-

- In March 2022, there has been a significant increase in shorter waits for appointments and a corresponding decrease in long waits (8 days and over) compared to April 2019. This means that waiting times for appointments have reduced.

	April 2019	March 2022	Variance 22 vs 19 (number)	Variance 22 vs 19 (%)
Same day	95,370	123,406	+28,036	+29%
1 day	13,490	20,658	+7918	+53%
2-7	41,723	51,242	+9,519	+22%
8-14	33,340	32,842	-498	-1.5%
22-28	16,295	7,501	-8,794	-53%
+28 days	6991	4,325	-2,666	-38%

Figure 6 – Waiting times for appointment



Challenges for Primary Care

Recruitment and Retention of GPs
Like most parts of the country, Shropshire, Telford & Wrekin (STW) has struggled over recent years to increase the number of GPs across our practices.

- GPs – whole time equivalent numbers have fallen from 285 in Sept 2015 to 250 in February 2022. This is a 12% reduction in overall GP workforce capacity.

- Partner GPs –whole time equivalent numbers have fallen from 229 in Sept 2015 to 168 in February 2022. This is a 27% reduction in overall GP Partner workforce capacity.

Covid additional requirements
As well as routine appointments, practices are required to provide more services to support the pandemic response including:
- Supporting the delivery of the ongoing Covid Vaccination programme
- Providing care for patients with symptoms of Long Covid
- Ensuring clinically vulnerable patients continue to receive the care they need in a safe environment

Managing the backlog

- Managing additional demand created by the elective backlog where patients turn to their practice for support because their elective treatment is significantly delayed.
- Deploying primary care resources to catch up with backlog primary care work:
    - childhood vaccinations and immunisations
    - screening appointments
    - reviews for long term conditions
    - Other routine GP work eg medication reviews, Severe Mental Illness, Learning Disability and Autism annual health checks, dementia reviews.
    - More patients coming forward for assessment of symptoms which they put off before because not immediately urgent. In a number of cases this has meant that their condition has become more complex as a result

Examples of Initiatives to support GP Access

- **GP Strategy**

The CCG has recently developed a new GP Strategy. In line with the STW ICS People Plan, and workforce strategies in other systems, the strategy is based around three, main elements:

- Attracting – encouraging/persuading people to become GPs
- Recruiting – enabling the recruitment of qualified GPs across STW
- Retaining – ensuring that those GPs who are recruited, choose to stay

It incorporates actions covering the following interventions:-

- Marketing the role of the GP
- Supporting the recruitment and deployment of GPs
- Engaging and networking
- Ensuring that professional development is available
- Ensuring that personal support is available
- Developing career opportunities/new ways of working

The strategy targets eight “key intervention stages” within the lifecycle of a GP’s career.

1. School/sixth-form students choosing medicine courses at universities
2. Medical Students
3. Foundation Year Doctors
4. GP Trainees
5. Newly-Qualified GPs
6. First5 GPs
7. Mid-Career GPs
8. Late-Career GPs

- **Primary Care Network recruitment to additional roles**

Expanding the workforce is one of the top priorities for primary care networks. PCNs are required to plan their future workforce requirements and can receive additional funding under the Additional Roles Reimbursement Sum (ARRS). There are a specified range of roles which can be funded and include clinical pharmacists, dietitians, OTs, first contact physios, paramedics, podiatrists, physician associates, care co-ordinators, health and wellbeing coaches, social prescribing link workers and nursing associates. The addition of these posts increases the multi-disciplinary offer available from general practice increasing the number of clinicians and non clinicians able to meet patient’s needs thus increasing the number of appointments available.

Recruitment of staff continues steadily across all eight of our PCNs with over 130 ARRS-funded staff currently in post.

- **Professor Claire Fuller's National Stocktake Report 'Next Steps for Primary Care Integration' May 2022**

In November 2021 Amanda Pritchard asked Dr Claire Fuller, CEO designate Surrey Heartlands ICS and GP, to undertake a stocktake on integrated primary care, looking at what is working well, why it's working well and how the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems could be accelerated. The review report was published at the end of last month.

The report indicated that a consensus emerged from the review - what is not working is access and continuity, with frustrations shared by both patients and staff alike. The report also confirms a consensus on what can be done differently.

- Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

- Streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team, using data and digital technology to enable patients to quickly find the right support to meet their needs.

- Ensuring those who would most benefit from continuity of care in general practice (such as those with long term conditions) can access more proactive, personalised support from a named clinician working as part of a team of professionals

- Taking a more active role in creating healthy communities and reducing incidence of ill health by working with communities, making more effective use of data and developing closer working relationships with local authorities and the voluntary sector.

All 42 ICS Chief Executives signed a letter of support for submission with the review report and a commitment to implement the necessary changes. STW is beginning this work with a joint development workshop between the Clinical Directors of our 8 Primary Care Networks and senior clinical leaders in Shropshire Community Health NHS Trust at the end of June. The aim is through clinically led conversations to start shape and build on what has already been done and identify where things can be done differently. STW are very fortunate that Professor Fuller has agreed to attend the workshop as keynote speaker.

- **Community Pharmacy Consultation Service**

This national initiative enables practices to make a direct referral for appropriate patients to a same day minor illness appointment with a trained community pharmacy. This improves access to timely care and frees up a practice appointment. There are currently 19 practices that have implemented this service and are referring patients to the service. Support is available to practices to set up and increase referrals including the ability to make e-referrals.

- **Enhanced telephony**

Feedback from patients is that it is not just access to timely appointments that has caused a poor patient experience of primary care. They have also experienced significant problems getting through to the practice on the telephone in the first place. This has largely been down to the functionality of the practice telephone systems to deal with the volume of calls.

The majority of STW practices utilise one telephone system provider. In order to help with the issues, the CCG has commissioned the company to provide an enhanced telephony support package for practices to have an improved understanding of their phone systems. It will provide the practices with the tools to understand call flows and how to record relevant messages (comfort messages); to review patient excessive queue lengths, average call handling times. Two practices have sessions booked this month with the remainder scheduled over the summer months.

Conclusion

- Access to GP services has changed significantly over the last 2 years as a direct result of the pandemic.

- GP services are extremely busy, demand continues to increase, there are 12% less GPs in post than 2015 but despite this General Practice is offering more appointments now than prior to the pandemic.

- The mode of appointment delivery has seen the largest shift with a larger reliance on telephone consultation and digital/online options as opposed to face to face. Whilst face to face numbers have increased in the last 6 months, this mixed model of delivery modes is the 'new normal' and is in line with the national direction to transform primary care services.

- Face to face appointments constitute the majority of appointments – 6 in 10 STW appointments are face to face.

- There has been an increase in appointments delivered same day, 1 day and 2-7 days and reduction in appointment waits of 8 days and over.

- A significant proportion of appointments continue to be delivered by a GP, however, there is an increasing range of staff employed by primary care which means patients have access to a wider range of skilled clinicians and non clinicians to meet their needs.

- Some patients continue to experience issues accessing their GP practice. All practices identified with access issues are targeted by the team for a practice visit and offered support to improve.

