NHS
Telford and Wrekin
Clinical Commissioning Group

Annual Report and Accounts
2020/2021

www.telfordccg.nhs.uk

Healthier, happier, longer

NHS
Telford and Wrekin
Clinical Commissioning Group

Table of contents

Section	Page
Performance Report	3
Performance overview by Accountable Officer	3
Statement of purpose and activities of the CCG	5
About us	5
Our vision and objectives	6
Population challenges	6
Working with partners	8
2020/21 financial position	11
Key issues and risks	12
Adoption of going concern basis	14
Performance Summary	15
Performance Analysis	17
Primary care	17
Telford and Wrekin Integrated Place Partnership (TWIPP)	20
Commissioning	24
Out of hospital transformation	26
Medicines optimisation	32
Finance	37
Quality, Innovation, Productivity and Prevention (QIPP)	37
Sustainable Development	38
Monitoring the Quality of Services	40
Engaging People and Communities	44
Equality, Diversity and Human Rights Report	59

Health and Wellbeing Strategy	64
Reducing Health Inequalities	65
Accountability Report	73
Corporate Governance Report	73
Members Report	73
Statement of disclosure to auditors	76
Governance Statement	79
Other sources of assurance	106
Control issues	109
Review of economy, efficiency and effectiveness of the use of resources	110
Head of Internal Audit Opinion	112
Remuneration and Staff Report	117
Remuneration Report	117
Staff Report	123
Trade union facility time	129
Expenditure on consultancy	130
Off payroll engagements	132
Exit packages and severance payments	132
Health and safety	134
Statement as to disclosure to auditors	134
Parliamentary Accountability and Audit Report	137
Fraud	137
Audit Report	134
External audit fees, work and independence	134
Annual Accounts	136

PERFORMANCE REPORT

Performance Overview by Claire Skidmore, Interim Accountable Officer

This year's Annual Report marks the end of a year which has been filled with changes and challenges. In a single year, we have responded to the COVID-19 pandemic, managed our transition to a single Clinical Commissioning Group (CCG) with our neighbours in Shropshire and prepared for the introduction of a shadow Integrated Care System (ICS) Board.

The COVID-19 pandemic has presented some of the most significant challenges the NHS has faced, both locally and nationally. As a system, we acted quickly to respond to the emergency, this has been sustained throughout the year and continues into 2021/22.

The pandemic has stretched resources and helped identify places where we can improve. It has also demonstrated where our strengths lie. We have worked closer than ever before with our partners across the NHS, other healthcare providers, local authorities, voluntary and community sector organisations, in a huge collective effort to save lives, protect the NHS, and facilitate a long-term response.

Locally, we have seen our practice membership work together in different ways and settings, using technology to provide online support wherever possible. Our acute and community trusts have adapted ways of work to provide care for our local population to the best of our ability throughout the challenges of the year.

Our CCG staff have worked in a number of settings to support the pandemic, including non-clinical functions which have experienced huge increases in demand, new tasks to support the response and redeployment into clinical settings to provide additional capacity.

Our partners in Telford and Wrekin Council have been a key partner in the response throughout, setting up support services and vaccination centres, widening the reach from our hospital, GP and pharmacy-based services. Together, we have ensured a high proportion of local people have received a vaccine.

The commitment of everyone to all our patients and local communities remains outstanding.

Within the context of this exceptional year, we have continued to make improvements to our services.

In December 2020, a new system was introduced across Shropshire, Telford and Wrekin to manage urgent, but not life-threatening health care needs. By calling NHS 111 first, trained staff can now book appointments for patients with the most appropriate service, or refer to the Emergency Department if needed. This has helped to improve the patient experience by helping to

ensure people are seen and treated sooner. A survey is planned to assess the patient experience of using NHS 111 First.

Our health and social care rapid response team is providing rapid referrals for people who are suffering a health crisis. This works to resolve the immediate crisis and then looks to put preventative measures in place to prevent further issues whilst helping people remain independent in their own homes.

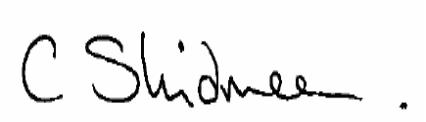
The multidisciplinary care home team involves primary care colleagues delivering enhanced support to people living in care homes through the use of digital technology. This also helped to provide additional support to care home staff at the height of the COVID-19 pandemic.

The national review led by Donna Ockenden, which is reviewing cases of serious and potentially serious concern at the Shrewsbury and Telford Hospitals NHS Trust has requested the CCG provides evidence to the review from the commissioning perspective to enable it to triangulate the information it has already received from families and the Trust. The CCG is cooperating fully with the review and evidence will be shared early in 2021/22.

Our transition to a single CCG for Shropshire, Telford and Wrekin on 1 April 2021 has also been a significant factor this year and represents a key milestone in our future. The move creates a number of opportunities to work more efficiently and effectively, so we can reduce health inequalities and make sure we provide value for money healthcare services when and where they are needed. Staff across both CCGs have worked hard to streamline processes and create a single structure through a complete management of change process.

At the end of this financial year we saw the departure of Dr Julian Povey from his position as Chair of the CCGs, as he returned to full time practice from 1 April 2021 at Pontesbury and Worthen Medical Practice. Mr David Evans, Accountable Officer, also left the CCG to take up a secondment opportunity with NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). Our thanks go to them both for their outstanding contribution to the CCGs throughout, and for leading the organisation through this exceptional year.

The next financial year brings with it a number of challenges, as we emerge from the pandemic and work together to reshape our services. On 1 April 2021 Shropshire, Telford and Wrekin became an ICS, and we are working with our partners across the system to establish new ways of working together for the benefit of our local health and care services.



Mrs Claire Skidmore
Interim Accountable Officer
14 June 2021

Statement of purpose and activities of the CCG

This section of the Annual Report provides summary information on NHS Telford and Wrekin CCG – its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed over 2020/21.

About us

NHS Telford and Wrekin Clinical Commissioning Group is a statutory body established under the Health and Social Care Act 2012. It was fully authorised as a CCG on 1 April 2013, with no conditions on its operations. The principal location of our business is at Halesfield 6, Telford TF7 4BF.

The CCG is a membership organisation. During 2020/21, there were 13 GP practices in Telford and Wrekin and they are all 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.

Telford and Wrekin CCG is responsible for designing and purchasing (commissioning) healthcare in the Telford and Wrekin area:

- We plan what services are needed to support the health needs of our local population
- We buy services such as mental health, hospital care and community services
- We monitor these services to ensure patients in 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
- 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 including NHS England, which is the organisation that is responsible for buying GP, pharmacy, dental and specialised services in our area and across England, to ensure that health services delivered locally are joined up.

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

Our other key local partner is Telford and Wrekin Council. We work closely together to commission services that cross social and health boundaries. This is done through the Better Care Fund (BCF) and services where we have developed a joint strategy, for example, mental health services for children and young people. We have also begun to align services across the four neighbourhood areas making up Telford and Wrekin, so that social care, self-help support services and health services are located closer to people's homes.

Our vision and objectives

Our vision reflects the changed driver from a focus on ill-health to a local one, driven by the need to help maintain an individual's wellbeing:

"Working with our patients, Telford and Wrekin CCG aspires to have the healthiest population in England. Healthier, Happier, Longer."

Working with our partners, NHS services, GP members and patients, we have identified five key objectives to help us deliver our vision of health service provision. These objectives guide our decision-making to deliver high quality, equitable, safe and locally driven care:

- To improve commissioning of effective, safe and sustainable services, which deliver the best possible outcomes based upon the best available evidence
- To increase life expectancy and reduce health inequalities
- To encourage healthier lifestyles
- To support vulnerable people
- In meeting the objectives above, to exercise CCG functions effectively, efficiently and economically, and in accordance with generally accepted principles of good governance and as an employer of choice.

Population challenges

We serve a total population of around 173,000 people across 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 from 24 per cent in 2010.

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

- During the 2011 Census, 80.2 per cent of the population of Telford and Wrekin reported that they had good or very good health. This is slightly lower than the 81.4 per cent in England. A further 6.2 per cent reported having bad or very bad health. This varied by age with, adults aged 16-64 at 3.2 per cent whereas over-65s were at 18.1 per cent.
- The life expectancy at birth in Telford and Wrekin is 78.1 years for males. The equivalent figure for females is higher at 81.8. Both ages are significantly worse than their equivalent England averages of 79.3 and 83.0 respectively.
- The standardised mortality ratio (SMR) due to all causes for those under 75 in Telford and Wrekin is worse than the national figure. This remains true when the separate and specific causes of either cancer, circulatory disease or coronary heart disease are separately considered.
- The SMR due to all causes (for all ages) in Telford and Wrekin is worse than the national ratio. This remains true when the separate causes of either cancer, circulatory disease, coronary heart disease, stroke, and respiratory disease are measured.
- The standardised incidence ratio (SIR) for all cancers in Telford and Wrekin is similar to the national ratio. This remains true when the separate cancer types of either breast, colorectal or lung cancer are measured. The SIR for prostate cancer, however, is significantly better than that nationally.
- The 2011 Census found 1,562 children (aged 0-15) in Telford and Wrekin with a long-term limiting health problem or disability that limited their daily activity. This amounts to a rate of 4.6 per cent of the 0-15 population. The rate increases with age, with those aged 0-4 having a rate of 2.5 per cent. The 2011 Census found 15,938 adults aged 16-64 in Telford and Wrekin with a long-term limiting health problem or disability that limited their daily activity – 14.7 per cent of the 16-64 population. In a more detailed age breakdown, the rate increases with age, with those aged 55-64 having the highest rate of 29.6 per cent.
- The 2011 Census found 13,495 of over-65s in Telford and Wrekin with a long-term limiting health problem or disability that limited their daily activity. This amounts to a rate of 56.0 per cent of the 65 and over population. Telford and Wrekin have 2,400 residents aged 16-64 with serious physical disability. A further 8,300 have a moderate physical disability. Telford and Wrekin is estimated to have 1,000 children aged 5-10 and 1,400 aged 11-16 with a mental health disorder.
- Telford and Wrekin estimates it has 17,400 adults aged 16-64 with a common mental health disorder. The majority of these (10,600) are female, a prevalence of nearly 20 per cent of all females aged 16-64. In men this prevalence is 12.5 per cent.
- In Telford and Wrekin, there are estimated to be 700 older people aged 65 and over with severe depression. The prevalence of severe depression in those 65 and over varies with age. It is most prevalent in the 85 and over age group at 3.9 per cent.

- Telford and Wrekin is estimated to have 1,800 residents aged over 64 suffering from dementia. The number of sufferers increases with age band, with 800 sufferers aged 85 and over.
- In Telford and Wrekin, it is estimated that 4,000 residents have a learning disability. The majority (3,300) have a baseline learning disability, the remaining 700 having a moderate or severe learning disability.
- The standardised admissions ratio of emergency hospital admissions in Telford and Wrekin is 112.8 for coronary heart disease (CHD), 136.3 for stroke, 116.7 for myocardial infarction (heart attack), and 112.1 for chronic obstructive pulmonary disease (COPD). All of these figures are worse than the national average.

All of the above figures are drawn from Telford and Wrekin Council's facts and figures webpage.

As a CCG, we are committed to working with patients and clinicians to help people manage their long-term conditions and ensure services can support the ageing population we have.

Working with partners

We continue to build on the strong history of partnership working in Telford and Wrekin through the Shropshire, Telford and Wrekin Sustainability and Transformation Partnership (STP) which at the end of March 2021 was confirmed as a Shadow Integrated Care System (ICS). We are leading on a number of initiatives with partners that are key to delivery of STP/ICS objectives and this will continue to be a key focus for us in 2021/22.

COVID-19

2020/21 has continued to be a very challenging year for the NHS nationally and locally due to the global COVID-19 pandemic. As a result, the normal delivery of services in the NHS ceased for the greater part of the year so that resources could be focused on the NHS fighting the pandemic.

This has resulted in partnership working on a vast scale locally to ensure we had capacity to treat both COVID-19 positive patients and non-positive patients in the safest way possible. We have used our emergency planning model to create a streamlined decision making process across the whole system to ensure that decisions were taken quickly but mitigating risk as much as was possible.

All providers, commissioners, local authority and third sector have been working together to support those suffering from COVID-19 but also to prevent the spread of the virus and to ensure local people were given the accurate and up to date advice on how to keep them and their families safe. The effort has been unprecedented and we would like to acknowledge all those organisations who have taken part and contributed their time, expertise and staff to this monumental effort. At the end of the financial year our attention has now turned to the safe restoration of services to our local populations.

Telford and Wrekin Health and Wellbeing Board (HWBB)

Our Chair, Dr Julian Povey and Accountable Officer, David Evans both sit on the HWBB. In June 2020, a new Health and Wellbeing Strategy was approved, which built upon the proposals with the additional priority to reflect new problems that had arisen as a result of the pandemic.

In developing its priorities and strategy, the process included a review of local intelligence, engagement workshop sessions with voluntary sector partners as well as a joint session between members of the Health and Wellbeing Board and the Telford and Wrekin Integrated Place Partnership to review progress and align priorities. Likewise, the strategy looked to align itself to the Telford and Wrekin Annual Public Health report recommendations and the commitments of the Long Term Plan for 2019-24 by the Shropshire, Telford and Wrekin STP.

The four cross-cutting priorities where the Board wants to make the fastest progress are:

- To develop, evolve and deliver the Telford and Wrekin Integrated Place Partnership Priority Programmes
- Tackling 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.

The HWBB also forms part of the STP/ICS governance structure to ensure that partnership working is truly at the centre of the delivery of the STP/ICS.

The Chair of the Health and Wellbeing Board has been consulted upon the content of this section of the Annual Report.

Telford and Wrekin Council

The Better Care Fund (BCF) continues to be an important focus for our partnership working with 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 STP/ICS. This work is allowing us to explore – in a more meaningful way – how health and social care services can be delivered in more community settings, closer to people's homes. Ultimately the aim is for services to be more integrated, so we support the whole person and not just a disease.

Health Overview and Scrutiny Committee, Telford and Wrekin Council

Our interaction with the Health Overview and Scrutiny Committee has continued to be significant during 2020/21. 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 Shropshire CCG

We work collaboratively with our neighbours in Shropshire CCG on several key issues including safeguarding, local maternity services, midwife-led units service review, primary care working programmes and lead commissioning arrangements with shared providers. We generally work in partnership on procurement programmes and are closely aligned when negotiating contracts with our provider trusts. We have also have a joint contracting function to support our commissioning processes and a joint quality function across both CCGs.

In 2020/21, NHS England and NHS Improvement (NHSE/I) approved a joint application by both CCGs to dissolve the current CCGs and create a single CCG; NHS Shropshire, Telford and Wrekin CCG on 1 April 2021. This has resulted in both CCGs aligning their governing body composition by appointing joint governing body members, adopting Constitutions that align decision making processes and also undertaking a management of change process with both staff groups to create a single staff structure ready for the creation of the new CCG.

NHS Midlands and Lancashire Commissioning Support Unit (MLCSU)

MLCSU currently provides most of our functions through a contract ranging from financial management to human resources and information governance. We continue to work with MLCSU in terms of consistency of services provided.

Emergency Preparedness Resilience and Response (EPRR)

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

2020/21 has been an unprecedented year for the NHS and in particular the principles of EPRR have been front and central in ensuring the correct infrastructure to deal with the COVID-19 pandemic incident has been in place.

Together with Shropshire CCG, we have led the multi-agency system response to the pandemic, ensuring a responsive, multi-agency approach to a complex, demanding and evolving incident.

We have been guided by the incident management instructions from NHS England (NHSE) and to address both these and the emerging local situation our incident management arrangements were quickly mobilised to manage all aspect of the response. Following mobilisation in February 2020, these structures have remained in place throughout 2020/21 to manage the ongoing response and have been adapted as required.

During 2020/21, NHSE departed from the usual annual EPRR self-assessment process in acknowledgement that organisations were fully engaged in the COVID-19 pandemic response. However, the CCG has maintained its director on call rota 24 hours a day, 365 days a 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. In addition, the CCGs have participated in an audit of its EPRR approach to the pandemic and have been assigned full assurance.

2020/21 financial position

Due to the COVID-19 pandemic the financial framework in operation during 2020/21 has been very different to previous years. The normal financial regime (including planning and contracting rounds) were paused in March/April 2020 and a temporary financial framework was put into place.

In the first six months of 2020/21, the CCG was given a budget to operate within based on 2019/20 spend with a small uplift, any variances from this budget for either COVID or non COVID expenditure were then funded retrospectively so that for the first six months of the year the CCG reported a break even position. Block payments to providers were also set at a national level to remove the need for contract negotiations or monitoring in year.

In the second six months of 2020/21, the CCG was again given a budget to operate within based on 2019/20 spend plus a small uplift plus an additional allocation assuming that Non COVID overspends in the first six months of the year would continue into the second six months.

Block payments to providers continued to be set at a national level. The key difference in the second six months was that there would no longer be any additional retrospective top up payments. The CCGs were given system level funds to support COVID expenditure and any growth across the system. There was a clear expectation that organisations and systems would manage within this funding and report a break even position.

The final 2020/21 position (subject to audit), shows Telford and Wrekin CCG exiting 2020/21 with a £1.3m deficit. This deficit will take the cumulative deficit carried into 2021/22 to a total of £7.4m.

This financial year has been a one-off in terms of both allocations received and expenditure trends due to unprecedented circumstances. The CCG ended 2019-20 with an in year deficit of £13.1m and a cumulative deficit of £6.1m. The transformation and efficiency programme planned for 20-21 has delivered £1.9m. The full programme was not delivered in part due to the COVID-19 pandemic and shift in priority focus for both the organisation and the wider system.

The underlying deficit for the two CCGs combined means that we start the new organisation in 21-22 with an underlying position of £71m deficit.

If we ignore the non recurrent nature of 2020/21, the three main drivers of the historic deficit continue to be:

Emergency activity (including A&E, non-elective care and ambulance)

Emergency care budgets significantly overspent in 2019-20. The final overspend against plan was £2.4m (6%) in emergency spells of care in hospital, £0.5m (6%) in A&E attendances and £0.4m (4.8%) in ambulance conveyances.

Individual commissioning (including continuing healthcare and mental health)

Individual Commissioning Costs also significantly increased in 2019/20. The overspend in this area was £4.6m (35%) over budget. The CCG saw a steep increase in costs particularly in the area of Mental Health, Adult Joint Funded and Adult Fully Funded where both numbers of packages and costs of care packages have risen.

Slippage in Quality, Innovation, Productivity and Prevention (QIPP) delivery

In 2019-20, £4.9m of the CCG QIPP (Quality, Innovation, Productivity and Prevention) target was categorised as 'unidentified' at the start of the financial year and despite efforts to develop schemes in year this value only reduced to £4.2m 'unidentified'. The CCG was able to deliver £5.8m of QIPP against the original target of £10.6m (55%). The remaining 45% slippage contributed to the 2019/20 in year deficit.

During 2020/2021, delivery of QIPP was challenging due to the impact of the pandemic. Block contracts were put in place with our main providers, a number of QIPP projects were suspended and many staff redeployed to other departments. However, the CCG was able to still deliver £1.9m of savings which were predominantly within the medicines management and individual commissioning teams.

As the CCGs come together to become a single commissioning organisation, the focus for both the CCG and the wider system is addressing the underlying financial position. The current assessment of the underlying financial deficit for the newly combined CCG in 2020/21 is a deficit of £71m. The system is currently working together to develop a sustainable financial plan that delivers stabilisation during 2021/22 and then improvement through transformation schemes from 2022/23 onwards.

Key issues and risks

We track the progress of our service providers (e.g. local hospitals, community services, primary care practices) against several national outcomes indicators and ensure that patient rights within the NHS Constitution are maintained. Additionally, we have set local priorities against which provider progress is monitored. Performance reports are presented to and scrutinised by every meeting of the Quality and Performance Committees in Common, a sub-committee of the

Governing Body and a summary of key issues presented to the Board on a monthly basis. The performance reports can be found on our website.

The key issues and risks include:

- The continued prevalence of COVID-19 and the precautions to manage the pandemic
- Non-achievement of quality related performance targets, including:
    - Acute hospital trust is rated 'Inadequate' by CQC
    - A recent CQC inspection of the Acute Hospital Trust rated services for Children and Young People as 'Inadequate'.
    - Smoking at time of delivery amongst pregnant mothers
    - Annual health checks for patients with learning disabilities.

We work with key providers to improve performance. Risks to sustainable recovery include:

- Workforce capacity – which is a challenge for most of our providers
- The impact on demand of our ageing population
- Culture and attitude to risk – which also impacts on demand.

COVID-19 expenditure

The CCG spent £8.5m on COVID-19 related costs in 2020/21. The breakdown of this is as follows:

Category of Spend	£
Acute Services	
Payments to Shrewsbury & Telford Hospitals NHS Trust	712,000
Mental Health Services	56,569
Section 117 CHC	482,258
Primary Care Services	
General Practice - Community base services	239,826
General Practice - IT	21,923
Care Home Support (CHAS)	29,520
Phlebotomy	65,254
Other	33,803
Patient Transport	445
Running (Corporate) Costs	26,716
Continuing Care Services	
LA commissioned	3,725,356
CCG directly commissioned	3,067,804
Continuing Health Care team	45,602
TOTAL SPEND 2020/21	**8,507,077**

This expenditure was fully funded by HM Treasury through an allocation from NHS England.