- Covid has become business as usual but it leaves primary care with a legacy of additional demands on their resources, not least the impact from the significant elective backlog and the backlog from practice routine work being stood down to concentrate on urgent primary care.

Recommendation

The Governing Body are recommended to note this report.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting 8 June 2022**

Item Number:	Agenda Item:
GB-22-06.059	Emergency Preparedness, Resilience and Response Annual Statement

Executive Lead (s):	Author(s):
Sam Tilley Director of Planning & Urgent Care Sam.tilley2@nhs.net	Sam Tilley Director of Planning & Urgent Care Sam.tilley2@nhs.net

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	S	D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Audit Committee	18 May 2022	I, S

Executive Summary (key points in the report):
Further to the completion of the Emergency Planning, Resilience and Response (EPRR) annual assessment, this paper provides an update on the outcome of the assessment and preparations as we transition from a CCG to an ICB

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Recommendations/Actions Required:

The Governing Body is asked to:

- Note the outcome of the 21/22 EPRR annual assessment and the associated work underway as a result of this
- Note the preparation to transfer from the CCG into the ICB as a category 1 responder

Emergency Preparedness Resilience and Response (EPRR) Annual Statement
Sam Tilley, Director of Planning & Urgent Care, Shropshire, Telford & Wrekin CCGs

Introduction

CCG's are required to participate in an Emergency Planning Resilience and Response (EPRR) assessment each year which is undertaken by NHSE. A report was provided to the Audit Committee on the outcome of this process for the 2021/22 assessment period and the further work planned for 2022 as well as outlining some of the headline changes anticipated in EPRR arrangements as the CCG transitions into an ICB on 1 July 2022. Following review at the Audit Committee, this paper provides an annual statement for the Governing Body in relation to EPRR

Report

ICB Transition Arrangements

Further to the Health and Care Bill being passed by Parliament and Integrated Care Boards (ICBs) being legally established on 1 July 2022, there is a commitment to amend the Civil Contingencies Act to designate ICBs as Category 1 responders where previously CCGs have been category 2 responders. This change will mean additional responsibilities and accountabilities for ICBs in comparison to the current duties placed upon CCGs.

Whilst we are still awaiting updated guidance documents from NHSE, the CCG is preparing for this transition with a programme of work during May and June 2022 to update and refresh our EPRR arrangements alongside the development of a work plan to ensure a clear programme of work around training, exercising and assurance is in place.

The NHS England EPRR Framework sets out principles of EPRR for the NHS in England at all levels. From 1 July 2022 this will also apply to ICBs. The framework is currently being updated to include specific reference to the role of ICBs. However, the Framework currently sets out the responsibilities of Category 1 responders as follows:

Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Cooperate with other local responders to enhance co-ordination and efficiency

In preparation for the commencement of the ICB, CCGs have submitted assurance documents to NHSE of the ICB's readiness to comply with their category 1 responsibilities. At the time of writing, final assessment feedback is awaited from the National NHSE team. However, in recognition of the transition from a category 2 to a category 1 responder the CCG/ICB will be implementing further competency based training for staff supporting EPPR activities particularly where staff have changed roles due to the ICB transition

Annual EPRR Assessment

In addition to an amended EPRR Framework that reflects the role of ICBs, a set of core standards for EPRR is in development by NHSE to guide organisations on what is required to fulfil their legal duties. This is anticipated to follow a similar annual assurance process as we have seen utilised for CCGs using the core standards for EPRR as a means of assuring readiness and ability to respond to incidents.

Due to a step back by NHSE of the usual annual assessment process during the Covid19 pandemic the annual assessment for 21/22 is the first full assessment for two years. For the 2021/22 period the CCG has

secured rating of “Substantial Assurance” Two areas (as set out below) were identified for further development, for which the Audit Committee supported the work being taken forwards as part of the development of the ICB’s approach.

Core Standards 12 – CCG combined Major Incident/Business Continuity Plan. Whilst the CCG has previously maintained a combined Major Incident / Business Continuity Plan, NHSE had requested that these be created as separate stand alone documents. An Incident Response Plan has now been drafted and has been shared with system partners for comment. This will be finalised for adoption by the ICB once it is officially in existence along with the Business Continuity Plan and EPRR Policy

Core Standards 18 & 20 – CCG actions in event of a Mass Casualty/Evacuation & Shelter event. This relates to a new approach to addressing mass casualty events and the allied requirement for shelter and evacuation following learning from the Covid19 pandemic about pressure on acute Trusts and plans that may be needed to support mass discharge.

The CCG has agreed with NHSE that in the case of the CCG (and therefore the ICB going forwards), particularly now the majority of our staff are home based, any specific evacuation of CCG/ICB office based staff would be covered by the CCGs Business Continuity Plan and therefore any Mass Casualty/Evacuation & Shelter Plan should be approached as a system as it would require a system response

As there are currently no areas who have achieved this standard, NHSE have agreed to work with us to develop our Mass Casualty/Evacuation & Shelter plan as part of or work programme for 2022/23 and a workshop is to be scheduled to compete this work as soon as possible.

The annual assessment process for 2022/23 will commence shortly. The Core Standards against which we will be assessed are expected imminently and submissions are due to NHSE by 31 August 2022

Summary and Recommendations

The Governing Body is asked to:

- Note the outcome of the 21/22 EPRR assessment and the associated work underway as a result of this
- Note the preparation to transfer from the CCG into the ICB as a category 1 responder

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held on: Wednesday 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.060	Summary Report of an extraordinary meeting of the Shropshire Telford and Wrekin CCG Quality and Performance Committee dated: 5th January 2022.

Executive Lead (s):	Author(s):
Zena Young - Executive Director of Nursing and Quality	Meredith Vivian, Chair, Shropshire Telford and Wrekin Quality and Performance Committee

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion	x	I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Full minutes approved at the Shropshire Telford and Wrekin CCG Quality and Performance Committee.	23rd March 2022.	

Executive Summary:

To provide assurance to the Governing Body that the safety and clinical effectiveness of services commissioned by Shropshire Telford and Wrekin Clinical Commissioning Group, and the experience of patients receiving those services, have been reviewed in accordance with the Quality and Performance Committee's Terms of Reference.

To provide a summary of the main items reviewed at the 5th January 2022 meeting.

Performance exception issues.

Recommendations/Actions Required:

Governing Board members are invited to receive this update report and are recommended to **note and discuss**: The Governing Body is asked to note for assurance and information.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? A project group will need to be resourced and recruited to.	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? Proposed changes to commissioned services are significant and require approval from NHSE/I to progress to public consultation.	No
5.	Are there human rights, equality and diversity requirements? The population this paper refers to includes those with legally protected characteristics of pregnancy and also refers to access to health services and associated health outcomes.	No
6.	Is there a clinical engagement requirement? There is a need for significant clinical engagement in the development of the model and associated timescale for delivery of any changes.	No
7.	Is there a patient and public engagement requirement? Changes to commissioned services are significant and require approval from NHSE/I to progress to public consultation.	No

Urgent Care Update

- A&E performance for December was 65.2%, trending 1.5% below 2019/20, National position 70.1% ranking SATH 103/114
- There has been a small improvement in patients being seen and triaged by a senior clinical decision maker <15minutes has always been challenged, however an improvement has been seen in December achieving 74% over Christmas usually c.40%
- Performance with booked appointments remains challenged c.60% - National 78%
- Ambulance handover showed a significant improvement from the 2nd week in December (SPA implementation) achieving 60+delays on several days, Ambulance transportations remain lower than 2019/20.
- The new Emergency Care Data Set (ECDS) metrics remain stable, and showed some improvement in the proportion of patients spending over 12hrs in the department from arrival.
- Patients waiting over 12 hours in the Emergency Department has improved. Flow is unstable with increasing sickness and COVID presentations.
- There is an acuity shift in presentations, although the number of patients presenting are low, the conversion rate has increased slightly but still remains comparative to the rest of the region.
- Emergency Department staffing issues were seen due to festive season annual leave and the increasing risk from the Omicron variant. The biggest impact regarding staffing issues is in the care sector,
- Community 2hr response has just has 1 postcode to recruit to; pathways are being pushed with WMAS and Primary care
- SPA went live on 8th December; early reports show that the service has avoided attendance from an additional 72 patients, 50% of which had complex needs.

Cancer Update

- SaTH 2ww cancer performance – The performance ofthe 2WW has dropped from 84% in November 2021 against a target of 93% to 73% in December 2021.
- There are challenges with the 2ww pathways for breast, gynaecology, haematology and lung. The ability to be able to offer one stop shops in the breast pathway has caused quite a significant pressure however; the Community Brest Clinic is expanding and continues to take that pressure away from the two week which should allow some recovery over the coming weeks and months.
- SaTH 62 day RTT performance – Nov 21 63.0% (target 85%) – prediction for Dec 21 56.2%
- Challenged 62 day pathways – ALL except skin
- Total patients waiting over 62 days with no DTT (as at 19/12/2021) – 290 (up 12 on previous week)
- Total over 104 days with no DTT (19/12/2021) – 78 (up 17 on the previous week)
- Issues remain with radiology capacity related to workforce.
- Workforce capacity issues remain a concern.
- Funding from WM Cancer Alliance has been made available for teledermatology hardware & software. Funding is also available for extra FIT tests for colorectal referrals. The challenge is having the staff available to implement this. Quality issues

SaTH

- CCG Senior IPC Lead visit to SaTH to join their internal Exemplar assessment; Suboptimal IPC standards and non-adherence to national IPC guidance previously noted. VTE assessment has seen a slight dip in performance, but no harms reported; prescribing completed even if assessment not recorded. The number of falls continues to remain an area of concern.

Maternity

- There were no Maternity Serious Incidents reported in November for the Trust.
- There is good timeliness of response from SaTH on RCA reports and action plans.
- Data quality still remains an issue as the Trust has previously advised that outmoded IT and hand held records approach to data capture is impacting on data quality; the implementation and roll out of Badgernet IT maternity record system is starting to improve data quality and there is on-going assurance work with the provider to review and improve data quality for the future.
- There were no neonatal exceptions reported however data is still limited at present.
- There remains a high level of service user satisfaction, with ongoing work being carried out to increase response rates. There is continued work with Maternity Voices Partnership (MVP) to ensure that patient experiences are captured and acted upon.
- All of the MLUs across the county are operational, however some are not providing intrapartum care in line with risk assessments.

SCHT

- CCG senior IPC lead visit to Ludlow Community Hospital as part of an announced quality assurance visit; Suboptimal IPC standards reported.

Safeguarding

- Challenges continue to exist around national Tier 4 provision for children.
- Executive to Executive escalation has taken place regarding reinstating face to face appointments for Review Health Assessments for children. Further information and assurance has been requested.
- A Domestic Abuse Resource pack to support practices will be disseminated when finalised.

WMAS

WMAS continue to report high demand for their service which in conjunction with delays in handover of patients at acute hospitals has caused significant delays in ambulance response times across the region. WMAS has raised the level of risk on its register to 25 – avoidable deaths due to ambulance delays or harm caused.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held on: Wednesday 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.060	Summary Report of the Shropshire Telford and Wrekin CCG Quality and Performance Committee dated 23rd March 2022.

Executive Lead (s):	Author(s):
Zena Young – Executive Director of Nursing and Quality	Meredith Vivian, Chair, Shropshire Telford and Wrekin Quality and Performance Committee

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Full minutes approved at the Shropshire Telford and Wrekin CCG Quality and Performance Committee.	27th April, 2022	

Executive Summary:

To provide assurance to the Governing Body that the safety and clinical effectiveness of services commissioned by Shropshire Telford and Wrekin Clinical Commissioning Group and the experience of patients receiving those services, have been reviewed in accordance with the Quality and Performance Committee's Terms of Reference.
To provide a summary of the main items reviewed at the 23rd March 2022 meeting.

Recommendations/Actions Required:

Governing Board members are invited to receive this update report and are recommended to **note and discuss**: The Governing Body is asked to note for assurance and information.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? A project group will need to be resourced and recruited to.	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? Proposed changes to commissioned services are significant and require approval from NHSE/I to progress to public consultation.	No
5.	Are there human rights, equality and diversity requirements? The population this paper refers to includes those with legally protected characteristics of pregnancy and also refers to access to health services and associated health outcomes.	No
6.	Is there a clinical engagement requirement? There is a need for significant clinical engagement in the development of the model and associated timescale for delivery of any changes.	No
7.	Is there a patient and public engagement requirement? Changes to commissioned services are significant and require approval from NHSE/I to progress to public consultation.	No

Performance exception reporting:

- **Covid**: Covid and the added UEC seasonal pressures with demand and increased length of stay impacted upon planned care recovery over the festivities and into the new year, the winter plans mitigated risk to a degree. Encouragingly numbers of hospital admissions have been falling throughout January, the position does remain unstable.
- **Shropshire Community Services:** Recruitment remains a focus and the Trust were on target to go live with the rapid response teams as per plan, pressures continue for community provision, in both available bed stock for step down/up care, constraints directly related to IP&C governance (COVID related) and the response/in-reach model. Respiratory and virtual wards are being planned using lessons learned from previous attempts to utilise them and these will help resolve some of the current capacity constraints by utilising a virtual response.
- **Urgent and Emergency Care (UEC):** Remains very challenged and does not currently meet Constitutional/National standards; There has been a National trend/uplift in the length of stay <7days and complex discharges, this has impacted upon the ability to move patients quickly through the Emergency Department and onto the wards. IP&C governance regarding the management of COVID has seen a number of system bed closures, this has severely impacted upon the ability to manage the back door and is reflected in this month's performance. Trajectories for improvement have now been set with the provider and can be seen in the UEC dashboard
- **Planned Care:** Elective recovery remains under pressure. Reduced activity due to workforce constraints and the pandemic continues. SaTH has been focusing purely on cancer pathways alongside the most urgent surgery (Emergency/ very urgent Priority 1 and Priority 2). Total list size continues to increase because of the inability to treat clinically routine patients and close RTT pathways. As much activity as clinically appropriate is still being delivered virtually, however, overall numbers of waiters have increased, in particular across Orthopaedics and General Surgery.
- **Cancer Performance:** The two-week wait metrics are deteriorating again directly relating to diagnostics and access to diagnostics which is linked to workforce issues. Other metrics are inconsistent (meeting target in one month and failing the next), with the exception of 31-day subsequent drug treatment which usually meets the required standard.
- **Mental Health:** IAPT recovery rates; Following a high number of patients being discharged from the service in September, performance has now stabilised in December and is showing achievement of the 50% standard. Performance of this important metric, particularly for minority and more at risk groups, will continue to be closely monitored and any variations of note will be investigated