The CCG was able to utilise these COVID-19 specific funds to implement a number of COVID-19 specific interventions in order to ensure the safety of our patients and that appropriate care could be delivered across the system during this period of escalation.

This included, for example, the re-deployment of staff, delivery of specialist IPC support and advice, delivery of specific Hot Clinics and a COVID-19 Management Service in primary care and designated COVID-19 beds in our community. Via these arrangements the CCG was able to meet the COVID-19 response requirements set out in NHSE guidance but also to meets its Emergency Preparedness, Resilience and response obligations.

EU Exit Funding

The CCG received no funding in 2020/21 in respect of EU exit costs and incurred no expenditure. The EU exit had no impact on the strategic objectives or priority outcomes of the CCG during 2020/21.

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 £1.3m and a cumulative deficit position of £7.4m. This is in the context of a temporary financial framework being in operation in 2020/21 due to COVID-19. In the first six months of 2020/21, the CCG was given a budget to operate within and any variances from this budget for either COVID or non COVID expenditure were then funded retrospectively so that for the first six months of the year the CCG reported a break even position. Further funding was provided for the latter six months of the year which included funding for estimated COVID costs and there was a clear expectation that organisations would manage within this funding and report a break even position.

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 however it is recognised that there has been a significant impact on how we operate. Our assessment of going concern is made on the basis that Government support is available to the NHS for all COVID-19 related costs and the CCG is fully participating in all financial returns and reviews.

The CCG have taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt are not materially impacted. These steps include securing remote access to financial systems for all finance staff and budget holders, and working with our 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 clinical commissioning group and the issue of a Section 30 report by the Secretary of State for Health indicates some uncertainty over the CCG's ability to continue as a going concern, the Governing Body, having made appropriate enquiries, have reasonable expectations that the CCG will have adequate resources to continue in operational existence for the foreseeable future.

As directed by the Group Accounting Manual 2020/21, the Governing Body have prepared the financial statements on a going concern basis as they consider that the services currently provided by the CCG will continue to be provided in the foreseeable future.

On 1 April 2021 the CCG will form one single commissioning group with NHS Shropshire CCG to become 'NHS Shropshire, Telford and Wrekin Clinical Commissioning Group'. The formation of this new organisation has been approved by both sets of Governing Bodies and NHS England and the services currently provided by the CCG will transfer entirely to the new organisation together with its assets and liabilities.

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

PERFORMANCE SUMMARY

Performance dashboard

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

During 2020/21, performance – and NHS activity generally – has been significantly impacted by the need to deal with the COVID-19 emergency. This has meant reductions in some areas of planned and emergency activity and the cessation of reporting on some key indicators. Consequently, despite performance in some aspects not meeting pre-COVID-19 expectations, the local health system has coped well with the COVID -19 emergency and endeavored to maintain critical services as much as possible particularly in relation to cancer care and other critical conditions. Inevitably, numbers waiting for elective care have increased during the last year and will present a significant backlog to be cleared.

Ambulance response time standards have largely been achieved by the CCG. The CCG has not met performance targets in respect of the Accident and Emergency four-hour waiting time standard. Improvements have however been made against 12-hour admission waits and ambulance handover delays at A&E. The Referral to Treatment (RTT) target for waiting times for elective treatment was not achieved by the CCG or the local hospitals as a result of elective capacity being severely constrained by the need to cope with emergency COVID-19 demand.

Work has commenced 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.

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 January 2021, we achieved 62 per cent. This was made up of 59 per cent achievement at Shrewsbury and Telford Hospital NHS Trust (SaTH), 59.0 per cent at Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH), 77 per cent at Shropshire Community Health NHS Trust and 68 per cent at all other providers. 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 at the height of 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 January, published figures showed 1,016 Telford and Wrekin 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.
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 48.4 per cent at January. This again is due to the impact of COVID and has been particularly felt in diagnostic endoscopy procedures which were impacted by a loss of physical capacity at SaTH. Endoscopy capacity is now being restored and additional Imaging capacity has been secured for the local health system. Endoscopy capacity is now being restored and additional Imaging capacity has been secured for the local health system to assist with the reduction in the waiting list backlog. Together these are beginning to make some headway in reducing the accrued backlog of patients waiting and the six-week target is expected to be achieved during Q2 2021/22.
A&E waits: Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	Work has continued throughout the year when the opportunity presented at SaTH, to improve processes around A&E. COVID-19 impacted A&E performance in terms of the need to introduce social distancing into operational procedures and in changing the nature of the case mix being treated. Performance at SaTH remained a significant challenge throughout the year, with 65.7 per cent of A&E attendances waiting under four hours in February 2021. Improvement Plans at SaTH are focused around improving patient flow and processes in the hospital to achieve quicker progress through A&E and earlier discharge, to reduce ambulance conveyances by developing alternate options other than A&E and implementing national recommendations around Same Day Emergency Care.
Cancer waiting times: First outpatient appointment for patients referred urgently with suspected cancer by a GP	Performance against the range of cancer targets has held up reasonably well in a difficult year due to loss of treatment capacity arising from the impact of COVID-19. This has been layered on top of existing underlying challenges in staffing capacity for a number of tumour types. Throughout the COVID-19 emergency, the focus has been on maximising the level

	of cancer services that could be maintained. Particular issues were experienced in relation to breast cancer 14-day standards due to a need to make physical changes to the waiting areas for treatment. This has been completed early in the new year, and an improvement in performance in this metric is now being seen. Figures for the end of January 2021 are shown below.
Category 1 ambulance calls: Category 1 calls to have an average emergency response within seven minutes and reach 90 per cent of calls within 15 minutes	The performance in the CCG has generally achieved the targets locally during 2020/21 in call categories 1, 2 and 3 and 4. The performance deteriorated slightly in the second part of the year in relation to categories 2 and 3 calls as activity volumes recovered from the initial drop in the first months of the COVID-19 pandemic. The performance contrasts sharply with that achieved in Shropshire illustrating the difference in a more rural area.
Mental health and primary care indicators	Many of the indicators relevant to these aspects have been suspended during the pandemic. The CCG has improved performance in achieving annual health checks for people with a learning disability and dementia assessment rates have held up reasonably well during the pandemic. Numbers of people presenting to the improving access to psychological therapies (IAPT) services decreased markedly during the pandemic but the expectation is that these will increase substantially over the coming year and that it will be priority aspect for the CCG recovery planning.

NHS Telford and Wrekin Clinical Commissioning Group

		Q4	Q1			Q2			Q3			Q4		
KPI	Title	2019/20	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	NHS Constitution and related indicators													
EB3	18-week waits: see IAF 129a	84.3%	78.2%	69.8%	58.2%	51.1%	53.6%	59.7%	62.8%	63.4%	62.3%	62.0%	60.7%	60.7%
EB4	Diagnostic waits: see IAF 133a	20.8%	65.8%	73.7%	66.6%	58.6%	61.0%	59.0%	52.6%	47.8%	48.2%	48.4%	41.8%	29.8%
EB6	CWT - 2-week cancer waits	94.3%	78.4%	96.2%	97.6%	99.2%	97.0%	93.9%	86.8%	85.0%	85.1%	82.5%	80.6%	82.9%
EB7	2-week breast waits	90.7%	56.5%	100%	100%	100%	92.6%	81.1%	20.4%	8.5%	6.5%	11.4%	16.4%	11.1%
EB8	CWT - 31 days to cancer treatment	98.0%	96.0%	100%	98.9%	98.5%	98.5%	98.8%	100%	100.0%	97.6%	94.8%	95.7%	90.8%
EB9	CWT - 31 days to treatment (surgery)	90.9%	100%	100%	100%	93.8%	94.1%	80.0%	100%	80.0%	82.4%	91.7%	81.8%	94.4%
EB10	CWT - 31 days to treatment (drugs)	100%	100%	100%	100%	100%	93.8%	100%	100%	100%	100%	97.0%	100%	100%
EB11	CWT - 31 days to treatment (radiotherapy)	96.3%	100%	100%	100%	100%	96.9%	100%	100%	100%	100%	100%	100%	100%
EB12	62-day CWT: see IAF 122b	78.0%	65.5%	58.6%	63.8%	74.3%	82.4%	79.5%	79.1%	77.8%	71.4%	70.3%	69.6%	58.7%
EB13	CWT - 62 days to treatment after referral from screening	83.3%	81.3%	66.7%	0.0%	n/a	100%	75.0%	100%	100%	83.3%	66.7%	0.0%	54.6%
	CWT - 62 days to treatment after consultant upgrade	90.3%	86.4%	80.0%	82.4%	85.7%	73.9%	87.5%	84.0%	94.1%	76.0%	81.0%	64.3%	82.8%
	A&E 12-hour waits for admission (SaTH)	94	0	0	3	1	4	4	13	39	77	134	98	23
EAS1	Dementia rates - see IAF 126a	63.4%	61.9%	59.9%	59.3%	59.5%	58.8%	58.5%	58.1%	59.0%	59.4%	59.9%	59.8%	60.1%
EH10	Routine Eating Disorders - seen within 4 weeks		95.5%			94.4%			94.1%			94.1%		
EH11	Urgent Eating Disorders - seen within 1 week		100%			100%			100%			83.3%		

PERFORMANCE ANALYSIS

Primary care

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

As part of the preparation for the new organisation, the primary care team has become part of the Partnerships Directorate. The team is led by an Associate Directorate of Primary Care, with three

primary care partnership managers acting as the first point of contact for individual practices and Primary Care Networks (PCN). The newly-structured 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 will lead and coordinate the delivery of training and development initiatives.

The CCG has 13 GP practices across Telford and Wrekin, which are all linked to one of four PCNs:

- Teldoc PCN
- Wrekin PCN
- Newport and Central PCN
- South East Telford PCN (formed on 1 April 2021).

One of the main areas of focus for PCNs during 2020/21 has been the introduction of the Enhanced Health in Care Homes (EHCH) requirements of the PCN Directed Enhanced Service (DES), which came into effect from 1 October 2020. The existing Care Homes Advanced Scheme (CHAS) was enhanced ahead of this date to recognise the additional support needs in care homes linked to the COVID-19 pandemic, and a wraparound support team known as CCHEST has been put in place to support the PCNs in the delivery of the EHCH.

The medicines management team has supported PCNs with the introduction of the requirements of structured education reviews. PCNs used protected learning time and peer review sessions to start to develop work around early cancer diagnosis and learning disability.

General practice has continued to prioritise learning disability annual health checks through the pandemic in line with the national guidance to reduce health inequalities and proactively engage those at greatest risk of poor health. In spite of the challenges of COVID-19, practices exceeded the annual target of at least 67 per cent of people on the learning disability registers receiving an annual health check before the end of March 2021 by reaching a total of 77 per cent – a real achievement.

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. Clinical Pharmacists, Social Prescribing Link Workers and First Contact Physiotherapists have been the main roles to be recruited to this year, with plans progressing around the recruitment of Mental Health Practitioners.

The rollout of the COVID-19 vaccination programme from December 2020 became the main priority and focus for PCNs in the latter part of the year, with general practice playing a vital role in this roll out. Our thanks go to all practices for their huge efforts and hard work in relation to this.

General practice has continued to be accessible to patients during the pandemic, with appointments offered remotely where possible but face-to-face when needed. The use of online and video consultations has increased rapidly to meet new ways of working.

The CCG has continued to support practices and PCNs in accessing all available funding and support from regional and national development schemes, including the offer of continued support

via the NHS England time for care team, GP Forward View funding and PCN development funding. One specific area of success has been in rolling out the GP/GPN Fellowship Programme which provides support and development for newly-qualified General Practitioners and General Practice Nurses. The COVID-19 pandemic has impacted on practice capacity to be able to maximise uptake of support offers during this financial year, however where offers have been available these opportunities have been shared.

The extended access service, offering clinical appointments to patients in the evenings and at weekends, has continued this year. Some capacity has been repurposed to support the COVID-19 vaccination programme in the latter part of the year.

Key achievements this year include:

- Regular communication with practices to support them and address queries in relation to the ongoing challenges linked to COVID-19
- Involvement in the design and management of the COVID staff testing programme for general practice staff
- Involvement in the STP-wide vaccination workforce group, enabling over 300 practice staff, CCG staff and locums to join the STP workforce
- Continuation of progress against identified priorities to address inequalities, for example delivery of learning disability health checks
- Collaborative working with our neighbouring CCG Shropshire CCG to engage 13 newly-qualified GPs and three newly-qualified GPNs supported on the NHSE/I funded Fellowship Programme across the Shropshire and Telford and Wrekin footprint
- Seven GP mentors supported to deliver mentoring sessions to colleagues
- Funding for newly-appointed GP First 5s leads
- Collaborative working with Shropshire CCG to provide support to PCNs to recruit over 60 new members of staff across the seven PCNs in Shropshire, Telford and Wrekin
- An enhanced Training Hub across the Shropshire and Telford and Wrekin footprint has enabled a number of training programmes to be delivered included continuing professional development (CPD) for around 240 general practice nurses

Primary care has taken a lead role in the establishment of a range of services in response to the COVID-19 pandemic, including the pulse oximetry at home service and the COVID-19 virtual ward.

The work of the primary care team is mainly overseen by the CCGs' Primary Care Commissioning Committee (PCCC) in common which receives regular updates on the key priorities. A Primary Care Risk Register ensures that identified risks are monitored and mitigated and this is overseen on a quarterly basis by PCCC.

National Diabetes Prevention Programme (NDPP)

The National Diabetes Prevention Programme is an NHSE/I commissioned scheme. When people are identified as being at risk of developing type two diabetes, they are referred into this nine-month lifestyle change management programme. Evidence from across England has shown this programme has reduced the risk of people going on to develop diabetes.

From April 2020, a new provider commenced delivery of this service. This new programme includes an online option for people who prefer it or cannot attend a local venue. As with many other services, the pandemic has significantly reduced the number of referrals into the service, however, in March 2021 referrals started to return to previous levels.

Telford and Wrekin Integrated Place Partnership (TWIPP)

Telford and Wrekin CCG has been working very closely with the local authority since 2015 to help the residents of Telford and Wrekin live healthier and happier lives. As part of this, we have talked with members of the public, patients, carers and frontline staff.

We have heard a strong message that people would like to be treated at home wherever possible, and that people want support and help to manage their health conditions.

Following the release of the NHS Long Term Plan in January 2019, Neighbourhood Working was reviewed to ensure it aligned to the Long Term Plan as well as the current and future needs of Telford and Wrekin.

Consequently, it evolved into the Integrated Place Programme, including the expansion of the Neighbourhood Steering Group into the TWIPP (the membership of which now includes senior representatives from SaTH, Shropshire Community Health NHS Trust, MPFT and PCN Clinical Directors) to drive the directional change to delivering community-based support to the people living within the boundaries of Telford and Wrekin.

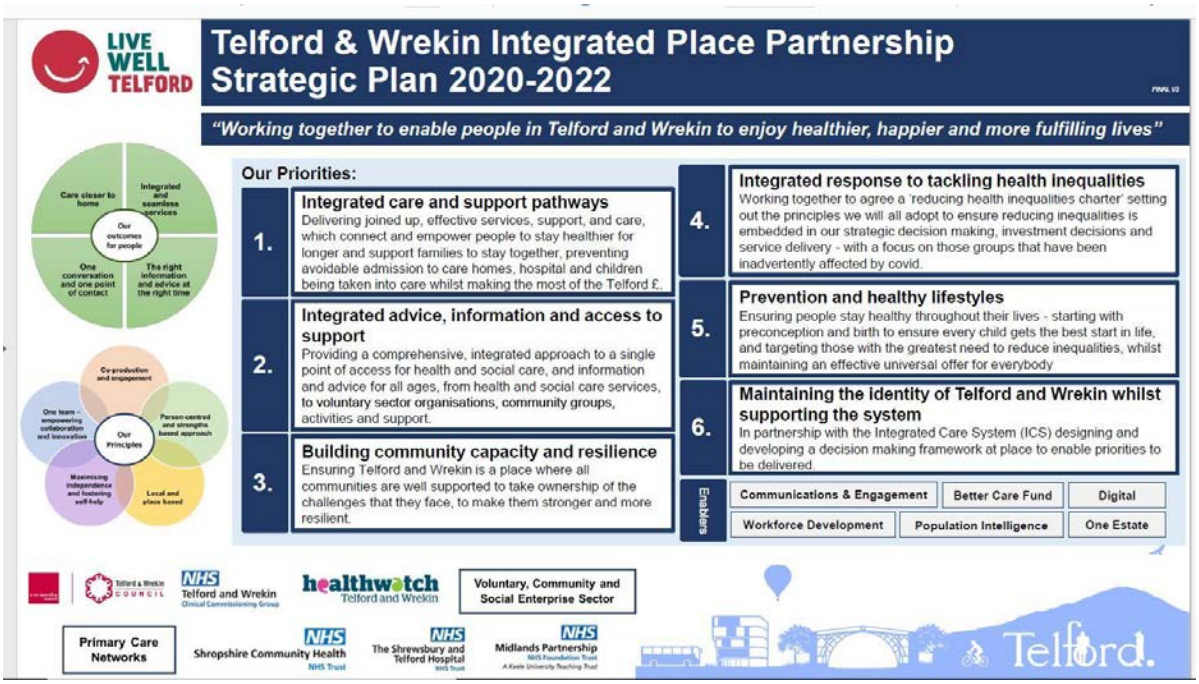
The work of TWIPP spans a broad range of services, aimed at supporting individuals to live well and receive care closer to their own homes whenever possible.

The full range of delivery programmes which involve partners from across all these organisations under the TWIPP umbrella are reported to the Health and Wellbeing Board.

Despite the demands of the pandemic,

TWIPP has met and updated its ambitions over 2020/21 and plans for the year ahead.

These are shown below:



TWIPP achievements during 2020/21

The links we forged during 2019/20 have assisted in our responses to the pandemic during 2020/21.

Multidisciplinary care home team

A picture of the care home staff team led by Team Leader Julie Roper

The multidisciplinary care home team has worked closely with our primary care colleagues to deliver enhanced support to those in care homes across Telford and Wrekin, utilising digital technologies to enable remote consultations.

The team offers education to care home staff, proactive care planning for residents and support for individuals to remain within their care homes, rather than in hospital, at the end of their lives.

During the pandemic, the team's collaborative approach has included support with reflective sessions with care staff. These reflective sessions provided care home staff with the opportunity to talk about their recent experiences and learn effective techniques for managing these.

The homes with which they were involved were so impressed by the support that they publicly thanked the team via the local media.

Health and social care rapid response team (HSCRRT)

At a multiagency workshop in September 2019, frontline staff told us they could achieve a greater impact if they had closer channels of communication and the ability to discuss and share information about patients. We know from talking to patients they also felt this disconnect between services provided by health and social care.

The HSCRRT was launched in November 2019 to work with individuals and their carers who are experiencing a rapid decline of their health and are in crisis. Individuals referred to the team are assessed within two hours. The team then put in place a plan to resolve the health crisis, work to prevent the crisis from happening again and allow the individual to remain as independent as possible in their own home if possible. The team integrates rapid response nurses, social workers, occupational therapists, GP clinical advisors and call handlers.

Staff work in the same building – making it easy to share knowledge, access other experts and solve problems together – despite being from different organisations. It provides a two-hour response as per the NHS Long Term Plan's aims and ambitions.

The team was evaluated and the final review report concluded in September 2020.

The report found that the HSCRRT provided (and continues to provide) a multidisciplinary, co-located, rapid community response service that reduces the need to convey to acute settings and delivers improved patient experiences and outcomes.

The report highlights that:

1. From the feedback received, people who have had support from HSCRRT have been "thankful", "impressed" and "positive" about the support they received from the team

2. HSCRRT received increasing numbers of referrals over time and the number of referrals into Telford Integrated Care Service (TICS) increased after the implementation and promotion of the HSCRRT, with TICS average referrals of 39 referrals a week between November 2019 and May 2020 – compared with an average of 28 for the same period the previous year

3. HSCRRT received referrals for a wide range of presenting needs. The top five presenting needs were social care assessment, falls, exacerbation of long-term conditions, end of life / palliative care, and urinary tract infections

4. The team reduces avoidable unplanned admissions – 93 per cent admission avoidance rate within the set criteria and saved 252 bed days over five months

5. HSCCRT has improved cross-organisational team working and the staff are also happy and productive

6. The team reduces duplication of referrals by instigating a single referral point into HSCRRT followed by multiagency triaging and providing one integrated response

7. Follow-up care has not been reduced by the implementation of the HSCRRT, but whilst follow up social care has increased this has been appropriate to meet identified needs and reduce long-term or more complex presentations to the service in the future

8. HSCRRT has improved access to a range of services and in a more streamlined manner using specific pathways developed through this pilot.

Following this positive evaluation and as part of the system-wide Winter Plan, this team expanded locally in Telford and Wrekin so it could deliver care to more individuals and assist in enabling the Shrewsbury and Telford Hospital NHS Trust (SaTH) to manage with the combined pressures of winter illness and the predicted increased number of COVID admissions.