Quality issues

- The minutes of the SQG meeting were shared with the Committee but for future reporting, a dashboard metric approach is being developed for quality and will ensure that mortality outlier alerts are included.
- An update on SI's falls action plan has been received and progress has been noted.
- Children's and Young person's mental health service improvements is work in progress and this in part is due to the need to recruit to some key positions to help support that work. Commissioners and providers have been working together closely appear to be working well against the backdrop of shortage of Tier 4 services

- Highley Medical Practice has been inspected by CQC and the report issued rated them as inadequate. The main areas of concern related to medicine safety and the monitoring of long-term conditions. The CCG have supported the practice with weekly and now fortnightly meetings to help them with their improvement plan.
- The Committee was provided with an update of the SaTH's CQC's review of conditions following the publication of the CQC report. There were 30 conditions across both sites and following the review there are now five, one condition has been counted twice as this is counted under two regulatory activities.
- The Committee was provided with an update from Shropcom on health visiting face to face contacts and advised that this remains a concern for the trust particularly for Shropshire. Data from January 2022 shows that the Telford team managed 92.6% and Shropshire only managed 55.4% of face to face visits.

LMNS Chairs Report

- Updated national guidance around community services, visiting and patient access during the Covid-19 pandemic, were released in early 2022. SaTH are currently meeting the guidelines associated with testing, supporting staff and the women that use the Maternity Services. However, as previously highlighted there is an ongoing concern around support partners being unable to accompany women when they attend the Maternity Triage Assessment Unit. This decision is guided by regular IPC assessments and support partners are only able to be present by exception with special consideration being given for the women to be seen away from the unit.
- There is ongoing concern over the intermittent closures of the Wrekin Midwife Led Unit. The intermittent closures are related to high levels of staffing absence and at present, SaTH are unable to provide assurance as to when the unit will reopen on a 24/7 basis. SaTH do feel that by April 2022, their staffing levels will improve significantly and the unit will be open more often than it is closed. SaTH are currently using the OPEL Escalation Tool to provide daily visibility to region and to the LMNS, regarding the services they are able to open and their capacity to accept. The LMNS will continue to request visibility of the MLU status and this will be discussed at each LMNS Programme Board.

Serious Incidents

- During Q3 2021/2022 there were a total of 63 Serious Incidents (SIs) including one Never Event, reported by the 4 main providers for Shropshire, Telford and Wrekin patients. This is an increase from 2021/2022 Q2 where there were 54 incidents reported. There were also 11 out of area SIs reported in Q3 2021/2022 compared to 6 in Q2 2021/2022. At the time of writing the CCG gave assurance to the Committee that all submitted SIs are tracked and monitored to completion.
- **MPFT** - reported a total of 24 SIs during Q3 compared to 18 in Q2 of 2021/2022. Unexpected deaths remain the most reported category accounting for 67% during Q3. The CCG have worked collaboratively with the Trust around the deep dive regarding unexpected deaths, the findings of the deep dive are currently with MPFT for the factual accuracy and additional actions.
- **RJAH** – reported no SIs or Never Events during Q3 compared to 3 during Q2 of 2021/2022.
- **SaTH** – reported a total of 23 during Q3 SIs which is lower than the 29 reported during Q2 of 2021/2022. Slips/trips/falls were the most reported incidents during Q3

with 10 in total. Pressure ulcers and diagnostic incidents were the second highest reported categories with 3 incidents each.

- **SCHT –** reported a total of 16 SIs during Q3 which is an increase from the 4 reported during Q2 of 2021/2022. Pressure Ulcers accounted for 94% of those reported during Q3. A thematic review will be undertaken in relation to pressure ulcers and the learning from which will be shared.
- During Q3 2021/2022 all SIs (including Never Events) were within the SPC limits.
- To note that with effect from February 2022 all CQRM meetings have been stood down in accordance with transition to ICB. All SIs are discussed at SI review meetings with all providers on a monthly basis (RJAH bi-monthly) and SIs are discussed at provider internal Quality meetings that the CCG are now present at.
- The Committee also noted that MPFT are experiencing an increase in completed suicides against the national average. This has been lower in Shropshire. However in Telford and Wrekin the Trust's completed suicide incidence is rising and it has been noted that there has been an increase in female suicides across all age categories, this has also been noted in Staffordshire. There has also been a rise in the factors of drug and alcohol with alcohol related deaths rising by 40% in Shropshire, Telford and Wrekin.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held on: Wednesday 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.060	Summary Report of the Shropshire Telford and Wrekin CCG Quality and Performance Committee dated 27th April 2022.

Executive Lead (s):	Author(s):
Zena Young – Executive Director of Nursing and Quality	Meredith Vivian, Chair, Shropshire Telford and Wrekin Quality and Performance Committee

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion	x	I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Full minutes approved at the Shropshire, Telford and Wrekin CCG Quality and Performance Committee and Shadow ICB Quality and Performance Committee, which met in common.	25th May, 2022	

Executive Summary:

To provide a summary of the main items reviewed at the 27th April 2022 meeting.

Recommendations/Actions Required:

Governing Board members are invited to receive this update report and are recommended to **note and discuss**: The Governing Body is asked to note for assurance and information.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? A project group will need to be resourced and recruited to.	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? Proposed changes to commissioned services are significant and require approval from NHSE/I to progress to public consultation.	No
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7.	Is there a patient and public engagement requirement? Changes to commissioned services are significant and require approval from NHSE/I to progress to public consultation.	No

Joint Committee in Common

- This meeting was the first meeting in common of the CCG Quality and Performance Committee and the shadow ICB Quality and Performance Committee.

Performance exception report

- COVID-19: The disruption and pressure continues, staff absence and Amber/Green pathways are impacting upon the front door and an increased length of stay, in particular with discharges of a complex need. SaTH have been running at high escalation for several weeks and at COVID-19 peak the system responded to mitigate the risk of unscheduled patients stranded at points of their journey, in particular 999.

Primary Care:

- Primary care appointments remain broadly in line with the annual mean, the percentage of those attended is above target in particular those seen face to face at c.62% and home visits at nearly treble the target. Workforce remains a constraint and risk for the system, mitigations are in place.
- Shropshire Doctors: Key Performance Indicators remain green, some concerns remain around staffing which have actions to mitigate, the Single Point of Access/Referral is working really well with C.3000 patients through the combined (CCC & SPA) service since January with a 93% non-referral to the Emergency Department outcome.

Shropshire Community Services:

- The winter schemes are now near completion and due to finish end of March, initial findings show that they have been beneficial to maintaining a safe and effective service, however a full evaluation is currently being taken and will be reported upon following approval. The alternatives to hospital admission workstream is also showing beneficial outcomes and exceeding locally set targets. Workforce constraints still exist within the two-hour rapid response model, but this has been mitigated with a proposed hybrid model.

Ambulance and 111:

- WMAS are doing well with managing patients that don't require an intervention from the Emergency Department, hear and treat is at a high of 23%. Category 1 and Category 2 call response times (mean) is a significant risk for the system a root cause for a drop in the standard is the time spent waiting at hospital for patient handover, mitigations are in place and the total lost hours has seen a reduction over recent weeks.

Urgent and Emergency Care (UEC):

- All operational standards remain challenged and reflect the position reported over the last three months relating to managing COVID. Significant operational site pressures continue due to winter and emergency demand, a number of scheduled Multi Agency Discharge Events (MADE) to include community and local authority which will help ease the pressure, this combined with staff returning to work will afford the system to make improvements on their position.

Cancer Care:

- Most metrics have shown inconsistent performance throughout the year. However, all measures fell short of target in January, and were still below target at the end of February, albeit with slight improvements in 2-week and 31-day waits which may lead to an improvement in 62-day waits in March. The number of 62-day waits going beyond 104 days at SaTH remains in double figures. Key risks still exist in two week waits, twenty-eight faster diagnosis and tumour pathways, all of which have actions to mitigate the current position.

Planned Care:

- UEC pressures are still impacting upon planned care recovery. No significant change in overall RTT performance, which remains at around 60% against a national target of 92%. The total number of waits therefore continues to increase, particularly in key specialties such as orthopaedics and general surgery. There are signs of recovery in ophthalmology, in which numbers waiting appear to have reached a plateau. The admitted waiting list continues to be clinically prioritised. The STW system is managing its P2 and P2C clearance times to levels better than the regional averages but due to capacity constraints and UEC/COVID pressures little progress has been made with P3 and P4 waits. Key risks remain in Referral to Treatment (RTT) and diagnostics, all of which have actions to mitigate the current position.

Mental Health:

- IAPT recovery rates; Following a high number of patients being discharged from the service in September, performance stabilised in December and is showing achievement of the 50% standard. Performance of this important metric, particularly for minority and more at-risk groups, will continue to be closely monitored and any variations of note will be investigated.

Quality exception report

- A process for owners of data is required to provide information on the issue and action on alerting indicators, this is being devised.
- A System Risk Register for Quality is not yet available, and discussions continue to ensure a risk register would be updated in a timely way from all relevant providers. There is a challenge of keeping this register up to date in the absence of an electronic solution, this is being worked through and discussions are taking place with governance leads.
- The IPC assurance plan for RJAH was received by the group and has been discussed by RJAH Trust Board.
- The System Palliative and End of Life Care Strategy was presented and agreed by the System Quality Group and is on the agenda for discussion and approval.

- The NICHE report update was discussed at the System Quality Group and it was noted that most actions were brought up to date and a further four actions were completed. One of the actions was reopened which was around pathways through the ED for hematology and oncology patients, in particular those who needed a direct route through to a ward, this is being addressed with the Trust and commissioning colleagues.
- System Quality Metrics are evolving. The System Quality Group is discussing the first set of metrics developed which are in line with the National Quality Toolkit and where to build further metrics to give a comprehensive overview of quality. Work continues to develop these further. Updates regarding issues and actions being undertaken are required from individual providers. This work is being supported by CSU in regard to collating business intelligence.

STW Palliative and End of Life Care Strategy

- The Shropshire Telford and Wrekin (STW) Integrated Palliative and End of Life Care (Adults) 2022 – 2025 is an output of a Shropshire Telford and Wrekin system review of end of life care and as a recommendation from a System Senior leaders' summit which recognised the need to improve the care for people in the last year of life.
- The STW Palliative and End of Life Care Steering Group is currently working through the processes to develop an Integrated Children and Young Persons Palliative and End of Life Care Strategy which is expected to be completed in the first quarter of 2022/23. An annual update will be presented to QPC.

Ockenden 2 report

The Committees received an update and discussed the key issues:

- The second Ockenden report sets out the findings of the review into care provided to 1,486 families, (involving 1,592 clinical incidents), primarily between 2000 and 2019, and sets out a blueprint for safe maternity care in the NHS.
- The Key findings from the independent review are:
  - failure in governance and leadership
  - failure to identify and investigate incidents
  - failure to learn lessons and prevent avoidable harms; patterns of repeated poor care
  - insufficient workforce numbers, skills and supervision to ensure safe services
  - continued concerns described by maternity services staff regarding fear to speak up about concerns

- The second report identifies recommendations:
  - 66 Local Actions for Learning (LAFL's)
  - 15 Immediate and Essential Actions for Learning (IEA's)

- SaTH will be receiving a detailed action plan to their Trust Board meeting in public in May and this will also be subsequently presented to the SaTH Safety Assurance Oversight Group (SOAG) for scrutiny and debate.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held on: Wednesday 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.060	Summary Report of the Shropshire Telford and Wrekin CCG Quality and Performance Committee dated 25th May 2022

Executive Lead (s):	Author(s):
Zena Young – Executive Director of Nursing and Quality	Meredith Vivian, Chair, Shropshire Telford and Wrekin Quality and Performance Committee.

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion	x	I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
To provide assurance to the Governing Body that the safety and clinical effectiveness of services commissioned by Shropshire Telford and Wrekin Clinical Commissioning Group, and the experience of patients receiving those services, have been reviewed in accordance with the Quality and Performance Committee's Terms of Reference.	25th May 2022	

Executive Summary:

To provide a summary of the main items reviewed at the: 25th May 2022 meeting.

Recommendations/Actions Required:

Governing Board members are invited to receive this update report and are recommended to **note and discuss**: The Governing Body is asked to note for assurance and information

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? A project group will need to be resourced and recruited to.	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? Proposed changes to commissioned services are significant and require approval from NHSE/I to progress to public consultation.	No
5.	Are there human rights, equality and diversity requirements? The population this paper refers to includes those with legally protected characteristics of pregnancy and also refers to access to health services and associated health outcomes.	No
6.	Is there a clinical engagement requirement? There is a need for significant clinical engagement in the development of the model and associated timescale for delivery of any changes.	No
7.	Is there a patient and public engagement requirement? Changes to commissioned services are significant and require approval from NHSE/I to progress to public consultation.	No