Progress on cardiovascular disease (CVD)

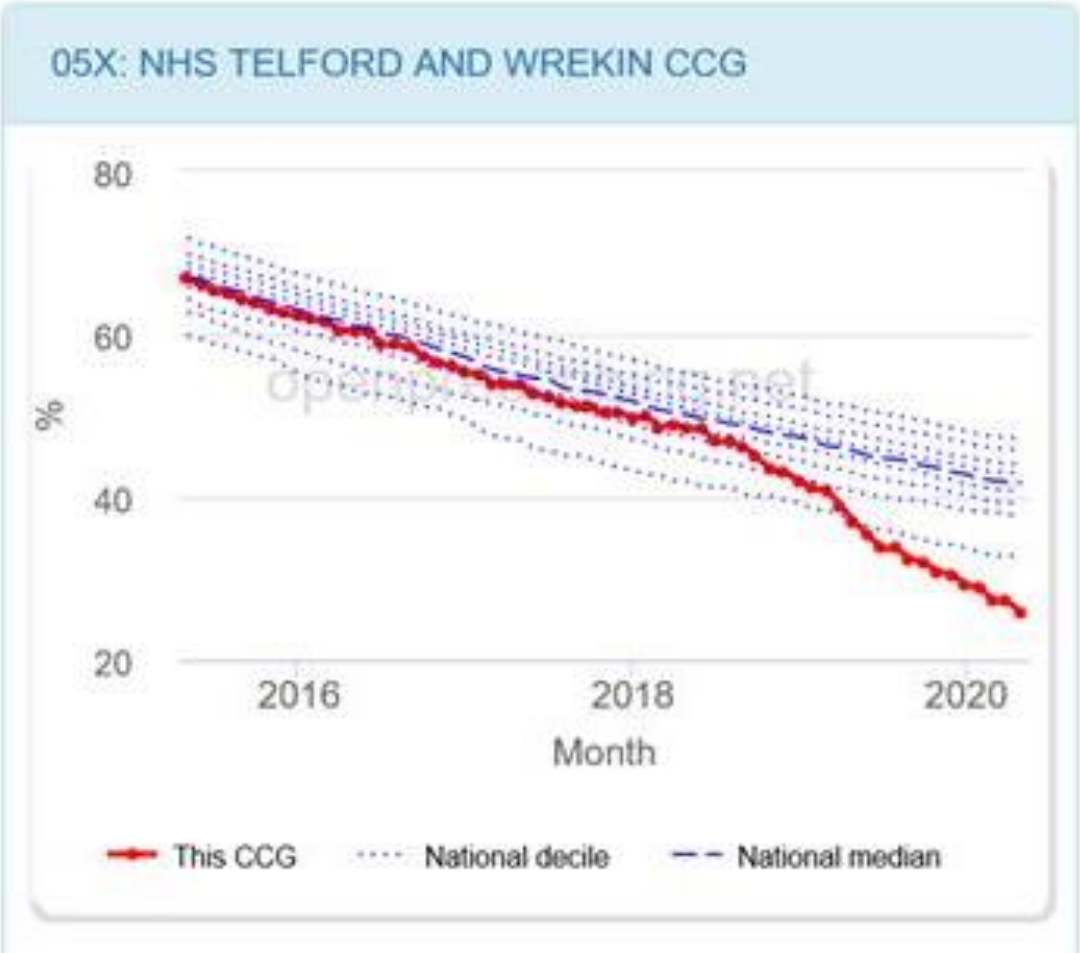
Cardiovascular disease is a general term for conditions affecting the heart or blood vessels. It's usually associated with a build-up of fatty deposits inside the arteries (known as atherosclerosis) and an increased risk of blood clots. It can also be associated with damage to arteries in organs such as the brain, heart, kidneys and eyes. Heart disease and stroke are the most common forms of CVD. Other forms include a 'mini-stroke' (transient ischaemic attack or TIA) and peripheral arterial disease (narrowing of the arteries, usually in the legs). We know too many people are dying early from these conditions in Telford and Wrekin.

The Telford Healthy Hearts programme looked at addressing the risk factors of high cholesterol (fatty deposits in the blood) high blood pressure, atrial fibrillation (rapid heartbeats) and heart failure. We established a clinical reference group, which includes one representative from each GP surgery. It meets monthly to agree interventions and drive implementation within their own practices.

Whilst the demands on primary care and the wider system have meant that the regular meetings have not happened, the impact of the work undertaken in 2019/20 has continued to be seen over 2020/21.

The chart below shows the percentage of low or medium intensity statins prescribed. National Institute for Health and Care Excellence (NICE) guidance on primary and secondary lipid modification recommends the use of a high-intensity statin (i.e. one that reduces LDL cholesterol

by 40 per cent or more). It can be seen that across England (the blue line) this has been happening, however, in Telford and Wrekin (the red line) this has happened markedly so since Telford Healthy Hearts was introduced and continued over 2020.



The next phase of this work is atrial fibrillation which is planned to commence across Shropshire, Telford and Wrekin as part of the single strategic commissioning organisation in 2021/22.

Commissioning

Integrated urgent and emergency care – NHS 111 First

In December 2020, a new system was introduced for people in Shropshire, Telford and Wrekin who have an urgent, but not serious or life-threatening, health care need. Anyone needing urgent care is asked to contact NHS 111 first to ensure they get the right help in the right place at the right time. The service, staffed by trained health advisers, can now book the caller a time slot for the most appropriate service, such as a GP, Minor Injury Units, Urgent Treatment Centres, or, if needed, A&E (Emergency Department) at the Royal Shrewsbury Hospital (RSH) or the Princess Royal Hospital (PRH) in Telford.

Booked appointments through NHS 111 have been introduced in England to help keep people safe and reduce the pressure on hospitals and staff. The new system 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.

It is too early to be definitive about the impact of this development, particularly given it is not possible to compare activity this year with last because of COVID-19, but the early signs are encouraging. 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 via 111. A patient survey is planned to assess patient experience of using NHS 111 First.

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. In December, January and February 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.

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.

Same Day Emergency Care – Royal Shrewsbury Hospital

In December 2020, the Royal Shrewsbury Hospital opened a new modular build Same Day Emergency Care Unit which will significantly improve 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.

Out of hospital transformation

System changes

During the year, some major changes have contributed to shifts in how the system operates including the response to COVID-19 and the impact it has had on services, patients, and staff, which meant more than ever working together as one cohesive system as a combined force with the same aims and objectives. Work also continued to align commissioning with NHS Shropshire CCG to become one integrated strategic commissioning organisation that would span the whole Shropshire, Telford and Wrekin footprint.

As the system, its structure has been 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, and these groups are:

- 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 across the system but with the need to revisit the scope, aims, objectives and anticipated outcomes. This work would be governed by a new system structure and programme boards.

Telford and Wrekin Integrated Place Programme and Shropshire Care Closer to Home have become the operational arms of this Community and Place Based Care Programme Board.

Neurology

The neurology service delivered at SaTH has been challenged for many years, primarily due to workforce limitations. These challenges led to patients experiencing long waits to see a consultant, which in turn led to the decision to close new referrals. Following a system agreement that the local service cannot be reopened in its current form, the CCG has been working with SaTH and

The Royal Wolverhampton NHS Trust (RWT) to develop a sustainable neurology service across Shropshire, Telford and Wrekin.

During 2020/21, COVID-19 has had and continues to have a significant impact on the implementation of the neurology service. During this period, the CCG has been working with the trusts in the development of the transfer of the neurology service from SaTH to RWT. This transfer is scheduled for early 2021/22.

Mental health

It has been a difficult year for mental health, learning disabilities and autism services during the pandemic. Many of our patients are in the extremely clinically vulnerable groups and in the first lockdown health, social care and the third sector worked together to ensure high-risk patients were contacted and had 'safe and well checks'.

As we are all aware, the rules around social distancing, face masks and isolation have had an impact on all of our mental and emotional wellbeing, but for some people that has made life very difficult. As a health and social care system, we have worked to try to put in as much support as we possibly could.

Most services now offer virtual consultations, although we know that this is not suitable for all people or for some conditions. Our diagnostic services for autism have been affected by being unable to see as many people face-to-face, when this is needed to make a diagnosis. Our dementia diagnostic services have also faced similar issues, but also this vulnerable group often do not want face-to-face contact because of the increased risks. We are now working hard to develop new ways of working.

Expanded community services:

- We now have a 24/7 mental health helpline
- Urgent Helpline (0808 196 4501 option 1 – under-18s; option 2 – over-18s)
- Expanded Crisis Home Treatment for adults and extended service for children and young people (CYP) to 24/7 in line with adults.
- We have increased access to psychological services for people who are feeling depressed and/or anxious through Improving Access to Psychological Therapies (IAPT)
- GP practices have continued to offer health checks for the most vulnerable – those people with a learning disability and those with severe mental health problems
- We have extended support out of hours, with
    - Telford's Mind Mental Health Services, Court Street Medical Practice, Madeley, Telford, TF7 5EE (07434 869248 talk2@telford-mind.co.uk)
    - Beam – support for children and young people – further detail is in the CYP section.

Despite the focus on the pandemic, we have continued to develop services across the Shropshire, Telford and Wrekin area in line with Mental Health Long Term Plan.

Specialist perinatal mental health services are now in place to support women and their partners where they have mental health issues associated with their pregnancy – referrals from a midwife or GP

- Increased support in the community to support people living with dementia to reduce the need to go into hospital
- Increased support into employment for people with severe mental health issues – referrals from mental health services
- A dedicated team is in place to support people with a learning disability and or autism to live successfully in the community
- Increased the numbers of professionals working to support people with severe mental illness
- The health and social care system has worked in a far more integrated way reducing barriers between services during this pandemic so that we are better able to support individuals.

Cancer

Improving cancer pathways continues to be a priority and is at the heart of the STP's approach to recovery of cancer services. Key actions have been undertaken during the last 12 months include:

- The Strategic Cancer Board has been re-established in the latter half of 2021 and will focus on a review of the Cancer Strategy
- Investment has been secured for time-specific projects, including:
    - Supporting primary care with the undertaking of cancer care reviews (CCR)
    - Developing the principles of Rapid Diagnostic Centres – focusing on non-specific symptoms pathway and pathways with challenged performance
- A living well video has been developed for patients to hear other patients' experiences, which continues to be available on SaTH's website. Face-to-face sessions were paused due to COVID-19, but sessions were developed virtually. Initial feedback has been positive, further sessions are planned and evaluation is to be undertaken.

The implementation of Living Well Passports has continued. Positive feedback has been received from both staff and patients, who feel it has given them back some control. Work will continue to evaluate.

Children and young people (CYP)

CYP Mental Health Long Term Plan update

The Shropshire, Telford and Wrekin Transformation Plan for Children and Young People's Mental Health and Wellbeing has 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 programmes 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
- There are 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 ASD diagnosis
- 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
- Telford has developed the Emotional Health and Wellbeing panel, which has been meeting since November 2019. This forms the multidisciplinary element of pre-diagnosis for the neurodevelopmental pathway and is being reviewed during the summer months. The CCG and local authority are developing a business case to develop a joint autism hub to support children and young people and their families to better understand their selves or child
- 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.

Community physical health update

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 nothing was stood down. All children were assessed and given a risk rating to decide what level and type of service they required. They offered many children virtual consultations via 'attend anywhere' 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 2021, 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
- Special school nursing.

SEND (Special Educational Needs and Disability)

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

During 2020/21, Telford and Wrekin jointly developed their SEND-specific Joint Strategic Needs Assessment (JSNA). The JSNA covers the current and future needs of children and young people with disabilities aged from birth to 25 years who have a special educational need or disability, and their families.

The SEND Code of Practice sets out a duty as 'Local authorities and CCGs must make joint commissioning arrangements for education, health and care provision for children and young people with SEND (section 26 of Children and Family Act, 2014)'

The Telford and Wrekin SEND JSNA 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, 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.

System governance

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

- The development of a recovery, restoration and 'new normal' governance structure within the STP/ICS has highlighted a need for a stronger CYP voice within our system
- 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, led by Jane Povey (SCHT Medical Director and STP/ICS Clinical lead), 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 STP/ICS
- 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 STP/ICS
- 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 place-based adaptations
- Develop a CYP's strategy setting out our agreed partnership priorities for the next three years.

Future work for 2021/22

There are plans in place to develop a partnership with CYP and their families across the STP/ICS with senior leadership, with the aim to support the delivery of CYP transformation as recognised in the NHS Long Term Plan.

Telehealth

We recognise the potential for the use of technology to support patients to manage their own conditions and reduce the need for GP and hospital attendances. A small pilot was undertaken between May and December 2020. The aim of the pilot was to gain an improved understanding of the impact and benefits of the technology. The technology was deployed to patients at home who had chronic obstructive pulmonary disease (COPD).

The patients would take their vital signs on a frequent basis, as agreed with their clinician. The principle of telehealth in this cohort of patients is to support self-management and reduce non-elective admissions to hospital. It is to be noted that the plan for implementing the pilot was completed before the COVID-19 pandemic.

There were significant challenges during COVID-19 – patients declined telehealth citing that they did not want the clinical team to go into their homes to set up the equipment during this period. Hospital admissions in this cohort significantly reduced as a result of the pandemic, making it difficult for the team to identify patients post-admission.

Based on the findings, it was recommended not to extend beyond the pilot period. It may be a consideration that this is revisited after the pandemic as an alternative to admission, and a discussion in relation to the wider virtual monitoring agenda. However, the implementation of the COVID-19 virtual ward and remote pulse oximetry may serve as a suitable alternative and enabler as more sustainable, cost-effective and primary care commissioned options for remote patient monitoring are considered.

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, commissioners and managers to help achieve these goals. Here is some background information and details about some of the things that we have done during 2020/21.

COVID-19 response

The medicines optimisation team have had a key role to play in the COVID-19 response. In the first wave, the team supported the 'hot sites' set up at the Shrewsbury Town Football Ground and Telford International Centre to assess patients showing COVID-19 symptoms and provide access to medicines. During the pandemic, they provided guidance on both the appropriate symptomatic treatment of patients who had not been admitted to hospital and helped to ensure that patients could continue to receive their regular medical treatment safely (including drug monitoring, providing advice on when this could be safely delayed and when it was essential it continued), particularly for vulnerable patients who were shielding.

Since December, many of the team have been supporting the COVID-19 vaccination programme 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 impacts of COVID-19, the team has seen a number of key achievements in clinical projects during 2020/21:

- **Wound care.** The team fully established a Wound Care Steering group which has enabled an STP/ICS approach to wound care management. The group has successfully reviewed the wound care management formulary for use across the local health economy and established several key documents to support wound care management including the debridement pathway and patient wound care passport. An audit was also conducted with community nursing teams to identify key areas for improvement and education support.
- **Respiratory.** Working with clinicians in SaTH and Shropshire Community Health NHS Trust information and guidance was developed to support patients and clinicians with COPD to manage infective exacerbations (rescue pack guidance) and prevent further decline 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
- **Pain management**. The team supported practices across Shropshire, Telford and Wrekin to review their patients prescribed high doses of opioids (>120mg morphine or equivalent strength doses of other opioids). Opiates are generally not a suitable treatment for chronic (long-term) non-cancer pain. The NICE guidance NG59 for the management of low back pain and sciatica in over-16s advises against the use of opioids for chronic back pain. Patients should not be prescribed >120mg morphine or equivalent/day since the risk of

harm increases substantially at higher doses. Any patients taking over this dose should be reviewed as the risks of harm outweigh the benefits of use. Through the provision of guidance for clinicians and two educational workshops targeting the approach to reviewing opioids in primary care, the Medicines Management Team has enabled a steady reduction of the percentage of high dose opioid prescribing.

The Prescription Ordering Department (POD)

The POD teams in Shropshire, Telford and Wrekin experienced an unprecedented increase in workload due to the COVID-19 pandemic. In order to prevent virus transmission, paper requests directly through practices were restricted heavily, meaning that more patients utilised the POD service than ever before.

The email facility was brought in to help relieve the incoming calls and to provide more accessibility to the POD service for patients. During 2020, 20k email requests have been processed for Telford and 67k for Shropshire.

This, in addition to more than 300k calls for Telford and 393k calls for Shropshire, has meant that the team has processed more than 750k repeat prescriptions to patients – approximately a 30 per cent increase on the previous year.

Whilst the majority of cost-saving interventions recording was halted due to the increase in call volumes, the team still managed to deliver more than £2m worth of savings to the local health economy by reducing medicines wastage and preventing unnecessary medication ordering.

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 a rolling training programme for care home staff. Much of the work has had to be done remotely due to COVID restrictions, but the team reviewed the medication of 3,000 care home residents and made 3,600 interventions improving quality and safety of prescribing, reducing waste, and reducing potential hospital admissions.

The Transfer of Care Around Medicines (TCAM) Project in care homes has been set up over the last year to support discharges from local hospital trusts into care homes across the locality. Shropshire was the first CCG nationally to offer a dedicated care home TCAM service accessing specialist elderly care pharmacist reviews, which has now been extended to discharges to Telford and Wrekin care homes. The project ensures that a patient admitted to the care home directly from a local hospital is receiving the right medicines and all changes have been safely managed, reducing the risks of another hospital admission. The team, working collaboratively with medicines

management teams in the West Midlands and with the West Midlands Care Home Pharmacy Network have also supported development of a Midlands Regional Medicines Reconciliation Policy.

Proxy Ordering in Care Homes is currently being implemented in care homes, practices and community pharmacies to digitalise and improve efficiencies with medication ordering. The project aims to improve medicines safety with a more efficient and auditable process.

Medicines formulary

Optimise Rx – Telford and Wrekin

This year could have been one of the most difficult years to roll out a new prescribing support system. All indications pointed towards this but Optimise Rx has proved its worth. Since April 2020, 12 out of the 13 practices in Telford and Wrekin have signed up to Optimise Rx, with an annual saving of £113,000 reflecting the engagement that practices have shown to the new system at a particularly challenging time. Safety and savings messages have increased to 1,755 over the past year. This will increase in time to align with systems used in Shropshire so that both systems emulate the same messages across Shropshire, Telford and Wrekin.

Formulary and medication switches

Cost-effective medication switches across Shropshire, Telford and Wrekin were impacted by redeployment due to COVID-19 but still exceeded planned target figures. Formulary decisions, medication changes, tags, warnings etc are now fed through to Optimise Rx, Scriptswitch and netFormulary to ensure that all systems are updated with new information. This will connect all systems with the work undertaken on the ground to produce savings through medication switches.

Encouraging self-care

During 2020/21, our work on encouraging self-care and reducing prescribing in GP practices was impacted by the coronavirus outbreak priorities. Our public engagement remained high, with several press releases and social media campaigns throughout the year. Our focus shifted to social media campaigns rather than place-based campaigns to ensure we reached our patients during lockdown.

Press releases we have released include ‘What is the difference between hay fever and coronavirus’ and ‘The importance of self-care during the national restrictions’.

Drugs of limited clinical value

For several years, we have been working on reducing the prescribing of medicines considered to be of low clinical effectiveness, medicines which have more cost-effective alternatives and medicines which are deemed to be low priority for funding by the NHS. Despite the COVID-19 pandemic, we have seen further reductions in this area this year – particularly with bath and shower preparations for dry and pruritic skin conditions, as collaborative working with dermatology, primary care clinicians, community pharmacies and within our own team (POD staff, care home,

project lead and locality pharmacy technicians) has made the implementation of, and the adherence to, our Joint Commissioning Policy a real success.

Antimicrobial resistance

We continue to support the UK's five-year national action plan 2019-24 which includes tackling antimicrobial resistance (AMR) and optimising the use of antimicrobials in humans. Antibiotic prescribing data is monitored closely both locally and nationally. Despite the additional challenges faced by health professionals managing patients with infections during the pandemic, the Shropshire, Telford and Wrekin CCGs have remained both below the national target and England's median for total antibiotic prescribing volume and use of broad-spectrum antibiotics.

During world antimicrobial awareness week in November 2020, we targeted health and social care workers undertaking a digital campaign focusing on urinary tract infections (UTIs) which are commonplace and frequently result in an antibiotic being prescribed. The campaign centred on publishing digital 'thank you' notes with links to key messages, resources and training to support appropriate management of UTIs.