- **Covid:** The disruption and pressure continues despite the reduction in numbers, constraints still exist across system wide capacity. The Demand and Capacity Group are looking at Bed Modelling, a retrospective and forecasted position using Population Health data.
- **Primary Care:** Primary care appointments remain broadly in line with the annual Mean, the % of those attended is above target in particular those seen face to face at c.63% and home visits remain double the target. Workforce remains a constraint and risk for the system, mitigations are in place.
- **Shropshire Doctors:** Key Performance Indicators remain green, concerns continue with staffing which have actions to mitigate. The Single Point Of Access/Referral is working really well with c.3250 patients through the combined (CCC & SPA) service since January with a 94% non-referral to the Emergency Department outcome.
- **Ambulance and 111:** WMAS hear and treat remains c.16% and see and treat @34%. Category 1 and Category 2 call response times (Mean) is a significant risk for the system, but has shown some improvement as the pressures ease with managing COVID and the surge of planned care recovery. Long ambulance waits remain a concern, St John started at PRH to cohort and release ambulances but this has had little impact.
- **Urgent and Emergency Care (UEC):** All operational standards remain relatively stable (still below standard), concerns regarding the % of total time spent in the emergency department >2% (9%), some mitigating actions exist to address Acute Medical flow which should have an impact.
- **Cancer Care:** The majority of the metrics remain stable but below current targets. There has been a slight improvement in Breast symptom referral c.2% on last month, some evidence that the new pathways are starting to work and demand has reduced slightly from recent highs. Urgent referral and screening 62d has significantly improved on last month c.25%. Key risks still exist in two week waits, 28-day Faster Diagnosis and Tumour Pathways, all of which have actions to mitigate the current position but are dependent on Diagnostic capacity/workforce.
- **Planned Care:** UEC pressures are still impacting upon planned care recovery but they are finally starting to ease , albeit slowly . No significant change in overall RTT performance, which remains at around 60% against a national target of 92%. The total number of waits therefore continues to increase, particularly in key specialties such as orthopaedics and general surgery. There are continued signs of recovery in ophthalmology, in which numbers are now starting to fall. The admitted waiting list continues to be clinically prioritised. The STW system is managing its P2 and P2C clearance times to levels better than the regional averages but due to capacity constraints and UEC pressures little progress has been made with P3 and P4 waits. Key risks remain in Referral to Treatment (RTT), long waiters (>104wks) and diagnostics, all of which have actions to improve but are workforce capacity dependent.
- **Mental Health**: Children with an Urgent Eating Disorder are waiting for longer than 1 week, and whilst the CCG and provider agreed funding for a remedial plan to reduce the number of children waiting the trust have as yet been unable to successfully recruit to the roles. This is also having an impact on the wider system especially in Acute services as well as in the place of safety suite at Redwoods which is normally used for Adults at risk but is increasing being used by a child, and therefore cannot hold any

adults. IAPT access continues to be lower than targets, and Physical Health checks for patients with an SMI (Serious Mental Illness) levels remain below national targets, although there has been small improvements made in Q4.

- **Shropshire (SHIPP) and Telford and Wrekin Integrated Place Partnership (TWIPP):** Both partnerships now have a suite of metrics and have agreed the reporting schedule. Both SHIPP and TWIPP will report on a group of 'proxy' measures quarterly as a standard starting April 2022 (June report), then annually the inequalities framework as an appendix. (This was incorrectly reported last month)

Quality 'alerts'

- **A new reporting arrangement has been established with the System quality Group raising those items requiring focused attention from the Quality and Performance Committee: Quality 'alerts'.**
- There will be ongoing costs associated with the implementation and running of Liberty Protection Safeguards. The funding of this is currently uncertain.
- The system quality risk register is a challenge to collate and keep updated by many partners. Partners contributed ideas and NHSE shared other systems risk registers to support.
- There has been a decrease in screening data other than for bowel cancer which is a concern. This is being raised with the primary care committee to understand actions.

Infection Prevention and Control

A quarterly report was received from the IPC tteam with the key issue relating to RJAH. A CCG & NHSE/I visit was undertaken in Quarter 4 serious concerns around IPC and governance in line with the Code of Practice on the prevention and control of infections (Hygiene Code) were identified. In response the trust outlined the significant range of mitigating actions being taken which were noted and supported by the Committee.

Patient Safety

The Committee received an update report on delivery of the Patient Safety Strategy, key achievements included:

- The CCG have a Patient Safety Specialist in post (Sharon Fletcher) 2021 who is leading our system work.
- The preparation to implement the new Patient Safety Incident Response Framework (PSIRF) is underway and will be launched in July 2022 and will allow for a 12 month implementation phase across systems.
- The online training program has been launched in the form of the Patient Safety Syllabus: Level 1 and 2 are available for all staff currently, including the board. Monitoring of compliance will be provided, however training will be rolled out in phases.
- Nationally there are connections being made with Patient Safety Collaboratives who will support a place-based approach to the Patient Safety Networks. The Patient Safety Networks will follow the ICS regional foot prints.

Annual Report of the Learning from Deaths of people with Learning Disability and Autism Review Programme (LeDeR)

- The Committees received a verbal update on the development of the report and, after discussion, felt able to recommend to the Governing Body that it consider the full report for approval.

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REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 27th April 2022**

Item Number:	Agenda Item:
GB-22.06.061	Finance Committee

Executive Lead (s):	Author(s):
Claire Skidmore Executive Director of Finance claire.skidmore@nhs.net	Geoff Braden Finance Committee Chair g.braden@nhs.net

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information			

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Finance Committee	27th April 2022	S

Executive Summary (key points in the report):

- Finance committee received the 2022/23 System Finance Plan with the initial deadline of submission 28th April with a further iteration expected in early June. The final plan was expected to show a deficit of around £34m. All organisations within the system have been asked to improve this position.
  There are a number of areas of investment including WMAS and NHS 111which the system have been asked to contribute to the cost pressure for the CCG.
  Work continues to progress on the System plan along with the Big Six, but these will have very limited impact in 2021/22, potentially impacting 2022/23 along with additional programmes. System controls have been adjusted for a realistic delivery of 3% plan this year and the committee was assured that this was achievable and realistic.
  The committee raised concerns over the potential lack of investment in Mental Health and confirmed that the CCG was one of the lowest investors in that area. The committee asked that this should be prioritised and not removed from the plan. This equates to around £10m. The committee asked that the Finance team take away this and approval for the plan was caveated on a review and consideration of extra mental health funding.
  Running costs were discussed with a potential overspend highlighted at around £750k above the target rate. It was agreed that this was a challenge against the tasks needed to be delivered but that a plan was necessary to address this overspend.

- The Value for Money QIPP update was presented to the committee which demonstrated the underlying position of the CCG vs the 1.6% task. The gaps in resources were discussed with improvements confirmed from September with vacancies and loans being closed.
  The forecast has been updated to deliver £7.2m which has been reviewed over the last month. Areas were discussed as further opportunities with the links to investment cases and Task & Finish group identified but the committee were pleased to see the progress and an improving trend.
  There is still a gap of £1m that still requires work to identify activities towards the 1.6% and Finance committee requested that continued to be addressed with executive team.
- Confirmation was received on month 12 report with a £4.3m deficit at year end. This is caveated that there is still to be a month 13 clawback from NHSEI that worsened the full year position by £200k.
- The Finance committee commended the Finance team for their hard work and effort that resulted in such an improvement in the full year position.
- The committee were updated on the Due Diligence plan and were assured that the work was on plan and no concerns were raised.
- It was confirmed that the GBAF has been updated and reflective of the risks.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication?	Yes
3.	Is there a risk to financial and clinical sustainability?	Yes
4.	Is there a legal impact to the organisation?	No
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:

Board to note the ongoing work to that is improving the Value for Money QIPP plans. To note approval given to the System Finance Plan.