Improving patient safety

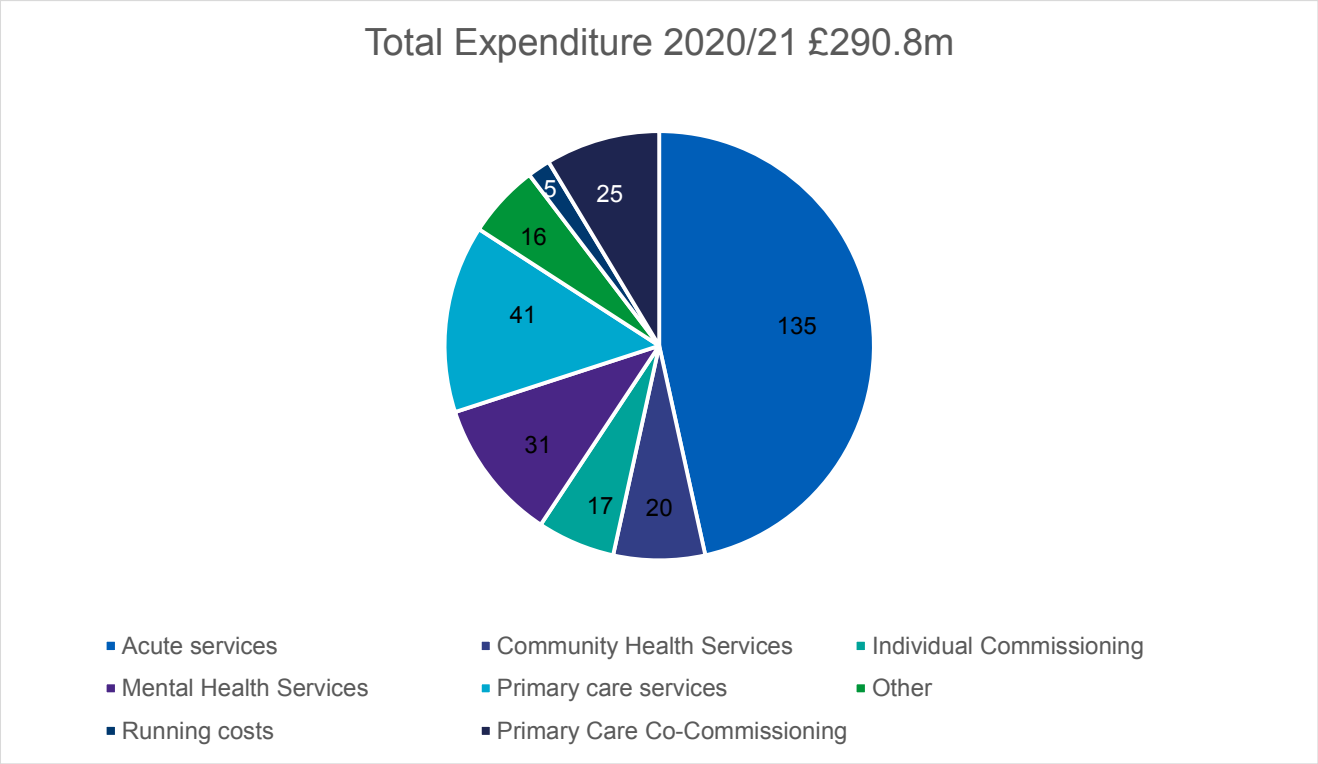
The medicines management team work with all local providers in order to promote the safe use of medicines. This includes conducting audits of the prescribing and monitoring of potentially High Risk Drugs, providing advice and guidance on appropriate use of medicines, cascading drug warnings and safety information to providers, and promoting and sharing learning from reported medication incidents.

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. This has been achieved by the introduction of a new netFormulary for the prescribing of medication and the use of Blueteq, which is a computer system designed to support clinical decision making.

Finance

In 2020/21 the CCG received a total allocation of £289.5m to spend on the healthcare of its residents. Total expenditure against this allocation was £290.8m and a breakdown of this by expenditure type is shown in the chart below: **NHS Telford and Wrekin Expenditure 2020/21 (£290.8m)**



Further analysis of expenditure, by type, can be found within the Annual Accounts on page 149-152 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 page 138 of this report.

Quality, Innovation, Productivity and Prevention (QIPP)

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

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

During 2020/2021, delivery of QIPP was challenging due to the impact of the pandemic. Block contracts were put in place with our main providers, a number of QIPP projects were suspended and many staff redeployed to other departments. However, the CCG was able to still deliver £1.9m of savings which were predominantly within the medicines management and individual commissioning teams.

During 2021/22 the Shropshire healthcare system will introduce an Intelligent Fixed Payment (IFP) System, a financial framework between the health partners who are performance managed within the Shropshire and Telford & Wrekin Integrated Care System (ICS), so that rather than using activity and price to determine contract income, the CCG resource limit will be allocated between system organisations based on net expenditure levels.

The four IFP partners will attempt to improve the system financial position over a number of years by working together and individually on improving the cost effectiveness of the health services provided. The system financial position will be the main measure of financial success although individual organisational financial reporting will remain the bedrock of financial governance arrangements.

As part of the development of the system financial sustainability plan, the aim is that in 2021/22 all system organisations will work to deliver a 3% efficiency target. For the combined CCGs this equates to a £13.5m efficiency target. Due to the IFP arrangements in place, the CCG will need to deliver this target from its non system expenditure portfolio.

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 plan to develop a Sustainability Policy during 2021/22, as the pandemic prevented this work to be undertaken during 2020/21 as a newly-created CCG across the whole of Shropshire, Telford and Wrekin which will set out several key objectives. We have also appointed a board level Sustainability Champion.

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

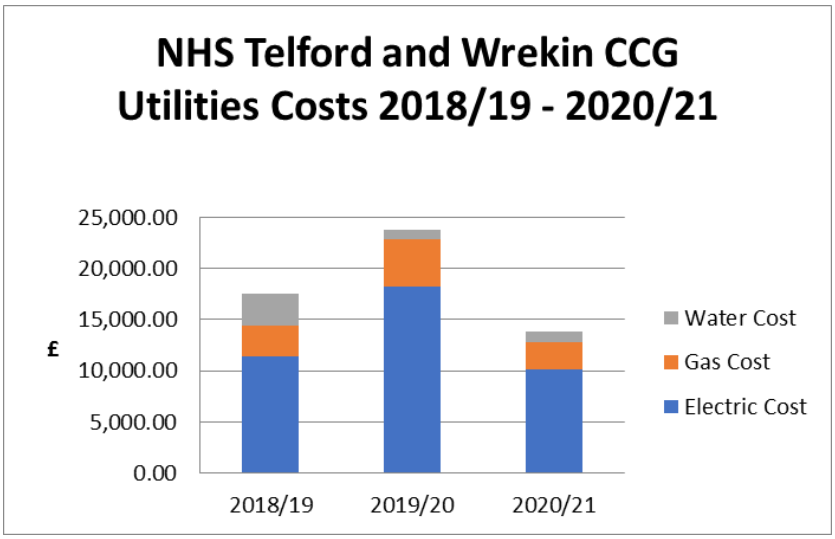
from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28 per cent by using 2013/14 as the baseline year.

More information on these measures is available on the Greener NHS website.

Energy

The graph below shows there has been a reduction in water costs, gas and electricity costs during 2020/21.

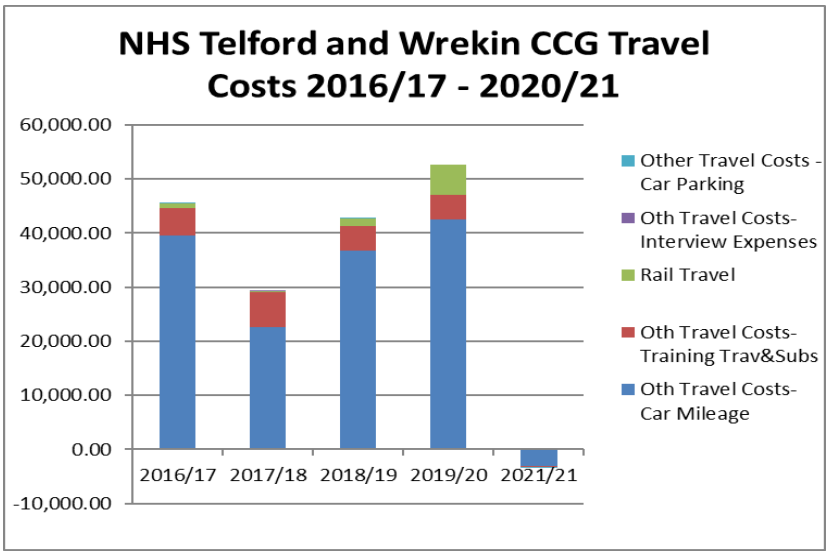
This is partly due to the CCG staff working from their homes for significant periods during 2020/21 whilst the country was subject to national lockdowns to combat COVID-19 pandemic, although the impact is less on energy costs as some staff still had to base themselves at the CCG's headquarters during these periods and so the buildings continued to require heat/ light and water.



Travel

This is due wholly to CCG staff working and meeting virtually to comply with the legal requirements to combat the COVID-19 pandemic. The figure in the graph shows as a negative due to a benefit from 2019/20 accrued costs (an estimate of costs not yet invoiced but expected).

This position demonstrates the contribution that virtual working has had and can continue to have on the sustainability of the CCG. The new single CCG is currently developing an agile working policy to implement in the first half of 2021/22 which will encourage staff to work from other bases including their homes using virtual technology so that some of these significant gains can be retained.



Improve quality – Care Quality Commission

The CQC gathers data from across the system into one place so professionals and the public can easily compare the performance of health and care services over a range of measures. Read more on the CQC website.

MONITORING THE QUALITY OF SERVICES

Improving the quality of services

Quality assurance principals and processes

The CCG holds 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 health care provided by and for that body.

As a CCG, we remain responsible for securing comprehensive services within the financial resources available to meet the needs of our population of Shropshire, Telford and Wrekin, and in doing so we must continue to assure ourselves of the quality of the services we commission

during the transition arrangements to the new quality governance framework and the anticipated statutory functions of the developing Integrated Care System (ICS) arrangements.

Quality concerns and risks are reported to our monthly CCG Quality and Performance Committees in Common. The quality team holds its own risk register which is updated as required and reviewed on a quarterly basis. Any high risk is included within the corporate risk register.

The highest quality risk during 2020/21 continues to be with Shrewsbury and Telford Hospital NHS Trust (SaTH) which has a history of challenges. In the main these relate to workforce provision; A&E performance; and the pace of maternity services transformation which is at present under external scrutiny from the Ockenden Review of historic cases. Some progress has been made, with the CQC retracting regulatory conditions relating to maternity services during 2020/21. The first Ockenden report has been published in December 2022 and the trust is responding to the requirements of the findings.

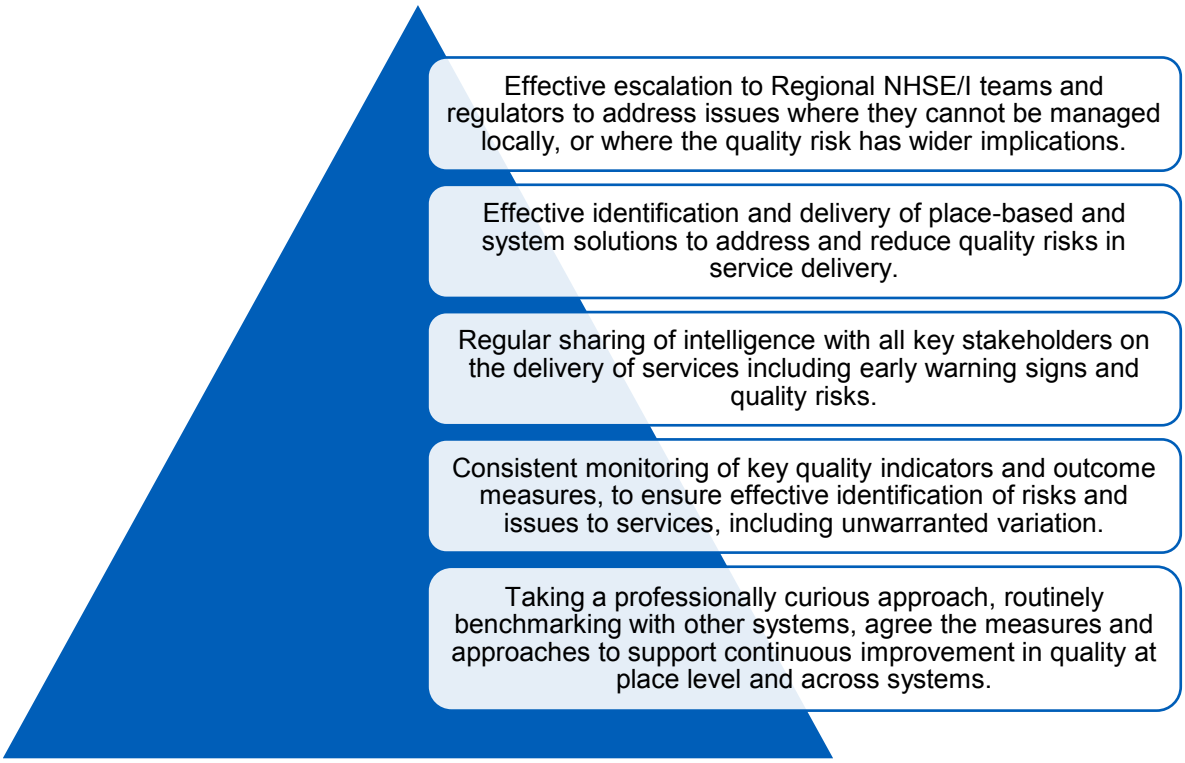
A more recent quality concern at SaTH was highlighted in the 2021 CQC inspection report into Children and Young people presenting with a mental health or learning disability. This group often present with complex health needs or social circumstances and we are working closely as a system to address the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

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, in order to contribute to the sustainability of out of hospital care, and to keep these vulnerable groups safe.

Since the COVID-19 pandemic, we have strengthened our infection prevention and control (IPC) measures working in partnership with local authority Public Health colleagues. We work in partnership to deliver proactive and reactive IPC measures – through training, advice and other direct support, as well as maintaining an oversight role where infection outbreaks occur. Through this approach, we have fully delivered the Chief Nursing Office for England's professional mandate to actively support these care settings and protect vulnerable service-users.

ICS Quality Strategy

2021/22 will be a period of change for our system as the organisation of healthcare changes. Working as an ICS will enable us to adopt a more strategic quality assurance function through establishing robust quality governance arrangements at system level to manage quality risks and inform ongoing improvement activities, including:



Over the next two years, we are leading work through the development of a system Quality Strategy, in collaboration with our partners, which reflects the changing priorities of the new single CCG organisation from April 2021 and the plans for an ICS from April 2022. The Quality Strategy describes improved opportunity for co-production of quality improvements and partnership working at both 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.

The priority areas we have identified within our Quality Strategy include strengthening our system approaches to:

- **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 (learning from lives and deaths – people with a learning disability and autistic people)
- **Patient experience**, with a prime focus of co-production as a principle of shared working.

Taking a transformational approach and adopting a single shared accountability framework will enable us to demonstrate over time:

- Improved quality and safety of services for individual service users
- Better outcomes and better service user experience for our population

- Our health care system will be safe and sustainable.

Safeguarding

The safeguarding team (Designated Nurses for Children and Looked After Children, Designated Lead Professional for Adults, Named GPs) continue to offer advice, guidance, support and training across the health economy to professionals including dentists, pharmacists and GPs. As part of the development of a single CCG organisation, we have strengthened the leadership capacity and organisation of our safeguarding team. We remain as committed as ever as an equal partner within the safeguarding partnership board arrangements for both local authorities in Shropshire, Telford and Wrekin, 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 more remote working within health, social care and education since the advent of lockdown measures
- An increase in harm to babies under 12 months old, with parental stress cited as the significant factor
- Reduced training opportunities within provider organisations, due to the diversion to frontline service delivery.

Our key safeguarding activities during 2020/21 included:

- Working closely with our local authority partners to assess levels of risk and prioritise and respond to these changing needs
- Developing and implementing our training and support offer to GP practices
- Maintaining our quality monitoring of, and improvement approach to all of our providers
- Working directly with hospital trusts to review and advise on best practice approaches to assure safeguarding is robust and resilient
- Maintaining a strong focus on attending to the health requirements for Looked After Children.

As well as continuing the above areas of activity, for 2021/22 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
- The Telford Independent Inquiry Child Sexual Exploitation/Abuse (IICSEA) is yet to conclude and we continue to contribute to this process.

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 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:

a) the planning of services
b) the development and consideration of proposals for changes, which if implemented, would have an impact on services
c) 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 be dependent in the way we interact and empower patients and the public to be involved in their own health care.

Governance and assurance

The CCG exists to set health care outcomes for the people of 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 to make better, more informed decisions about the services which are needed by all of our diverse local communities.

This commitment is embedded in our Constitution which sets out how it will make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting commissioning arrangements. It is available on our website.

Our priorities

- To make health and care services available when and where they are needed
- To work together with our partners to achieve the best results
- To deliver value for money and improve productivity
- To commission high quality, safe services which improve health outcomes.

The CCG Governing Body receives assurance on the robustness of its involvement and relationship with the public through the established Assuring Involvement Committee (AIC). In line

with its Terms of Reference, the AIC has up to 12 volunteer members which include 11 members of the public and the Governing Body Lay Member for Public and Patient Involvement. The Committee is chaired by a volunteer member and meets on a monthly basis with a full agenda and discusses with the commissioners the Communication and Engagement Plans for each proposal on new or changing services commissioned by the CCG. The Chair of the AIC completes a report following each Committee meeting, which is then presented to the next CCG Governance in public for assurance purposes.

Our Communications and Engagement Strategy, which can be found on our website, demonstrates how we will include patients, the public and stakeholders in our decision making to continually improve services. It also outlines how we will adhere to our statutory responsibilities to carry out effective consultation and engagement and is aligned to our equalities work programme to ensure that we work with our whole population and groups who may be underrepresented. It sets out our principles on how we will involve and engage with patients and the public and the value that the CCG has on involvement. We have an action plan that sits with the strategy that sets out the practical actions we will undertake to deliver our strategic priorities.

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
- 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 13 member GP practices of the CCG have individual Patient Participation or Practice Patient Groups (PPGs) that work with their respective practices on issues affecting the local residents of that practice. Representatives from the PPGs meet monthly and give feedback to the CCG on issues affecting patients and the public.

NHS England Patient and Public Engagement (PPE) Assurance Rating

Every year, NHS England conducts a review of how CCGs across the country engage with local patients and public. This forms part of the Integrated Assurance Framework by which CCGs are assessed.

The last assessment for 2019/20 was rated as ‘Green Star’.

Impact of participation

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

You said, we did…

Patient feedback	Actions to address	Change
The local Dementia Champions are trying to work with a local practice on behalf of clients but there is a problem now they are working from home and not the practice office as they are not able to send information to a personal email address. Worried about the time it is taking to sort stuff out.	The Patient Engagement Lead contacted the primary care team to highlight this feedback.	Primary care worked with the Dementia Champions and the practice. A new nhs.uk account has been set up so that information can be sent securely. This will be rolled out to the other Dementia Champions.
The STP communication and engagement team wanted feedback on a letter that was part of a toolkit for healthcare professionals to use when talking about advanced care planning.	The local patient groups had shared the draft letter with its members and collected feedback from them.	Following the patient's feedback, they have acted on their suggestion and will not include the letter and have agreed that they need to have a face-to-face conversation with the patient.

Review of phlebotomy services

Background

As of September 2020, there were 508,613 people registered with GPs in Shropshire, Telford and Wrekin. The number of blood tests completed is in excess of 650,000 – which roughly equates to 1.3 blood tests for every person, every year. The CCGs worked together to review the service.

As a result of the COVID-19 pandemic, a number of short-term interventions were put in place to maintain service access. This work revealed some outstanding issues and variations in service provision that raised the profile and provided a mandate for a system-wide review.

This case for change has been captured in the completion of an equality impact assessment.

Aim and objectives of engagement

To ensure the views of service users underpin the new commissioned model of phlebotomy.

Key stakeholders were identified including patients; carers, general public, Healthwatch Shropshire and Healthwatch Telford and Wrekin, general practice, phlebotomists, clinicians, service providers and the Joint Health Overview and Scrutiny Committee (JHOSC) of Shropshire Council and Telford and Wrekin Council.

An Engagement Task and Finish Group was established, which included representation from clinicians, managers, Healthwatch, patients and commissioners to help develop the Communication and Engagement Plan.

The Communication and Engagement Plan was shared with the JHOSC.

Engagement approach

There is a wealth of public health data from the Joint Strategic Needs Assessment that helped identifies the key areas for any targeted engagement.

The engagement work targeted representation from:

- Protected characteristics (including people with a learning disability and mental health conditions)
- Rurality
- In the first and second most deprived decile.

Initially, there was a review of existing data which was gathered from stakeholders, public, service users and carers over the last six months, including from Patient Advice and Liaison Services (PALS) and Complaints, Friends and Family Test, plus intelligence from Healthwatch and feedback from patient groups.

An online survey was developed to form the basis of the engagement. There were a number of multiple choice options to enable analysis and options for free text. In addition, patients could choose to complete the Equality Monitoring form which provides further data and helps the CCGs to monitor the reach into the seldom-heard and protected characteristics groups.

Alongside the online survey, we promoted the offer of paper surveys to be posted out to people who were not able to access digital technology. These were sent back via a Freepost address and collected safely by the team. Those that were not comfortable receiving paper copies, were invited to telephone the CCGs where a call handler was able to complete the online survey on their behalf.

The CCGs also introduced the use of a QR (Quick Response) code, which could be used by smart phones, by scanning the code which took them directly to the online survey.

The survey was open for four weeks initially. The Engagement Task and Finish Group reviewed the data that had been collected during this period. Following discussion, it was agreed to extend the survey for another three weeks to enable more targeted promotion to elicit further views.

In addition to the survey, a number of focus groups were established to enable a free discussion around the phlebotomy service. People who used the service on a regular basis were targeted,

including a local respiratory group and diabetes support group. A checklist was developed to ensure consistent information. Whilst there will be limitations in the analysis that can be completed, this will provide qualitative information to the final report. However, where this is normally done in a face-to-face manner, they were conducted virtually due to the COVID-19 limitations.

Running alongside the public engagement, surveys were designed to gain the views of the providers who use and/or refer into the service. It included GPs, senior nurses, healthcare assistants, primary care practice managers, consultants and allied health professionals (AHPs). A focus group was also held with phlebotomists.

Communication

A comprehensive promotional programme was developed to ensure effective communication including a press release, social media, posters, website and newsletter copy, and targeted emails to support groups.

Feedback

Following the period of engagement, a report was written and will be presented to the Steering Group so that they have information to be able to develop the options for the phlebotomy service.

Encouraging uptake of the COVID-19 vaccine

In December 2020, the national rollout of the COVID-19 vaccination started with the creation of various vaccination centres across the county. Although take-up of the vaccination has increased over the months, data and feedback showed that there were communities where uptake was very low.

A system-wide equalities group including the CCG, local authorities, community leaders, health professionals and equality and inclusion leads came together to share information and facilitate engagement on increasing uptake.

A communications and engagement plan was developed and following feedback and agreement with communities and community leaders a number of toolkits were developed to help address some of the concerns, worries and questions that had been fed back.

- We have been working with local businesses with a high proportion of Eastern European employees to circulate key messages about the COVID-19 vaccine to their workforces and we are organising on site engagement sessions and/or vaccination sessions where appropriate.
- Engaged with the two main organisations supporting Eastern Europeans living in Shropshire, Telford and Wrekin. Questions were submitted by members of the communities and community leaders have participated in Q&A videos with clinicians and recorded

talking about their experience of having the vaccine. These have been shared with through the community communication channels.

- Information and videos in different languages have been produced with clinicians and have been shared through social media and across the ICS.
- We have worked with community leaders and faith leaders to gather insight, create resources and channel key messages about the vaccination programme.

In addition to this using guidance from national sources we have adapted information for people with learning disabilities and those with sensory impairment. Our toolkits include:

- Care sector toolkit
- Bulgarian Language toolkit
- Businesses toolkit
- Eastern European Communities Toolkit
- COVID-19 toolkit for seldom-heard groups
- COVID-19video for seldom heard groups
- Large print version of COVID-19 information.

The Equalities Group continues to meet, to look at data, feed back and work with local communities.

Single strategic commissioning organisation

The NHS is undergoing a major transformation following the publication of the NHS Long Term Plan and future vision of integrated care systems.

Following a decision to have one strategic commissioning organisation within the Shropshire, Telford and Wrekin Sustainability and Transformation Partnership (STP), the CCGs developed a Communication and Engagement Plan, to aid with the transition to a single strategic commissioning organisation. The plan is available on our website.

During 2019/20, the first engagement event was held with stakeholders in Shrewsbury and was well attended.

During 2020/21, there has been continual engagement with the Governing Body, GP practice membership, executive team and staff. In addition a further two stakeholder events have been held, supported by NHS Midlands and Lancashire Commissioning Support Unit.

The second event held in December 2020 invited patients, carers, Patient Participation Group members, support organisations, Healthwatch Shropshire and Healthwatch Telford and Wrekin to attend a virtual event.

Using pre-recorded videos and breakout rooms, delegates were invited to take part in small, facilitated discussions following videos notes were made by the facilitators. Following this session,

delegates were then invited to move into a larger meeting with other delegates to take part in a question and answer session. After the event, a feedback report was produced by MLCSU. The report was shared with the directors of the CCGs to provide responses to the questions raised to feedback to participants.

In March 2021, delegates who had already attended the first and second events were invited to a virtual event where they could listen to presentations from directors on the patients' voice, structure and implementation and partnership working.

Extended access survey

Extended access appointments have been provided in Telford and Wrekin CCG through a hub design since 16 September 2019.

The extended access service provides pre-bookable, routine primary care evening and weekend appointments for all residents registered with a Telford and Wrekin GP. Appointments are delivered via two hubs, operating over four locations. Appointments are also available over bank holidays.

Patients access the appointments via their own surgery and can make the appointment in-hours or be automatically directed to the call centre to book out of hours.

As part of the contractual agreement, the extended access service was required to conduct a patient survey. Feedback gained from the survey will be used to inform the commissioning of the new service, which is expected to run from April 2021.

A small Task and Finish Group comprising of patient representative, commissioning manager and quality lead was created to complete this piece of work. The Communication and Engagement Plan was taken to the Assuring Involvement Committee for discussion.

To support the communication to patients who have used the service, banners were designed for the CCG and practice websites, text messaging to patients using practice systems and tweets from the CCG's Twitter account.

Due to the COVID-19 pandemic and restrictions on face-to-face meetings, an online survey was developed. There was discussion on how to ensure all users of the service were able to participate if unable to access the survey online. As the majority of patients receive virtual consultations in line with guidance, and the use of paper is discouraged, options within a surgery were not available. Agreement was gained from the service to allow patients to contact their call centre anonymously and for a call handler to complete the survey on their behalf.

The survey commenced in February 2021, with regularly uploading of data to provide interim findings.

Engagement using technology

During the COVID-19 pandemic, the CCGs have not been able to engage in the normal way by having face-to-face meetings or drop-in events. As organisations started to become aware of and use technology, there were more opportunities to join in conversations virtually with established groups.

Although this was challenging at first, it has highlighted that by increasing the use of technology, we can reach further into our communities.

Patient feedback and relevant data

We use a number of differently sourced pieces of information to help triangulate our understanding of patient experience of the health services we commission.

The primary data source we use for population health is the Joint Strategic Needs Assessment (JSNA) – a statutory process undertaken by Telford and Wrekin Council to inform the development of priorities across the county.

The process brings together and explores a wide range of data, performance information and intelligence to identify those issues where the county is doing well and also those which remain a challenge and where more needs to be done.

This data is used by CCG commissioners to begin service redesign projects and to help determine what services we need for our local population. The communications and engagement team also consider this information when stakeholder mapping for specific engagement and consultation projects.

The JSNA is not one single document – individual parts of the JSNA can be found on Telford and Wrekin Council's facts and figures page.

In addition to this the CCGs also have the following information on specific services:

- Complaints and PALS queries made to the CCGs and to its providers which can highlight trends
- Quality and commissioning teams also gather information from quality and contracting meetings with our providers on patient experience and quality issues
- Surveys of GP patients and other services we commission
- NHS Friends and Family test outcomes by provider
- Information received via Healthwatch Telford and Wrekin and CQC reports.

How we reach diverse and potentially excluded groups

When identifying stakeholders for engagement, we are sure to seek out the 'seldom-heard'. We look at the nine protected characteristics outlined in the Equalities Act 2010, plus carers, people

who suffer from a mental health problem or addiction and those who are socioeconomically deprived.

To support development of commissioning plans and decision making, it is essential that engagement and communication methods consider the needs of people with a protected characteristic and enables them to participate.

An example of how practical engagement delivery is designed to meet the needs of our diverse population is the engagement that was done for the review of the phlebotomy service. It was established from current data that most patients at some time will have had blood taken for analysis and therefore we needed an approach that met the needs of our population.

Using active members of the communities, we targeted emails to groups within our ethnic communities. Patients who accessed support for substance misuse were offered the opportunity to join a focus group. Patients whose first language is Polish were also offered the opportunity to attend a focus group supported by a local translator.

These examples undertaken in the year have enabled progress to be achieved in line with our equalities objective 1, where we are 'Improving lives of local people and patients'.

Working with partner organisations

Throughout the county, there is a myriad of patients groups and voluntary organisations supporting people. It has been difficult to visit the groups during the COVID-19 pandemic, but we continue to send out regular updates on the pandemic to the groups known to us as well as a number of engagement opportunities.

Examples include:

- Virtual meetings with Telford Patients First Group and Healthwatch Telford and Wrekin keeping them updated with the progress on the pandemic
- Members from both Shropshire Patient Group and Telford Patients First Group being part of the Engagement Task and Finish Group for the phlebotomy service review
- Drop-in to the 'virtual' monthly meetings with the local respiratory and diabetes groups to discuss their experience of using the phlebotomy services.

How we involve patients and the public

Our engagement with patients and the public is vital to our work. We use a range of communications channels to communicate to keep patients and the public informed such as:

- News releases
- Website
- Newspaper columns
- Radio adverts

- Website updates
- Posters and leaflets in GP practices and community venues
- Social media, for example Facebook and Twitter
- Sending event attendees reports of the outcomes
- For some projects, newsletters and direct communication
- Individual phone calls and emails to people who have been involved
- The Telford Patients First Group help communicate messages to individual Patient Participation Groups.

Enabling and supporting those patients and the public who wish to get involved

For patients and members of the public who have an interest in being actively involved with the CCG, they are offered informal discussions to find their area of interest.

For those patients who prefer to sit on a working group or steering group as part of a procurement or service redesign process, they will be offered an initial briefing together with ongoing support at those meetings, until they feel comfortable to attend on their own.

The CCG's reading group has been supported and involved in checking any documents the CCG produces that will be public-facing.

Learning and best practice

During our experience of engaging, involving and consulting with patients, carers and the general public in 2020, we have made contact with a number of groups and individuals which will help future engagement. The CCGs' communication and engagement staff also have a more detailed understanding of the processes and delivery methods that work with different groups of people to illicit a response that can be used to design improved engagement in the future.

Future plans

The coming year will continue to bring new opportunities for the communication and engagement team. Our priorities will focus on:

- Engaging and informing patients, as we move to a single strategic commissioning organisation
- Working with Healthwatch Shropshire and Healthwatch Telford and Wrekin to ensure that local residents are fully engaged with Shropshire, Telford and Wrekin's transformation of health and care services
- More integrated working with our communication and engagement colleagues across our Strategic Transformation Partnership (STP) area to share knowledge and expertise

- Supporting neighbourhood initiatives to build local networks as a key enabler for the CCG's self-care and management of long term conditions projects
- Enhancing our relationships with seldom-heard groups that make up the nine protected characteristics in our area and building new ones
- Delivering engagement forums, workshops, focus groups, commissioning intentions events and the CCG's Annual General Meeting.

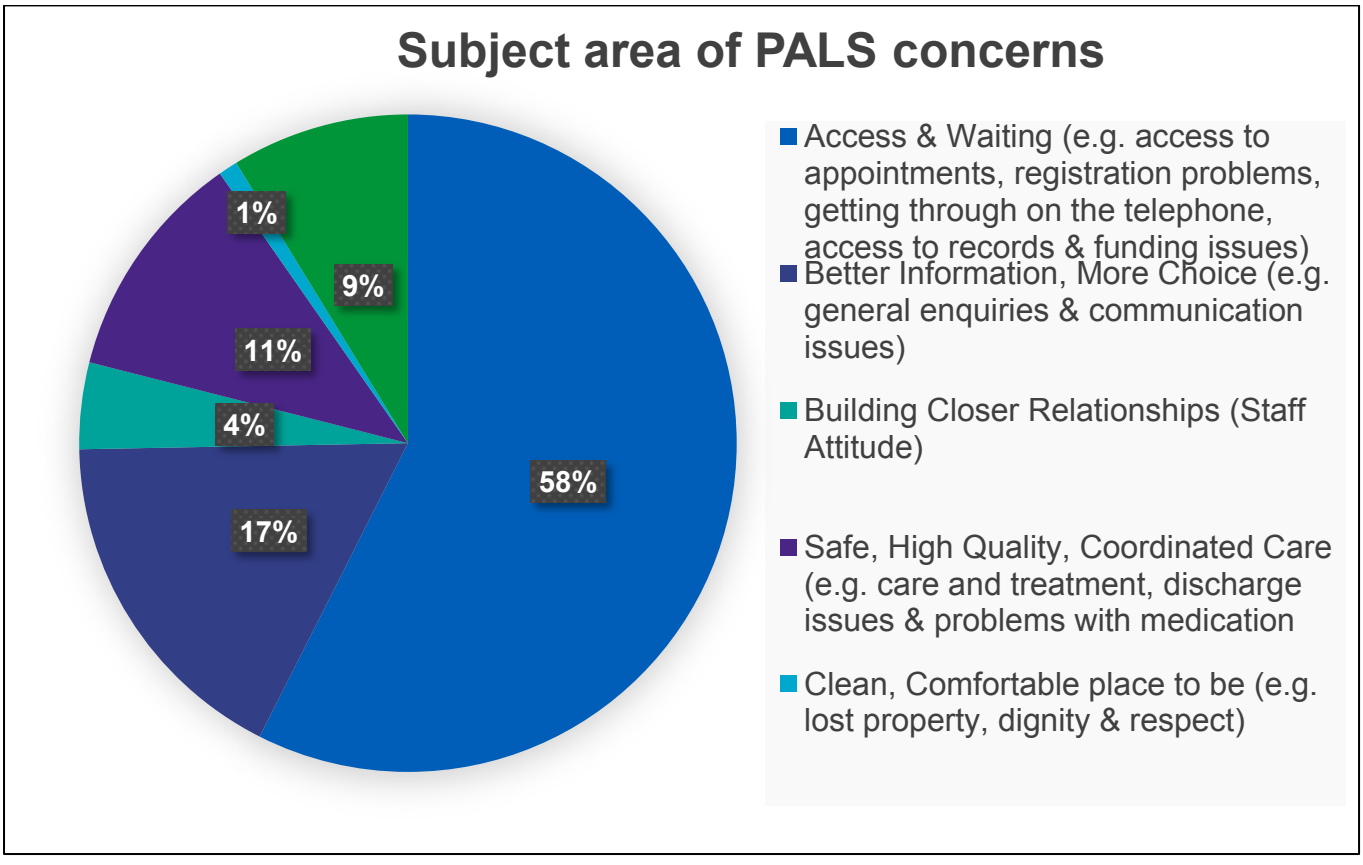
Patient Advice and Liaison Services (PALS)

PALS is integral to Telford and Wrekin CCG's commitment 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 intermediary and a 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 2020/21, 423 contacts were received through PALS. This is an increase on the 323 enquiries received in 2019/20, and is largely due to COVID-related queries.

The chart below illustrates the 'domains of patient experience' that the PALS enquiries received during 2020/21 related to.



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

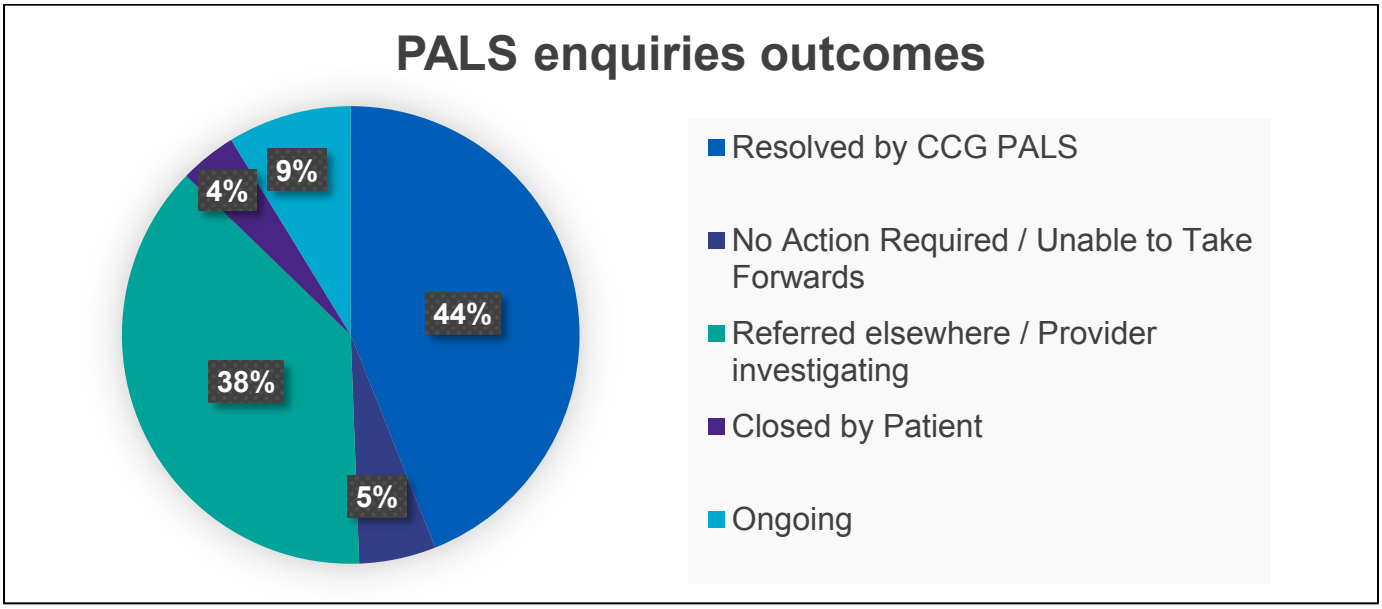
Of the enquiries that related to primary care, the majority concerned GP practices with queries about options for registering as a new patient and some concerns about poor communication.

For hospital services, a high percentage of contacts were around access to appointments and included delays with dates for surgery and routine review appointments. The vast majority of these delays were caused by the impact of COVID-19.

Nearly half of the enquiries received about CCG services related to the Prescription Ordering Department. These included callers having problems getting through to the service, due to the surge in demand from patients who were no longer able to submit their prescription request in person at their GP Practice due to COVID-19 restrictions.

Whilst there were fewer enquiries in 2020/21 about community services, there was an increase in mental health concerns. These were mainly about access to mental health services, with a number of these relating to autism spectrum disorders for both children and adults.

The chart below shows what happened with the queries and concerns received by PALS.

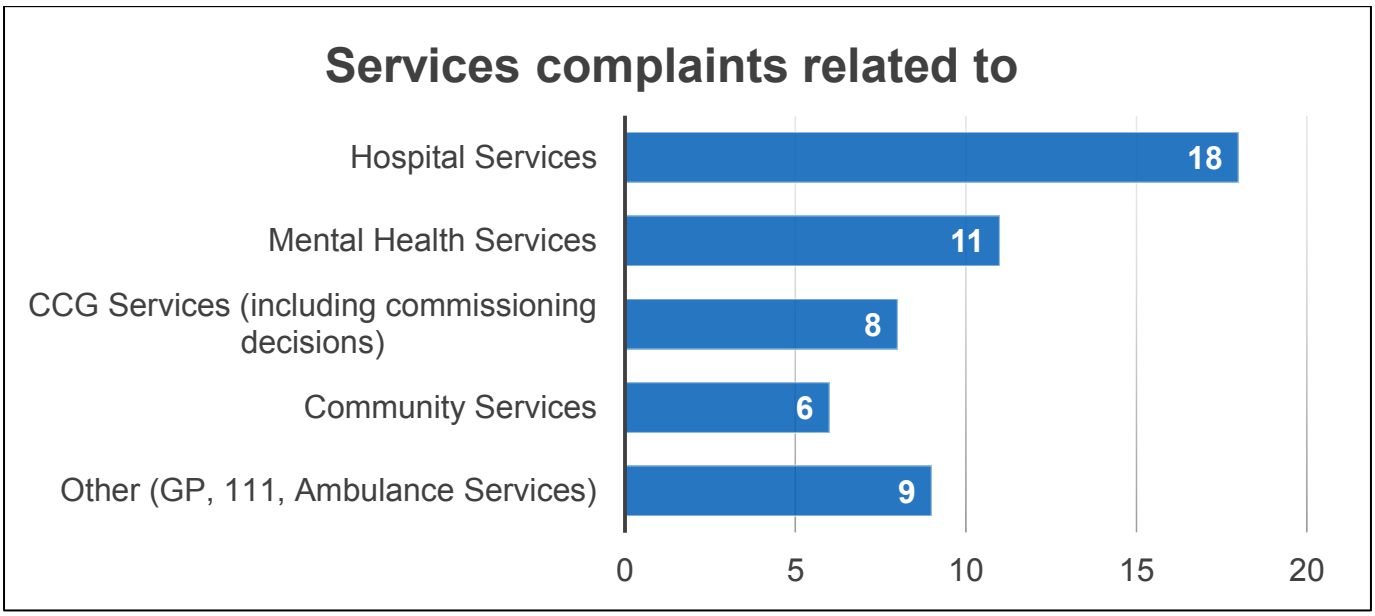


The percentage of enquiries relating to other NHS providers more than doubled compared to the previous year, but the largest percentage of outcomes continued to be those resolved within the CCG.