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Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting held on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.062	Summary Report of the Shropshire, Telford and Wrekin CCG Audit Committee held on 16th March 2022 & Extraordinary Audit Committee on 20th April 2022

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Geoff Braden Audit Chair g.braden@nhs.net

Action Required (please select)									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary (key points in the report):

Audit committee 16th March 2022

- The Committee received the EPRR Annual Assessment, following the process of the annual business continuity process.. The plan included learning from COVID along with a more detailed inclusion for agile and home working arrangements. The process separating the business continuity and major incidents will be taken up separately with NHSEI.
- A further update with completed actions from the March meeting will be presented at a later Audit Committee.
- The Audit committee has taken delegated oversight of the due diligence process to transition to the ICS The committee received the updated approach for parallel reporting to the ICS Audit & Risk committee.
  and considered that the process was robust and highlighted areas for additional information to enhance assurance. Only two key commissioning policies were outstanding, and confidence was high that these could be concluded before the end of June 2022.
- BAF and Directorate Risk Register was presented and agreed with up to date risks and mitigation to address. The committee noted and recognised the risks were updated and reviewed. not being updated or had no risk owner identified. Limited assurance was provided on Safeguarding risks for both adult and children services and asked for this to be an agenda item on a future audit committee.
- Draft Annual Governance Statement was received as part of the Annual Report. It outlines the accountable officer's statutory duties in terms of ensuring the CCG has robust internal control mechanisms. The document was assured and agreed.

- Policy Alignment Update. The list of policies were received and the committee assured that the list of outstanding policies and procedures were on track for completion by end June 2022.
- Information Governance update was received with an update on the 2021/22 DSPT, the latest bi monthly report from CSU IG team, the content of the SARs log and SIRO report. Further updates will be received at future Audit Committees. the 95% target was achieved in a rolling 12 month period this year and this is a significant achievement for the IG team.
- Updated draft Annual Internal Audit report was received with moderate or limited assurance across the summary report. Recognition was included that there was good oversight and actions taken against the recommendations. With an appreciation of the challenges from COVID. A full and final report will be received in May committee. Final reports were received on Complaints, Conflicts of Interest, Individual Commissioning – Funded Nursing Care, with updates on action plans and inclusion into BAF & DRR. Internal Audit Plan for the coming year which was noted by the committee.
- External Audit advised that there was still some dialogue on the audit with the deadline moved to 26th April and completion to 8th June. There was little update on any proposed changes to the audit or accounting standards for 2021/22. With the concern of the financial sustainability for CCG and the subsequent single organization. The committee received an update on the Audit Risk Assessment 2021/22 which is a standard report as part of the annual assessment. A number of risks to the Audit plan 2021/22 were covered and the fees involved.
- Counter Fraud progress report was received and details discussed. With no issues raised from National Fraud Initiative 2020/21 for either Telford & Wrekin or Shropshire being raised.
- Losses, Special Payments and Waivers were received with no losses or special payments in the period. It was noted that a number of waivers had been completed with the Committee given assurance that normal service reviews will be reinstated.

Extraordinary Audit Committee 20th April 2022

- The committee received an update on the Due Diligence checklist and specifically the Quality and Escalation process update. The previous staffing challenges were confirmed as being addressed and progress being made. The committee noted,discussed and recognised the progress being made. Further updates were requested.
- Draft Annual Accounts 2021/22 were received and it was recognised that it had been a challenging year with COVID and associated issues making things extremely challenging. The year end deficit was £4.3m, with an accumulated deficit of £134m. This is a significant improvement from the >£9m forecasted overspend at the end of H1. The committee noted and recognised the huge efforts that the finance team and others had put in to achieve this improved outcome.
- Draft Annual Report 2021/22 including the Annual Governance Statement was received. Standard guidance is given on how the report is presented and the content. The committee made some suggestions and raised some further work to be done but was happy to assure and approve the draft report.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation?	No
5.	Are there human rights, equality and diversity requirements?	No

6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:
Board to note the update and the policies approved.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.063	Primary Care Commissioning Committee (PCCC) Summary Report (June 2022)

Executive Lead (s):	Author(s):
Ms Claire Parker Director of Partnerships NHS Shropshire CCG and NHS Telford and Wrekin CCG Claire.parker2@nhs.net	Donna MacArthur Lay Member - Primary Care

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary :

The detail below provides a short summary of the items, discussion and actions from Primary Care Commissioning Committee 4th May 2022.

Finance update:

- Premises Costs Reimbursement was discussed as the accounted figure showed an under-spend in the report, but an over-spend on the Risk Register. At the end of 2021 a large accrual was submitted as a provision for premises unknowns, as it is often difficult to predict. It became apparent during the year that the under-spend figure is the release of the prior year accruals.

However, it was advised that the premises overspend should remain on the Risk Register until the work has been carried out to help identify the underlying position in relation to premises. A deep dive will be undertaken of the underspend or overspend and will assist prioritisation of the Primary Care Estates Strategy.

Efficiency schemes should be reviewed, particularly where a contract which had not delivered as expected. Wound Incontinence and Self Care schemes should also be reviewed. This work will be taken forward into the Integrated Care Board Primary Care Committees.

Primary Care update:

- Shropshire, Telford and Wrekin CCG has received national funding to support a Children's and Young Peoples Asthma project.
- GP Strategy for workforce was approved
- Lantum locum electronic service has shown some benefits during the last period of Covid-19 pressures with 10 GP surgeries going into business continuity during the most recent wave.
- An update on the Blood pressure monitoring @home scheme was given
- An update on the most recent practice visits was given with discussion about co-ordination to ensure the practices feel supported.
- No further estates updates other than those previously reported.
- Shrewsbury Health and Well Being Hub – further engagement work with the public on shaping the services and investment into primary care will commence over the next few weeks
- Draft 'Care-taking' policy was circulated for comments before obtaining legal oversight and final approval via the committee electronically.
- Caretaking is intended to be short term emergency provision to ensure services are maintained in the event of a Practice closing unexpectedly.
- An update on the GP patient survey will be given by a report to the Primary Care Commissioning Committee for the Integrated Care Board.
- Primary Care Risk register was updated, reviewed and approved for transfer to the Primary Care Commissioning committee in the Integrated Care Board governance.
- The delegation agreement for Primary Care Commissioning will need to be signed off by the Integrated Care Board on 1st July 2022 as part of the transition from the CCG.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).* Conflicts of interests were recognised and managed throughout the discussions.	~~Yes~~/No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	~~Yes~~/No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	~~Yes~~/No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	~~Yes~~/No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	~~Yes~~/No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	~~Yes~~/No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	~~Yes~~/No

Recommendations/Actions Required:
Board representatives NHS Shropshire, and Telford and Wrekin CCG are asked to receive this paper for information

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin Governing Body Meeting held in public on 8th June 2022**

Item Number:	Agenda Item:
GB-22-06.064	Locality Chairs Summary Report (May 2022)

Executive Lead (s):	Locality Chairs:
Claire Parker Director of Partnerships NHS Shropshire, Telford & Wrekin CCG Claire.parker2@nhs.net	Dr Ian Chan Dr Ella Baines Dr Katy Lewis Dr Matthew Bird

Action Required (please select):										
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	X

History of the Report (where has the paper been presented:		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Locality meetings	24 March 2022 & 24 May 2022	S

Executive Summary (key points in the report):

The detail below provides a short summary of the items discussed at the first Locality Meeting in Common of the North, South, Shrewsbury & Atcham and Telford Localities, held on 24 March 2022, chaired by Dr Bird

CCG update:

- The Ockenden report will be released on 30th March, 2022. Members noted that support is available via MPFT and the Lighthouse Service for expectant mothers and families who have concerns.
- Changes to death certification and cremation regulations that come into being from 25th March, 2022.
- Access to prospective patient records (from 1st April 2022) through the NHS app that is about to be launched.
- The RCGP would be releasing information for Practices, in addition to training options, in due course. The prospective workload for General Practice was outlined.