Complaints

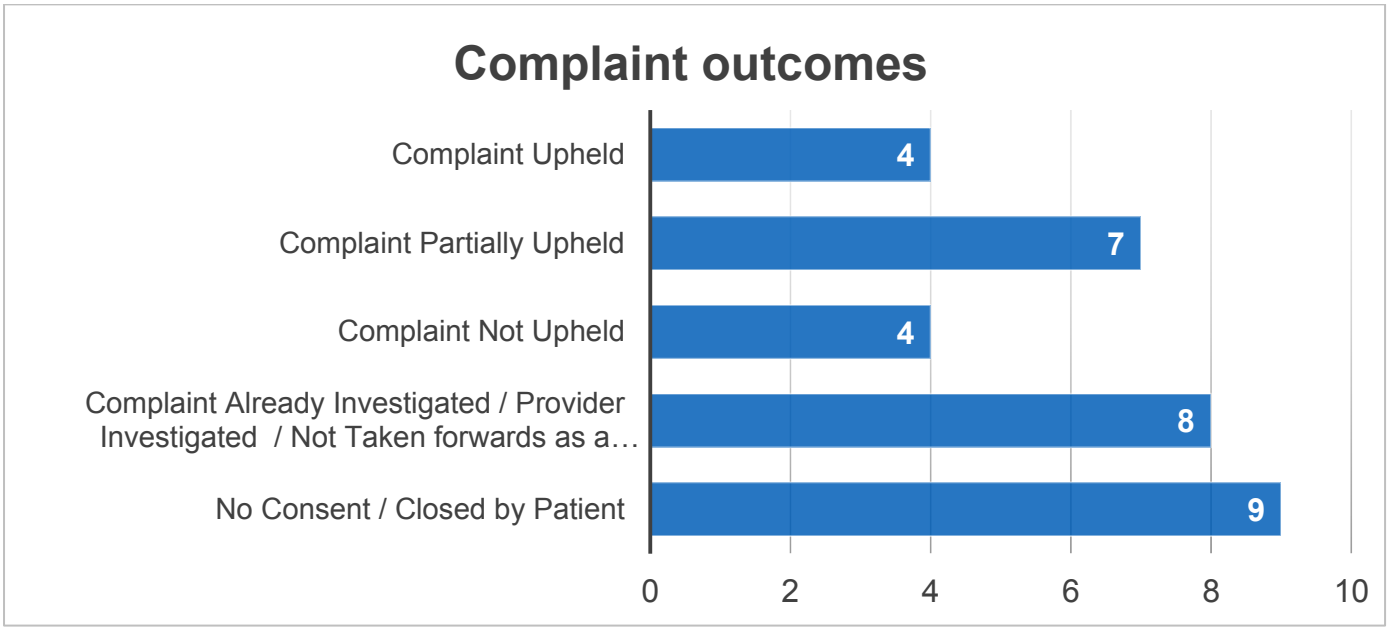
During 2020/21, Telford and Wrekin CCG received 52 complaints – the same number received the previous year.

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.



The number of complaints about the CCG has more than halved since last year, but (with the exception of community services) there has been a slight increase in complaints regarding provider services.

Of the 52 complaints received, 27 are ongoing. The graph below shows the outcomes for complaints where the process has been completed during 2020/21.



Ombudsman

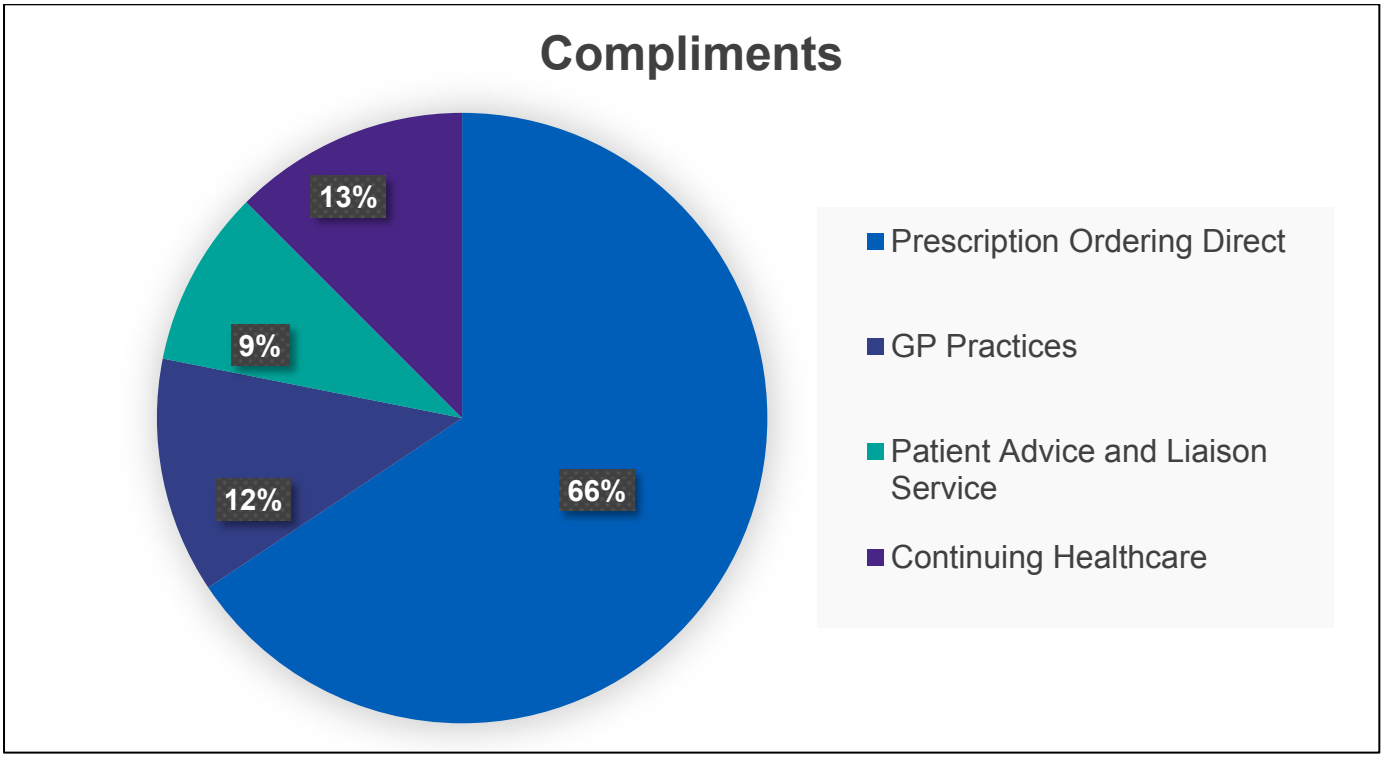
The public have the right to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for review if they are not satisfied with the CCG's response. There was only one PHSO case that Telford and Wrekin CCG have been involved with during 2020/21. This concerned mental health services. The case file (including a response to the complaint) was passed to PHSO, who have reviewed the case but are not investigating further.

MP letters

During 2020/21, Telford and Wrekin CCG received 28 letters or emails from local Members of Parliament (MPs) relating to the healthcare of constituents. Half of these concerned hospital services, just four concerned CCG decisions and the remainder were about other NHS services (mental health and primary care). As in previous years, the majority of concerns that were raised related to access to services and appointments.

Compliments

In addition to dealing with complaints, concerns and enquiries, the CCG also receives positive feedback in the form of compliments. As can be seen in the chart below, during 2020/21 the majority of compliments were related to the Prescription Ordering Department (POD) service.



As an example of how compliments can help provide context, the CCG received 21 compliments about POD, two complaints and 10 PALS cases there were a mixture of enquiries and concerns. Therefore on balance, the feedback about POD was mostly positive.

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. Below are examples of where changes have been made to services following patients providing feedback to the CCG:

- Following the emergence of COVID-19, the Prescription Ordering Department (POD) service experienced a six-fold increase in the number of calls received. This resulted in long delays for patients trying to order their medication. Staff from other parts of the CCG were redeployed and trained to help deal with calls. In addition, an email address was created so patients had an alternative method for placing an order. This helped ensure that the most urgent requests were dealt with promptly and gave patients greater flexibility in how they could order their medication.
- A patient complained about their experience in A&E, where they were left alone in a bay for two hours despite alarms sounding due to their rapid pulse and low blood pressure. The hospital apologised for the patient's experience and provided details of changes made as a result including an increased level of senior staff present to support staff and patients. Additional regularly documented patient safety checks have been put in place to identify and rectify concerns without delay.
- Concerns were raised by residents about a recovery house (for people with mental health needs who have left hospital) about the quality of care provided. The concerns were investigated and an action plan was developed involving residents, staff and the CCG. This resulted in a more focussed approach to supporting residents' needs, their recovery and development.

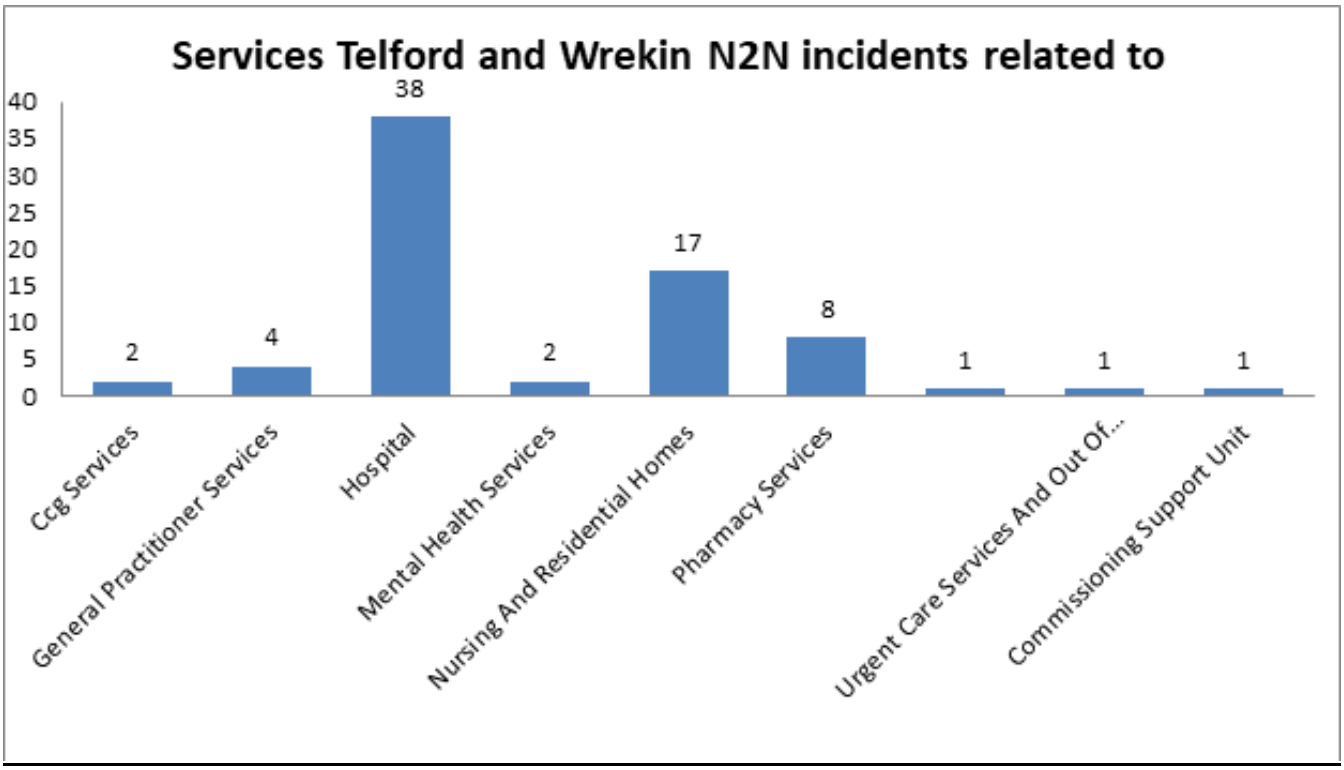
NHS to NHS concerns

This process gives NHS organisations the opportunity to identify and feedback where there are concerns relating to patient care delivered by NHS commissioned healthcare providers.

It also allows the CCG to identify any trends relating to specific areas or departments, and to take appropriate actions as required.

During 2020/21, Telford and Wrekin CCG received a total of 74 NHS to NHS concerns.

The table below illustrates a breakdown of the areas these concerns related to:



Below are examples where the incidents raised have led to improvements in services:

- Discharge issues about SaTH have led to work being commenced on a trust-wide thematic review. A task and finish group has also been set up with local health and social care providers, to see how improvements can be made. Updates to documentation have already been made as part of this work
- A GP practice has changed their process so that calls relating to a request for complex wound management will be put through to a practice nurse to ensure the services can be delivered
- It has been agreed that when a consultant is adding an addendum to a report, this must be telephoned through to the relevant clinical team for awareness.

EQUALITY, DIVERSITY AND HUMAN RIGHTS REPORT

We believe that equality and inclusion include addressing health inequalities and should be embedded into all 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 to the services we commission (buy).

We are keen to involve local people in the continuing development and monitoring of this aim to ensure that we commission the right health care services, provide well-trained staff to deliver and ensure our providers meet the equality 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.

To help monitor how the NHS was working towards these functions, the NHS Equality Delivery System (EDS2) was launched in November 2013. It is a toolkit designed to help NHS organisations and staff review their performance for people with characteristics protected by the Equality Act 2010 and identify how improvements may be made.

The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender re-assignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race including nationality and ethnic origin
7. Religion or belief
8. Sex
9. 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 four main goals. More information on the scoring mechanism is available on NHS England's website.

The results of the CCG assessment can be found on our website.

We have continued to rate ourselves as 'developing' across most goals. We recognise that to progress from this level, we need to understand the needs of individuals accessing healthcare services and ensure we can evidence how we have acted to promote equalities.

We utilise some key processes to help us understand in more detail how different groups access healthcare. A key source of information is the Joint Strategic Needs Assessment (JSNA) for the resident population of the CCG, which analyses the health needs of the population of the area. The JSNA informs and guides commissioning of health, wellbeing and social care services to improve health and wellbeing and reduce inequalities. The JSNA informs the Joint Health and Wellbeing Strategy.

The JSNA is available on Telford and Wrekin Council's website.

The most recent 2017 Telford and Wrekin Population profiles by ward are available on Telford and Wrekin Council's website.

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.

We have made targeted efforts to engage with groups who make up, some or all, the nine protected characteristics this year, particularly but not exclusively around COVID-19. These include:

- The Polish community has received information in Polish to share with patients about the spread of COVID-19
- The Shropshire, Telford and Wrekin Equality, Diversity and Inclusion Group has worked with the STP to help develop information about the COVID vaccine
- A COVID-19 vaccination communications toolkit has been sent to groups in the ethnic communities and supporting the nine protected characteristics. This includes posters in various languages and videos
- The CCGs' new Joint Governing Bodies now have a jointly-appointed Patient and Public Involvement Lay Member for Equality, Diversity and Inclusion
- As part of ensuring we are hearing our population's views of their needs, we continued to engage with pregnant women and new mothers as part of redesigning future services for the midwife-led units and the local maternity services (LMS) as a whole. To enable new mothers and their partners to attend, we continue to facilitate meetings where young children can come along and play, whilst the parents take part in discussions. With the help of our local authority and community health trust partners, we also identified several groups for parents and toddlers in specific areas where transport was an issue and visited the groups to talk with the members. Shropshire, Telford and Wrekin Maternity Voices

Partnership continues to use social media to enable a wider group of women, partners and families to get involved. In addition, several face-to-face groups have also been established locally. It had been identified the previous year that we needed to improve engagement with local Asian women's support group, the local Polish community and the local traveller community where discussions took place with women and their partners around maternity experiences and redesign of maternity services.

- We continue to record equality monitoring data as part of our complaints function. From this monitoring, we have deduced that most complainants are White British and heterosexual, which would require us to explore why other groups are not utilising the complaint process. Further work will be done with groups representing the nine protected characteristics during 2020/21.
- 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 are able to specify how we will communicate with them about their medical treatment. The policy is available on our website.

As we transition into a single CCG on 1 April 2021, we will continue to build on our aim to make strong links with those groups that make up the nine protected characteristics and other groups include people suffering from mental health problems and substance misuse.

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.

Quality monitoring of patient experience reports from providers is also undertaken to identify themes and trends, and ensure actions are put in place.

We normally record equality monitoring data as part of the complaints function but this has been delayed due to the capacity issues arising from redeployment of staff due to COVID-19. We plan to resume this recording for the new financial year 2021/22.

Under the EDS2 Equality performance toolkit, we are required to set our self-equality objectives at least every four years. Our objectives are:

- To improve lives of local people and patients
- Inclusive leadership and a representative and supported workforce.

Workplace Race Equality Standard requires us to ensure employees from ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Our current workforce representativeness of ethnicity is 9.83 per cent as shown below. This can be compared to an ethnic minority percentage of 10.5 per cent in the Telford and Wrekin population. Population information is based upon JSNA information from June 2019 on Telford and Wrekin Council's website.

Telford and Wrekin CCG percentage of staff by pay band and ethnicity as at 31 March 2020 (collected annually in July for previous year)

Pay band	White	BME	Unknown / Not Stated	Average total
Apprentice	0	0	0	0
Band 2	1.64%	0.82%	0	100.00%
Band 3	17.21%	1.64%	0	100.00%
Band 4	5.73%	0	0	100.00%
Band 5	6.55%	0	0	100.00%
Band 6	9.83%	1.64%	0.82%	100.00%
Band 7	6.55%	0.82%	0.82%	100.00%
Band 8 - Range A	10.65%	0	0	100.00%
Band 8 - Range B	4.09%	1.64%	0	100.00%
Band 8 - Range C	4.09%	0	0	100.00%
Band 8 - Range D	3.27%	0	0	100.00%
Band 9	0	0	0	100.00%
Very Senior Managers (VSM)	15.57%	3.27	3.27%	100.00%
Grand total	85.18%	9.83%	4.91%	100.00%

Our self-certification statements can be found on our website.

Based upon our analysis of its Workforce Race Equality Standard (WRES) data, we have identified key actions which can be found in our action plan on our website.

We recognise that unfair discrimination is unacceptable and, in this respect, we have made a statement of policy on equal opportunities in employment through our 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 colour, 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 Equality and Inclusion Report above. This is further supported by our Equalities and Diversity Policy, which sets out our vision that all employees should follow.

HEALTH AND WELLBEING STRATEGY

Health and Wellbeing Boards are an important feature of the reforms brought about by the Health and Social Care Act 2012.

The Health and Wellbeing Board acts to ensure that key leaders from the health and care system work together to improve the health and wellbeing of its residents. Health and Wellbeing Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best to deliver services as well as promoting integrated working among local providers.

The Health and Wellbeing Boards receive regular updates from the CCG about programme of work designed to deliver against the priorities within the strategies.

Telford and Wrekin Health and Wellbeing Board

The Health and Wellbeing Board refreshed its Health and Wellbeing Strategy in February 2020. In light of COVID-19, a new Health and Wellbeing Strategy was approved in June 2020, which built upon the proposals with the additional priority to reflect new problems that had arisen as a result of the pandemic. The CCG as members of the Health and Wellbeing Board have approved the refreshed strategy.

In developing its priorities and strategy, the process included a review of local intelligence, engagement workshop sessions with voluntary sector partners as well as a joint session between

members of the Health and Wellbeing Board and the Telford and Wrekin Integrated Place Partnership (TWIPP) to review progress and align priorities. Telford and Wrekin CCG local service redesign plans are informed by the Health and Wellbeing Strategy as a key partner in the TWIPP.

Likewise, the strategy looked to align itself to the Telford and Wrekin Annual Public Health report recommendations and the commitments of the Long Term Plan for 2019-24 by the Shropshire, Telford and Wrekin STP.

The four cross-cutting priorities where the Board wants to make the fastest progress are:

- Develop, evolve and deliver the TWIPP priority programmes
- Tackle health inequalities in the borough
- Improve emotional and mental wellbeing
- Protect people's health from infectious diseases and other threats.

Over 2020/21, the CCG has presented reports to the Health and Wellbeing Board in relation to progress of the joint programmes that form part of the TWIPP, notably an in-depth report on the integrated health and social care rapid response team in June. The work of the teams to deliver this was recognised by the Health and Wellbeing Board members.

Other reports have detailed the CCG leadership in the restore and recovery phases of the local response to the pandemic, updates relating to the mental health transformation around trauma informed care and how the system was responding to the increased demands of winter pressures through joined-up schemes and plans.

REDUCING HEALTH INEQUALITIES

The CCG has a duty under Section 14T of the Health and Social Care Act 2012 to reduce inequalities. This will be discharged during the planning and redesign of services through the use of equality impact assessments. The duty to deliver services with due regard to reducing inequalities forms part of the standard NHS Contract with all providers.

The impact of COVID-19 has been particularly detrimental on people living in areas of greatest deprivation, on people from ethnic minorities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations.[1]

The local and national response to the impact of COVID-19 in the first few months of 2020 was planned and delivered as an emergency response to the pandemic.

As part of this, Telford and Wrekin CCG worked with service providers to complete equality impact assessments to identify sectors of the community that may be impacted upon by immediate stepping down of services and consider how these could be addressed. An example of this is the work undertaken to identify high-risk, vulnerable patients who required ongoing primary care services. Primary care and community nurses from Shropshire Community Health NHS Trust worked in collaboration to deliver essential services such as home visiting for urgent needs.

In August 2020, there was national guidance shared that CCGs need to address the health inequalities that had widened over the pandemic by developing and implementing an eight-point plan:

Protect the most vulnerable from COVID	**Restore NHS services inclusively**	**Digitally-enabled care pathways**	**Accelerate preventative programmes for at-risk groups**
Support those who suffer mental ill-health	**Strengthen leadership and accountability**	**Ensure datasets are complete and timely**	**Collaborate locally in planning and delivering action**

Working with partners across the system, Telford and Wrekin CCG and Shropshire CCG have begun working across these eight areas, and will continue to do so across the forthcoming year.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

The below tables indicate an assessment of the work being carried out across the eight areas.

Achievements

Protect the most vulnerable from COVID	Restore NHS services inclusively	Digitally-enabled care pathways	Accelerate preventative programmes for at-risk groups	Support those who suffer mental ill-health	Strengthen leadership and accountability	Ensure datasets are complete and timely	Collaborate locally in planning and delivering action
Collaboration and delivery with voluntary community and social enterprise (VCSE) on a robust support offer for clinically extremely vulnerable (CEV) and other vulnerable groups Established robust system links with care sector and businesses Joint working primary care and Shropshire Community Health NHS Trust identification and targeting of CEV patients including care home residents	Cancer and maternity care and support plans Restored Diagnostics Restored Immunisations Cancer Living Well (LW) passports Individual services across providers have used clinical information available to target those at higher risk Some organisations have commenced monitoring of health inequalities data	System has developed at pace digitally-enabled pathways in primary care Telephone appointments Digital outpatients Digital cancer appointments Online mental health support Worked with local Healthwatch to review impact of switch to digital	Social prescribing Healthy weight strategies Blood pressure at home monitoring Health checks for people with learning disabilities Food insecurity programmes Children and young people mental health support through schools Trauma informed	24/7 access line Crisis support Sanctuary Suicide prevention Bereavement offer TogetherAll online support Social prescribing Delivery with VCSE	All key organisations have named board level health inequalities lead	Provider organisations commenced work on importance of ethnicity data collection COVID expansion funding used to support primary care with ethnicity data coding Available data being used to assist with COVID vaccination	SEND Board Integrated place partnerships (SHIPP and TWIPP) Joint delivery of local vaccination programme Vaccinating the homeless Delivery with VCSE

			work				

Areas outstanding for 2021/22

Protect the most vulnerable from COVID	Restore NHS services inclusively	Digitally-enabled care pathways	Accelerate preventative programmes for at-risk groups	Support those who suffer mental ill-health	Strengthen leadership and accountability	Ensure datasets are complete and timely	Collaborate locally in planning and delivering action
Continuation of activities to date Prioritisation of COVID vaccination programme	Routine and coordinated data collection across the system	Review impacts on accessibility regarding digital pathways including reviewing recommendations of Healthwatch survey on digital inclusion Cross-system methodology for data collection and analysis	Community development at place Continue roll out of trauma informed work Developing diabetes population health management programme	Implementation of non-clinical approaches to supporting people in crisis Primary care local enhanced service Access to psychological therapies and support	Regular reporting on progress to identify areas for further intervention either at an individual provider level or as a system	Continuation of progress to date to improve collection of ethnicity data to assist with service planning and monitoring	Implement agreed ICS principles Coordination of data collection and reporting Create whole system understanding of inequalities and local response Transformation plans Continued delivery of place-based priorities Population health management – decision support unit

Plans for delivering outstanding commitments. Delivery through:

Protect the most vulnerable from COVID	Restore NHS services inclusively	Digitally-enabled care pathways	Accelerate preventative programmes for at-risk groups	Support those who suffer mental ill-health	Strengthen leadership and accountability	Ensure datasets are complete and timely	Collaborate locally in planning and delivering action
Continuation of targeted vaccination, including engagement with ethnic minorities and other at-risk groups Vaccination Delivery and Inequalities Group	Develop and implement system monitoring and evaluation of outcomes To be led by CCG performance team	Develop consistent approach to evaluate impact of change of delivery mode Digital Enablement Group (includes clinical input) and Business Intelligence (BI) Group	To embed agreed principles in all restorative and transformation planning Two Place Boards (SHIPP and TWIPP) Programme boards for six big ticket items	Mental health transformation plans Dual diagnosis steering group Primary care / PCNs Voluntary sector is a key partner Learning disability and autism and local maternity system programme boards	Requirement to report to ICS Board progress across the key eight Embed key eight in all six key focus areas	To form part of regular reporting to ICS board as part of action against the key eight	Health and Wellbeing Strategies Place partnerships PCNs Transformation programmes Six big ticket items

Key learning to date

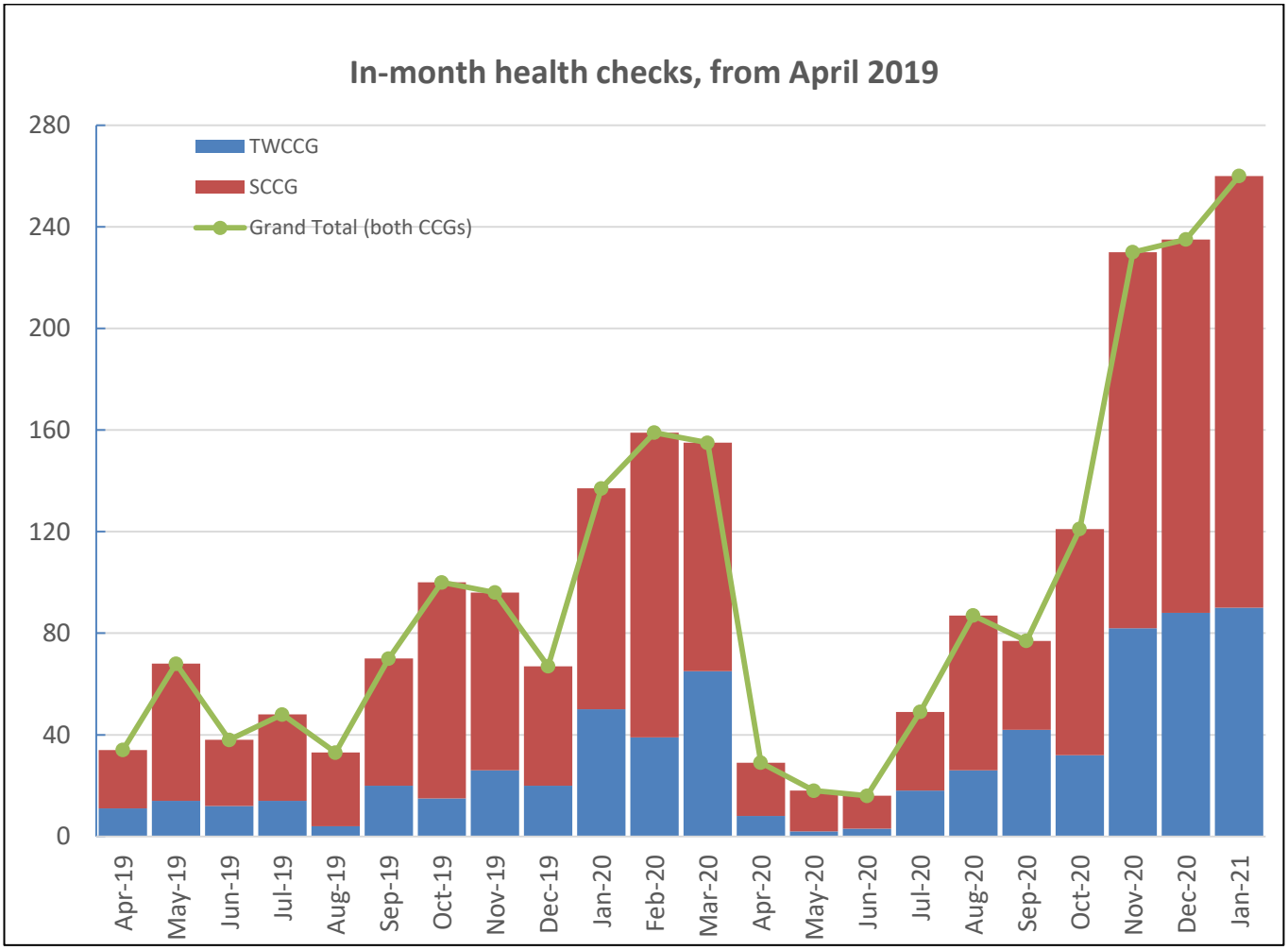
Protect the most vulnerable from COVID	Restore NHS services inclusively	Digitally-enabled care pathways	Accelerate preventative programmes for at-risk groups	Support those who suffer mental ill-health	Strengthen leadership and accountability	Ensure datasets are complete and timely	Collaborate locally in planning and delivering action
Regular public communication is vital Combining datasets gives a powerful understanding of vulnerable people (beyond CEV)	The need to bring together the clinical prioritisation that has guided the system restore with data on health inequalities	Mixed review of digital appointments Positive feedback on digital appointments for cancer Key learning in the Healthwatch report	Programmes can adapt to deliver digital approaches with consideration of accessibility and loneliness	Significant rise in access to vol sector mental health phone lines and sanctuary, significant increase in suicidal ideation Increase in children and young people self-harm	Aware system has dispersed leadership across population health management Inequalities Senior Responsible Officer (SRO) with separate task and finish group Equalities, Diversity and Inclusion (EDI) Group Workforce EDI Group Vaccination Inequalities Group Digital Enablement Group and that there needs to be a refocus on core leadership	Communication across organisations is at the core of developing this work	Collectively Shropshire, Telford and Wrekin can support residents, service users, vulnerable and reduce inequalities so much better than as individual organisations Vital that we work with the VCSE as equal partners in planning and delivery

Example of actions to address under health inequalities eight-point plan

Prioritising physical health checks for those with learning disabilities

Telford and Wrekin CCG has prioritised the physical health checks of those individuals with learning disabilities. This is important, as we know individuals with learning disabilities are at higher risk of physical health conditions which can be identified through regular health checks.

The chart below demonstrates the number of health checks achieved by primary care each month since 2019, and demonstrates the increase achieved through a targeted approach of prioritising this work in primary care. This is an excellent achievement, as primary care dealt with the different ways of working to manage the demands of the vaccination programme as well as delivering services in a COVID-19-safe way.



COVID-19 vaccine equalities activity

As a member of the system vaccine equalities group, we have been supporting the system's work to increase the uptake of the COVID-19 vaccination amongst different groups within our communities. Working with the equality, diversity and inclusion leads, partners, community leaders and the communities themselves, we have mapped our groups and the organisations able to help facilitate engagement and share information.

We have developed communications and engagement plans supported by toolkits addressing the specific concerns and questions raised by our diverse population, bringing together national and locally developed resources with the support of local healthcare providers and community representatives. The individual toolkits are specifically tailored to support the engagement with the different groups identified as being more vaccine hesitant.

By talking to our communities, we continue to gain a better understanding of the appropriate channels for reaching those who are seldom-heard and their needs, involving individuals trusted and respected by them. This work is being supported with local data to help target resource and activity to where it is most needed.

Engaging the support of a range of clinicians and staff of different ethnicities, we have produced short films to share factual information about COVID-19 vaccination with our communities and facilitated opportunities for our seldom-heard communities to put their questions to local clinicians and recorded these sessions for wider dissemination.

We have also engaged the support of our different communities to share their experiences of having the vaccine in different languages. To increase the diversity of our media spokespeople, we have organised media training for more of our staff to better represent our diverse population. These individuals have been at the fore of our media activity to encourage vaccine uptake amongst different ethnic minorities.

We continue to reach out to our local communities, working with system partners, through our community leaders and communications channels to monitor and respond to their questions and concerns. This includes providing factual information to counter concerns about the Oxford AstraZeneca vaccine through trusted individuals, sharing key messages about receiving the vaccine during Ramadan, a question and answer event for social care workers to address specific concerns, including in relation to fertility and pregnancy, and a programme of vaccination community engagement activity and pop-up services.

ACCOUNTABILITY REPORT

Corporate Governance Report

Members Report

Telford and Wrekin CCG is a membership organisation composed of the 13 GP practices located within the geographical area of Telford and Wrekin. When the members of the group meet to conduct business as the CCG, this is known as the CCG Practice Forum. Each member practice will nominate one GP representative to represent the practice in all matters considered at the Practice Forum, and if necessary, exercise a vote. The Practice Forum delegates the majority of decision making to the CCG Governing Body and this is outlined in the CCG Constitution.

The member practices are outlined below:

Practice Name	Address
Charlton Medical Centre	Lion Street, Oakengates, Telford, TF2 6AQ
Court Street Medical Practice	Court Street Medical Centre, Court Street, Madeley, Telford, TF7 5DZ
Dawley Medical Practice	Webb House, King Street, Dawley, Telford, TF4 2AA
Donnington Medical Practice	Wrekin Drive, Donnington, Telford, TF2 8EA
Hollinswood and Priorslee Medical Practice	Downemead, Hollinswood, Telford, TF3 2EW
Ironbridge Medical Practice	Trinity Hall, Dale Road, Coalbrookdale, Telford, TF8 7DT
Linden Hall	Station Road, Newport, near Telford, TF10 7EN
Shawbirch Medical Practice	5 Acorn Way, Shawbirch, Telford, TF5 0LW
Stirchley Medical Practice	Sandino Road, Stirchley, Telford, TF3 1FB
Teldoc	Malinslee Surgery, Church Road, Malinslee, Telford, TF32JZ
The Surgery	Wellington Road, Newport, near Telford, TF10 7HG
Wellington Medical Practice	The Health Centre, Victoria Avenue, Wellington, Telford, TF1 1PZ

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, lay members, and patient representatives.

CCG Governing Body composition during 2020/21 changed during the year. This was due to the Governing Bodies of Telford and Wrekin CCG and Shropshire CCG agreeing to appoint joint Governing Body members from 1 August 2020, in order to allow greater alignment of governance structures in preparation for the creation of a single CCG for Shropshire and Telford and Wrekin:

CCG Governing Body Member	Role
Dr Jo Leahy (voting) to 31 July 2020	GP Chair
Dr Julian Povey (voting) from 1 August 2020	GP Chair
Dr Ian Chan (voting) to 31 July 2020	GP/Healthcare Professional Member
Mrs Rachael Bryceland (voting)	GP/Healthcare Professional Member
Mrs Carolyn Fenton West (voting) to 31 July 2020	GP/Healthcare Professional Member
Dr Adam Pringle (voting)	GP/Healthcare Professional Member
Dr Michael Matthee (voting) from 1 August 2020	GP/Healthcare Professional Member
Dr John Pepper (voting) from 1 August 2020	GP/Healthcare Professional Member
Ms Fiona Smith (voting) from 1 August 2020	GP/Healthcare Professional Member
Dr Martin Allen (voting)	Secondary Doctor Member
Mrs Julie McCabe (voting) from 1 August 2020 to 31 January 2021	Registered Nurse Member
Mr Geoff Braden (voting)	Lay Member – Governance
Mr Neil Maybury (voting) to 31 July 2020	Lay Member – Patient and Public Involvement (PPI)
Mr Meredith Vivian (voting) from 1 August 2020	Lay Member – Patient and Public Involvement (PPI)
Mr Peter Eastaugh (voting) to 31 July 2020	Lay Member – Primary Care

Mr Gary Turner (voting) from 1 August 2020 to 30 August 2020	Lay Member – Primary Care
Mrs Donna MacArthur (voting) from 1 October 2020	Lay Member – Primary Care
Mr David Evans (voting)	Accountable Officer
Mrs Claire Skidmore (voting)	Executive Director of Finance
Professor Steven Trenchard (voting)	Interim Executive Director of Transformation
Mrs Zena Young (voting)	Executive Director of Nursing and Quality
Miss Alison Smith (non-voting)	Director of Corporate Affairs
Dr Julie Davies (non-voting)	Director of Performance
Mrs Sam Tilley (non-voting)	Director of Planning
Ms Claire Parker (non-voting)	Director of Partnerships
Dr Deborah Shepherd (non-voting) from 1 August 2020	Interim Medical Director
Mr Ash Ahmed (non-voting) from 1 August 2020	Associate Lay Member PPI – Equality Diversity and Inclusion
Dr Stephen James (non-voting) from 1 August 2020	Interim Chief Clinical Information Officer
Mr Patrick Spreadbury (non-voting) to 31 July 2020	Chair of the Assuring Involvement Committee – observer
Mr Jonathan Rowe (non-voting) to 31 July 2020	Local Authority Member – observer

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 Audit Committee has been meeting as committees in common with the Audit Committee of Shropshire CCG in preparation for the transition to a single CCG in April 2021.

Composition of the Audit Committee:

- Mr Geoff Braden (Chair) – Lay Member Governance
- 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 Governing Body 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 Governing Body members and other committees where membership is different can be found on our website.

Information Governance (IG) incidents

Telford and Wrekin CCG has reported a total of five incidents during 20/20/21. The scoring for IG breaches changed from 0-2 to Reportable or Non reportable, All of 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.

Modern slavery

Telford and Wrekin CCG fully supports 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 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 CCG 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 CCG and enable them to ensure that the Accounts comply with the requirements of the Accounts Direction)
- Safeguarding the CCG'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 CCG 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 CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

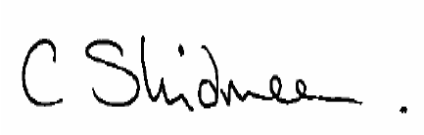
In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and Social Care, and in particular to:

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my CCG Accountable Officer Appointment Letter.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information
- The Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.



Mrs Claire Skidmore
Interim Accountable Officer
14 June 2021

GOVERNANCE STATEMENT

Introduction and context

NHS Telford and Wrekin CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2020, 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 clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my 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 good governance as are relevant to it.

Telford and Wrekin CCG is a clinically-led membership organisation made up of GP practices within the geographical area of Telford and Wrekin and which is also coterminous with Telford and Wrekin Council. The CCG was established under the Health and Social Care Act 2012 and is a statutory body which has the function of commissioning services for the purposes of the health service in England. 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 which can be found on our website.

The year 2020/21 has seen an unprecedented emergency response from the NHS to the COVID-19 global pandemic. The impact on the CCG has also been unprecedented, in that staff and resources have been redeployed to support frontline services. The governance processes for the CCG have, in line with national guidance, also had to be changed temporarily to fit this emergency situation, with some committees of the Governing Body and membership stood down or meeting less frequently, agendas streamlined and risk management processes focusing on the CCG Board Assurance Framework and system Gold Command emergency response. The CCG undertook these changes to ensure that its focus and resources were reserved to meet the challenges from COVID-19 during 2020/21.

In addition to the response to COVID-19, in August 2020 Telford and Wrekin CCG realigned its committees and the composition of the Governing Body in closer alignment with those of Shropshire CCG in order to create more aligned decision making processes in preparation for the transition into a single CCG from 1 April 2021. Consequently, the following pages outline the final structure adopted but also outline the changes made to membership of the old and new Committees and Governing Body.

The membership of the CCG is made up of 13 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 group has reserved some decisions to itself to make through the mechanism of Membership Forum which is outlined in the Scheme of Reservation and Delegation that forms part of the Constitution.

The Membership Forum met six times during the year. Membership Forum members and attendance are listed below:

Name of practice	Names of Practice Forum members	Meetings attended during 2020/21 as at 31 March 2021
Charlton Medical Practice	Dr D Sharp	2
Charlton Medical Practice	Anne Thorpe	2
Court Street	Dr Teresa McDonnell	6
Court Street	Maria Humphries	5
Dawley Medical Practice	Dr H Bufton	6
Dawley Medical Practice	Nicki Mott / Denise Hallett	6
Donnington Medical Practice	Dr J Hudson	6
Donnington Medical Practice	Angela Crompton / Bernadette	5

	McCormick	
Hollinswood/Priorslee MP	Dr R Mishra	6
Hollinswood/Priorslee MP	Mala Mishra	0
Ironbridge Medical Practice	Dr M Garland / Dr S Eli	5
Ironbridge Medical Practice	Helen Lippitt	6
Linden Hall, Newport	Dr S Waldendorf	4
Linden Hall, Newport	Karen Sloan	3
Shawbirch Medical Practice	Dr C Freeman / Dr P Coventry / Dr C Garrington / Dr P Davies/ Dr E Steedman / Dr C McDermott	6
Shawbirch Medical Practice	Ruth Waldendorf	4
Stirchley Medical Practice	Dr M Innes / Dr N Gureja	6
Stirchley Medical Practice	Tracie Craddock	3
Teldoc	Dr I Chan (Chair)	6
Teldoc	Nakash Lewis	0
Wellington Medical Practice	Dr D Ebenezer / Dr N Singh	3
Wellington Medical Practice	Tania Burrows	0
Wellington Road, Newport	Dr K Douglas	6
Wellington Road, Newport	Lynn Kupiec	5
Woodside Medical Practice	Dr M Thompson	4
Woodside Medical Practice	Teresa Beasley	4

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.