Primary Care Representation on ICB/ICS:

- Members were advised that a specific session was scheduled for April to enable all Practices to comment on the options/solutions relating to how Primary Care will be represented on the ICB.
- Dr Ian Chan provided members with an overview of the developments of the ICB in terms of General Practice representation in the longer term. Concern was expressed over where and how General Practice will be represented in the system.
- Members were advised that a meeting of CCG leaders, together with Sir Neil McKay and Simon Whitehouse will take place to discuss the way forward for General Practice.

- The Locality Chairs had discussed the matter and there exists a consensus that General Practice representation, within the new structure, is an important issue.
- It was agreed that information should be shared prior to the meeting proposed in April 2022 to facilitate shared understanding and open communication.
- It was agreed that a united view was needed, for the benefit of all. The need to act swiftly to formulate a shared view was extolled.

Updates to the meeting in common:
- 2 ww proformas- no issues reported
- Referral pathways into Urology- Mr Elves attended the meeting and the opportunity for co-design with Primary Care was embraced
- Community Breast Pain Clinic- no issues reported with referral process
- Asthma, personalized care for young people
- Community Services update
- Mental health update
- Diabetic foot screening- discussion around referrals to podiatry for mild to moderate and concerns that this is leading to confusion about the service- members agreed to feedback
- Shared Care agreements- members agreed the need for improvements to resources on CCG website and clarification of pathways
- FIT testing- members were updated on changes to the provision of FIT testing

Individual Locality Meetings:
- The four localities held individual meetings following the meeting in common
- The main item of discussion for all was Primary Care representation on the ICB/ICS
- The meetings discussed how the localities could continue to meet and have a voice within the new organization

Meeting of the Localities in Common on 24th May 2002. The meeting was chaired by Dr Katy Lewis with updates on:
- Outpatient redesign Julie Garside led a discussion around the importance of GP engagement in this redesign work.
- Appointment Process for Primary Care Board Simon Whitehouse and Claire Parker led a discussion about the ICB development and the appointment process for Primary Care membership on the board.
- Primary Care Leadership for ICB Deborah Shepherd led a discussion on how Primary Care can engage in the new organisation.
- Podiatry and Foot Health Services a discussion with the SCHT Podiatry team about the services in place and support and training offered to practices.
- GP Strategy Phil Morgan presented the new GP strategy
- An update paper was also received on Mental Health Services.

Recommendations/Actions Required:
Board representatives for NHS Shropshire, and Telford and Wrekin CCG are asked to receive this paper for information.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No

4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

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NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 8 June 2022.**

Item Number:	Agenda Item:
GB-22-06.065	Assuring Involvement Committee (AIC) Chair's Report from the meetings held on 24th March, 28th April, and 26th May 2022

Executive Lead (s):	Author(s):
Edna Boampong	John Wardle - Chair

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	x	D=Discussion		I=Information	x

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
This is the report from the Chair of the AIC to the Board		S I

Executive Summary (key points in the report):

The detail below provides a short summary of the items, discussion and actions from the Assuring Involvement Committee.

The committee has met three times since my last report to the Board. It did not meet in February as there was only one potential item for the committee to review but staff were not available due to the school half-term holiday.

AIC meeting dated 24 March 2022:

- The Eye Care Transformation Programme: The committee was keen that all partners involved worked collaboratively to ensure there was no duplication of engagement. It was noted that SaTH had been working independently on an eye-care strategy but was now aligned with the CCG's work. The Committee noted that, despite the efforts of the team, many service users (including some on the committee) were not aware of the programme. The Committee suggested that a report on actual engagement should be brought to the committee later in the process – the list presented to the committee identified potential participants in engagement but a significant number had not actively engaged.

- Healthier Minds Festival: The Committee commented that this appeared to be a promotion and awareness event but was reassured by the presenters that the intention was to increase understanding of people's needs. The committee also sought information as to how much involvement there had been from local community leaders in the planning of the event.

- The Shrewsbury Health and Well-being Hub: The committee had continued to invite the programme team to attend following the initial engagement but the plan for the second round of engagement was still in development stage. Although no one attended the March meeting, a written briefing document had been submitted. The discussion raised a number of concerns, many focussed on the disparity between the reported engagement and the perceived level of engagement of patients. Committee members spoke of their own experience and that of contacts in the areas affected who had reported seeing little publicity and engagement. The team would be asked again to come to a meeting to allow the committee to get a greater understanding and ask questions of the team.

AIC meeting dated 28 April 2022:

- The Health and Well-being Hub: The meeting received a presentation on the second phase engagement plan for the Wellbeing Hub. The team conveyed the initial listening exercise could have been improved – although this was a good news story of investing in the area, it could also be interpreted as dis-investment with the bringing together of practices in the same area. The team explained the next phases of the engagement which were likely to include a public consultation in late summer/early autumn.

  Committee members expressed a view that the GP practices were not communicating well with their patients about the Hub. Whilst the CCG had provided engagement materials, it was the practices responsibility to communicate with their patients. The committee had concerns about this "gap". A question was asked about the required transport provision that would be required. This is apparently outside of the project's remit but some discussion with the local authority with the aim of securing enhanced public transport provision. The questioning by the committee was lengthy which emphasised the concerns members had/have. It became clear that a significant problem was the indirect engagement route to patients affected through the requirement for GP practices to be invested in communicating.

  The committee felt the presentation received was a positive one, but it was very dependent on the ability of the team to be able to reach the patents affected – something that appeared to be a challenge to date.

AIC meeting dated 26 May 2022:

- The future of the AIC: A discussion about how assuring involvement and reducing inequalities might be handled under the ICB structure which would come into place in July. Members put forward suggestions based on their experience on the current committee and how things had improved, both in terms of participation by members but also in the quality and focus of presentations made to the committee. The remit of the committee would not be "like for like" and a recruitment process for new members would be undertaken through the summer. Everyone hoped that this would result in many more applicants coming forward to enable a more diverse membership.

Recommendations/Actions Required:
The Governing Body is recommended to accept this report for information

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	~~Yes~~/No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	~~Yes~~/No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	~~Yes~~/No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	~~Yes~~/No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	~~Yes~~/No

6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	~~Yes~~/No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	~~Yes~~/No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	Yes
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	Yes
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	No