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 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 six times during the year in total. From 1 August 2020, the CCG appointed, jointly with Shropshire CCG, new Governing Body members to align decision making processes in preparation for the creation of a single CCG across Shropshire, Telford and Wrekin. The names of members and their attendance are listed below in tables showing membership prior to 1 August 2020 when the composition changed and post 1 August 2020:

Names of Governing Body members Up to 31 July 2020	Board Role	Meetings attended during 2020/21
Dr Jo Leahy (voting) to 31 July 2020	GP Chair	2 of 2
Dr Ian Chan (voting) to 31 July 2020	GP/Healthcare Professional Member	2 of 2
Dr Rachael Bryceland (voting) to 31 July 2020	GP/Healthcare Professional Member	2 of 2
Mrs Carolyn Fenton West (voting) to 31 July 2020	GP/Healthcare Professional Member	2 of 2
Dr Adam Pringle (voting) to 31 July 2020	GP/Healthcare Professional Member	2 of 2
Dr Martin Allen (voting)	Secondary Doctor Member	2 of 2
Mr Geoff Braden (voting)	Lay Member – Governance	2 of 2
Mr Neil Maybury (voting) to 31 July 2020	Lay Member – Patient Public Involvement	2 of 2
Mr Peter Eastaugh (voting) to 31 July 2020	Lay Member – Primary Care	2 of 2
Mr David Evans (voting)	Accountable Officer	2 of 2
Mrs Claire Skidmore (voting)	Executive Director of Finance	2 of 2
Mrs Zena Young (voting) from 1 April 2020	Executive Director of Nursing and Quality	2 of 2
Professor Steven Trenchard (voting)	Interim Executive Director of Transformation	2 of 2
Mrs Liz Noakes (non-voting) to 31 July 2020	Statutory Director of Public Health	1 of 2
Ms Claire Parker (non-voting) from 1 April 2020	Director of Partnerships	2 of 2

Miss Alison Smith (non-voting)	Director of Corporate Affairs	2 of 2
Dr Julie Davies (non-voting) from 1 April 2020	Director of Performance	2 of 2
Mrs Sam Tilley (non-voting) from 1 April 2020	Director of Planning	2 of 2
Mr Patrick Spreadbury (non-voting) to 31 July 2020	Observer – Chair of the Assuring Involvement Committee – observer	2 of 2
Mr Jonathan Rowe (non-voting) to 31 July 2020	Observer – Local Authority Member – observer	1 of 2

Names of Governing Body members From 1 August 2020	Board Role	Meetings attended during 2020/21
Dr Julian Povey (voting) from 1 August 2020	Joint GP Chair	4 of 4
Dr Rachael Bryceland (voting) from 1 August 2021 2020	Joint GP/Healthcare Professional Member	4 of 4
Dr Michael Matthee (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Dr John Pepper (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Dr Adam Pringle (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Mrs Fiona Smith (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Mrs Julie McCabe (voting) from 1 August 2020 to 31 January 2020	Joint Registered Nurse	2 of 3
Dr Martin Allen (voting) from 1 August 2020	Secondary Doctor Member	3 of 4
Mr Geoff Braden (voting)	Lay Member – Governance	4 of 4

Mr Meredith Vivian (voting) from 1 August 2020	Lay Member – Patient Public Involvement	4 of 4
Mr Gary Turner (voting) from 1 August to 30 September 2020	Lay Member – Primary Care	1 of 1
Mrs Donna MacArthur (voting) from 1 October 2020	Lay Member – Primary Care	3 of 3
Mr David Evans (voting)	Accountable Officer	4 of 4
Mrs Claire Skidmore (voting)	Executive Director of Finance	4 of 4
Mrs Zena Young (voting)	Executive Director of Nursing and Quality	4 of 4
Professor Steven Trenchard (voting)	Interim Executive Director of Transformation	4 of 4
Ms Claire Parker (non-voting)	Director of Partnerships	4 of 4
Miss Alison Smith (non-voting)	Director of Corporate Affairs	4 of 4
Dr Julie Davies (non-voting)	Director of Performance	4 of 4
Mrs Sam Tilley (non-voting)	Director of Planning	4
Dr Deborah Shepherd (non-voting) from 1 August 2020	Interim Medical Director	4 of 4
Mr Ash Ahmed (non-voting) from 1 August 2020	Associate Lay Member PPI – Equality Diversity and Inclusion	3 of 4
Dr Stephen James (non-voting) from 1 August 2020	Interim Chief Clinical Information Officer	4 of 4
Rachel Robinson (non-voting)	Director of Public Health for Shropshire	3 of 4
Liz Noakes (non-voting)	Director of Public Health for Telford and Wrekin	3 of 4
Lynn Cawley (non-voting)	Chief Officer – Healthwatch Shropshire	4 of 4
Paul Shirley (non-voting) to 11 November 2020	Chief Officer – Healthwatch Telford and Wrekin	2 0f 2

The CCG Governing Body has appointed the following committees:

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.

During 2020/21, the CCG also agreed to the Audit Committee meeting with the Audit Committee of Shropshire CCG as Committees in Common to transact business common to both CCGs. The Audit Committee has retained its meeting schedule during COVID-19 but reduced its agenda items to focus on key areas of governance assurance. It has met a total of 10 times during 2020/21, which is included in the attendance table below.

Names of Audit Committee members Up to 1 August 2020	Meetings attended during 2020/21
Mr Geoff Braden (Chair)	4
Mrs Carolyn Fenton West	3
Mr Neil Maybury	1
Dr Ian Chan	1

Names of Audit Committee members From 1 August 2020	Meetings attended during 2020/21
Mr Geoff Braden (Chair)	6
Mr Meredith Vivian	6
Mrs Donna MacArthur	6
Mr Ash Ahmed	6

The highlighted areas of the Audit Committee's reports are as follows:

- 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.

The Audit Committee undertakes an annual self-assessment of its own effectiveness to help inform its own programme of work and the Annual Report it presents to the CCG Governing Body annually.

Remuneration Committee

The Remuneration Committee recommends to the Board appropriate salaries, payments and terms and conditions of employment.

During 2020/21, the CCG also agreed to the Remuneration Committee meeting with the Remuneration committee of Shropshire CCG as Committees in Common to transact business common to both CCGs. The Remuneration Committee has met twice separately and six times in common as required during COVID-19.

Names of Remuneration Committee Members Up to 1 August 2020	Meetings attended during 2020/21
Mr Geoff Braden (Chair)	1 of 2
Dr Jo Leahy	0 of 2
Mr Neil Maybury	2 of 2
Mr Peter Eastaugh	2 of 2

Names of Remuneration Committee Members From 1 August 2020	Meetings attended during 2020/21
Mrs Donna MacArthur (Chair)	5 of 5
Mr Geoff Braden	6 of 6
Mr Meredith Vivian	6 of 6

The highlighted areas of the committee's reports are as follows:

- Review and recommendation on remuneration policies
- Review of continuous service audit action implementation
- Review of performance related remuneration for Very Senior Managers (VSM) and policy development.

Planning Performance and Quality Committee (PPQ)

The PPQ Committee oversees and provides assurance on performance and quality of commissioned services. The committee met three times during the year. The Planning, Performance and Quality Committee reduced its meeting schedule during COVID-19 to bi-monthly.

Names of PPQ members	Meetings attended during 2020/21
Mr Neil Maybury (Chair)	3
Dr Ian Chan	1
Mrs Rachael Bryceland	3
Mrs Carolyn Fenton West	3

The highlighted areas of the committee's reports are as follows:

- Fit4All
- Multidisciplinary care home team
- PPQ Integrated Performance and Quality Report
- Finance Report – monthly
- Neurodevelopmental pathway
- Maternity update
- SaTH Oversight Assurance Group
- Infection prevention and control update
- LeDeR (learning from lives and deaths – people with a learning disability and autistic people) update
- Annual Reports and update on safeguarding children and adults and Looked After Children
- Children and young people (CYP) update
- Non-medical referrals to radiology
- West Midlands Ambulance Service / 111 performance update
- SEND update
- Neurology service update
- Learning Disability and Autism Restoration Plan.

Finance Committee

The Planning Performance and Quality Committee ceased on 31 July 2020 and was replaced by the Finance Committee operating from 1 August 2020.

The Finance Committee oversees and provides assurance on the financial delivery of commissioned services. During the remainder of 2020/21, Telford and Wrekin CCG agreed to the Finance Committee meeting with the Finance Committee of Shropshire CCG as Committees in Common to transact business common to both CCGs. The Committees in Common have met five times during 2020/21 which is included in the attendance table below.

Names of Finance Committee members	Meetings attended during 2020/21
Mr Keith Timmis – Lay Member Governance for Shropshire CCG	5
Mr Geoff Braden – Lay Member Governance for Telford and Wrekin CCG	5
Mr Ash Ahmed – Joint Lay Member PPI	5
Dr Mike Matthee – Joint GP / Healthcare Professional	5
Dr Martin Allen – Joint Secondary Care Doctor Governing Body Member	4

The highlighted areas of the committee's reports are as follows:

- STP finance update
- Finance Report – Month 5/8/9/10/11
- Value for money and QIPP update – Month 5/8/9/10/11
- Finance Strategy update
- 2021/22 Plan update
- Update on development of the 2021/22 position and Medium-Term Financial Strategy (MTFS)
- Governing Body Assurance Framework and key messages to Governing Body
- Review of Continuing Healthcare (CHC) Action Plan
- Minutes of PPQ meeting.

Quality and Performance Committee (Q&P)

The Planning Performance and Quality Committee ceased on 31 July 2020 and was replaced by the Quality and Performance Committee operating from 1 August 2020. The Quality and Performance Committee oversees and provides assurance on the quality of commissioned services. During the remainder of 2020/21, the CCG agreed to the Quality and Performance

Committee meeting with the Quality and Performance committee of Shropshire CCG as Committees in Common to transact business common to both CCGs.

The Committees in Common have met seven times during 2020/21, which is included in the attendance table below.

Names of Q&P members	Meetings attended during 2020/21
Meredith Vivian	6
Geoff Braden	0
Keith Timmis	7 (including chairing the meeting in September 2020)
Rachel Bryceland	6
Dr Martin Allen	6
Julie McCabe	4 of 5

The highlighted areas of the committee's reports are as follows:

- Quality and Performance Exception Reports
- Update on care home work
- Patient Experience Insight Reports
- Shrewsbury and Telford NHS Hospital Trust Oversight and Assurance Group (SOAG) update
- SEND update
- Neurodevelopmental pathway update
- Attention deficit hyperactivity disorder (ADHD) procurement update
- High intensity user service update
- Continuing Healthcare (CHC) update
- QIPP Board update
- Safeguarding and Looked After Children update reports
- CCG Quality Strategy Report to include Operational Plan
- Infection prevention and control report
- Maternity update
- Serious incidents update
- Ulysses update
- Quarterly Primary Care Quality Report
- CHC update
- Learning disability health checks
- LeDeR update

- Learning disabilities update
- Breast cancer two-week wait performance report
- Healthwatch updates
- Policies and information for approval.

The Joint Strategic Commissioning Committee (JSCC)

The Planning Performance and Quality Committee ceased on 31 July 2020 and was replaced by the Joint Strategic Committee operating from 1 August 2020. The Joint Strategic Commissioning Committee oversees and provides assurance on the commissioning of services and has delegated decision making from both the Governing Body of Shropshire CCG and Telford and Wrekin CCG to make binding decisions on their behalf. The Joint Committee has met seven times during 2020/21 which is included in the attendance table below.

Names of Joint Strategic Commissioning Committee members	Meetings attended during 2020/21
Mr Ash Ahmed (Chair)	6
Mrs Donna MacArthur	3 of 4
Ms Julie McCabe (last attended Jan 2021)	4
Mr Geoff Braden	2
Mrs Fiona Smith	7
Dr John Pepper	6
Mr David Evans	2
Mrs Claire Skidmore	7
Mrs Zena Young	5
Mr Steve Trenchard	5
Attendees:	
Dr Julian Povey	5
Mrs Claire Parker	6
Mrs Sam Tilley	5
Dr Julie Davies	5
Dr Deborah Shepherd	4

Ms Alison Smith	1
Ms Michelle Davies / Mrs Tanya Miles – Shropshire Council	5
Cllr Andrew Burford – Telford and Wrekin Council	3
Mr Jonathan Rowe – Telford and Wrekin Council	4

The highlighted areas of the committee's reports are as follows:

- Autism spectrum disorder pathways
- NHSE/I Restoration and Recovery
- NHS 111 Demand and Dispositions
- COVID recovery updates
- Deep vein thrombosis pathways
- ICS Transformation Programme Board updates
- CCG Procurement Strategy
- Breast Cancer Improvement Plan.

Primary Care Commissioning Committee

This committee oversees the commissioning of primary care under delegated decision making authority from NHS England. It was a committee introduced in April 2015 following amendments to the CCG Constitution. The Primary Care Commissioning Committee stood down its meetings during COVID-19 from March to August 2020. From 1 August 2020, the CCG agreed to the Primary Care Commissioning Committee meeting with the Primary Care Commissioning Committee of Shropshire CCG as Committees in Common to transact business common to both CCGs. The committee met three times during the year.

Due to COVID-19, the CCG stood down its Primary Care Commissioning Committee during the period 1 April 2020 to 31 July 2020.

Names of Primary Care Commissioning Committee members Up to 31 July 2020	Meetings attended during 2020/21
Mr Peter Eastaugh (voting)	0
Dr Andy Watts (voting)	0
Mr David Evans (voting)	0
Mrs Claire Skidmore (voting)	0
Mrs Zena Young (voting)	0

Miss Alison Smith (voting)	0
Mrs Carolyn Fenton-West (non-voting)	0
Dr Ian Chan (non-voting)	0
Dr Jo Leahy (non-voting)	0

Three PCCC in Common meetings took place in the period 1 August 2020 to 3 February 2021. These were scheduled meetings which took place in October and December 2020, and February 2021. Two extraordinary meetings were called in November 2020 and February 2021 which are not included in these figures.

Names of Primary Care Commissioning Committee members From 1 August 2020	Meetings attended during 2020/21
Donna Macarthur from 1 October 2020	2 of 2
Meredith Vivian	3
Colin Stanford to 31 February 2021	2 of 2
Andy Watts	2
David Evans	0
Claire Skidmore	3
Steve Trenchard	1
Zena Young	2
Claire Parker	2
Attendees:	
Dr Julian Povey	3
Dr Adam Pringle	3
Dr Deborah Shepherd	2
Julie Davies	0
Nicky Wilde to 3 November 2020	1
Vanessa Barrett, Healthwatch Shropshire	3
Paul Shirley, Healthwatch Telford and Wrekin to 30	1

October 2020	
Barry Parnaby, Healthwatch Telford and Wrekin from 1 February 2021	1

The highlighted areas of the committee's reports are as follows:

- Primary care performance reporting: financial performance reporting, quality and performance monitoring, quarterly assurance and primary care information technology.
- In addition, the Primary Care Committee has overseen the development and implementation of the following during 2020/21:
- Review of Terms of Reference
- Finance update
- Quality Report
- Pharmacy workforce model
- PCN Report
- Primary Care Strategy delivery
- Court Street boundary change
- Shropcom business case – Dawley
- GP patient survey
- Risk Register
- Pontesbury/Worthen merger application
- Annual Electronic Declaration (eDEC)
- Quality Outcomes Framework
- Churchmere/Dodington merger proposal
- Primary care quarterly Quality Report.

Individual Funding Committee (IFC)

The IFC approves commissioning decisions for individual funding requests on behalf of the group. The Individual Funding Committee stood down its meetings during COVID-19 from March to August 2020. Due to a cessation of services during COVID-19, the committee has not met between 1 April 2020 and 31 March 2021.

Names of Individual Funding Committee members	Meetings attended during 2020/21
Mr Neil Maybury (Chair)	0
Dr Adam Pringle	0
Mrs Helen Onions	0
Mrs Jacqui Seaton	0

Dr Ian Chan	0
Rachael Bryceland	0
Dr Jo Leahy	0

Between 1 April 2019 and 31 March 2020, no cases were taken to the IFC for consideration and no reviews (appeals) were held during 2020/21.

Joint Individual Funding Committee

In August 2020, the CCG Governing Body created a Joint Individual Funding Committee with Shropshire CCG. The Joint Committee approves commissioning decisions for individual funding requests on behalf of the group. Due to COVID-19, it has not met during the year.

Names of Joint Individual Funding Committee members	Meetings attended during 2020/21
Ash Ahmed (Chair)	0
Dr Adam Pringle	0
Dr Mike Matthee	0
Rachael Robinson	0
Liz Noakes	0
Michele Rowland-Jones	0

The committee has not met since its creation on 1 August 2020 due to COVID-19.

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 stood down its meetings during COVID-19 from March to August 2020. The committee met six times during the period 1 April 2020 and 31 March 2021.

Names of Assuring Involvement Committee members	Meetings attended during 2020/21
Mr Patrick Spreadbury (Chair)	6
Mrs Beverley Ashton	6
John Bowden	0

Cynthia Butler	5
Mrs Valerie Dawson to 19 November 2020	1
Mrs Valerie Graham	6
Mr Neil Maybury (Lay Member PPI) to 31 July 2020	0
Anna Parkinson	6
Steven Pickavance	6
John Wardle	5
Mr Meredith Vivian (Lay Member PPI)	6

The highlighted areas of the committee's reports are as follows:

- Patient involvement – COVID-19 restoration and recovery
- Telford and Wrekin Integrated Place Partnership
- Engagement opportunities
- GP primary care communications and engagement
- Extended access survey
- Review of phlebotomy service
- COVID-19 vaccination progress
- NHS 111 services
- Complaints and PALS
- Re-installation of services (post COVID-19)
- Single strategic commissioning organisation engagement Event
- Recruitment to new Assuring Involvement Committee
- Audiology review
- Services update – COVID-19
- Musculo-skeletal services.

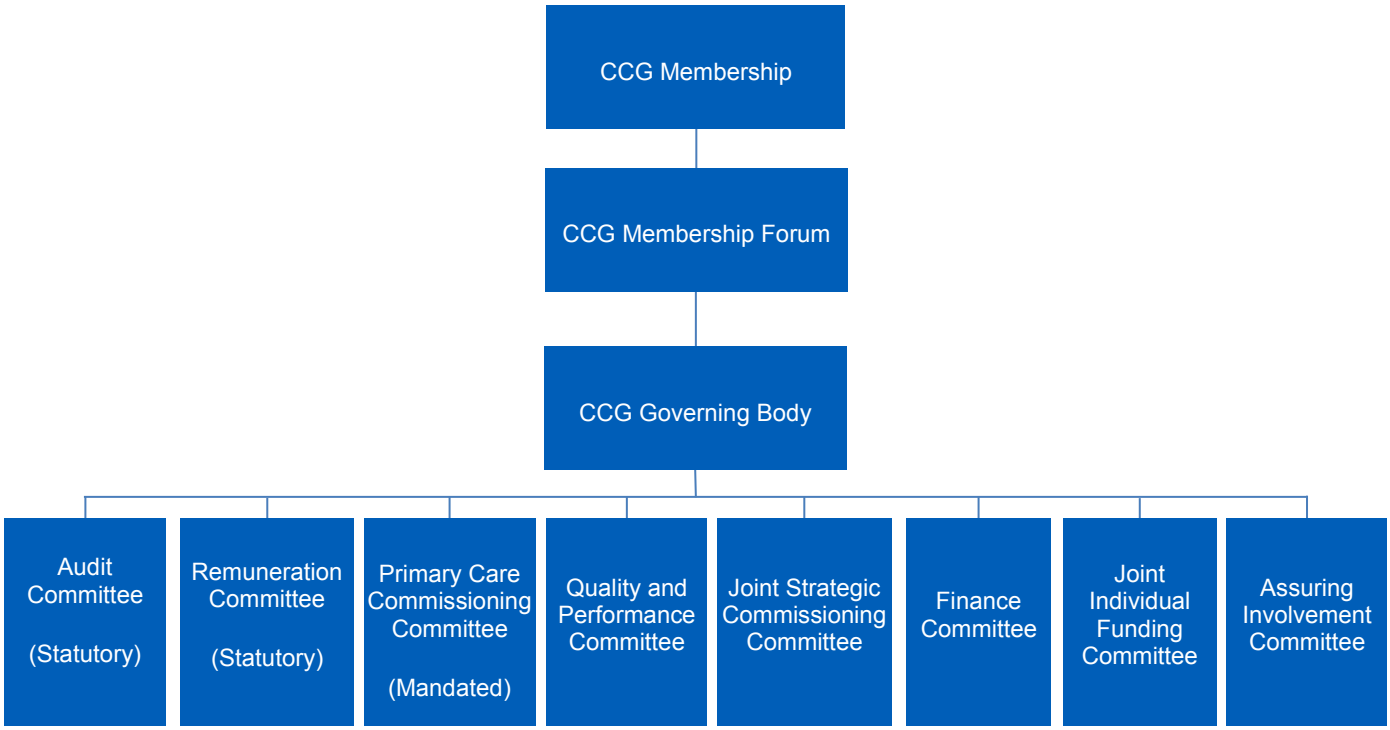
Membership of the committees and sub-committees of the CCG Governing Body is outlined in respective terms of reference which are included in the CCG's Constitution and Governance Handbook. Attendance at these meeting is recorded in the minutes of each meeting.

The CCG has reflected on its own effectiveness and performance as part the monthly assurance checkpoints undertaken by NHS England for all CCGs during 2020/21. The outcomes of these are reported to the CCG Governing Body and Practice Forum by the Chief Officer and published on the CCG's website as a year-end statement.

The CCG Governing Body has also been working with an organisational development partner to help facilitate discussions and agreement with Shropshire CCG Governing Body on the transition to a single strategic commissioner across the whole county, part of which is to

develop strong governance processes to address the forthcoming changes in commissioning and to contribute to making 20 per cent savings to the CCG's running costs as directed by NHS England and NHS Improvement. The CCG Governing Body also receives regular reporting from committees via Chair reports and for those committees with delegated decision making an Annual Report that seeks to summarise that Committees effectiveness in discharging its duties.

The governance structure for the CCG from 1 August 2020 as described in the CCG's Constitution is shown in the diagram below:



UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance. 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 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 of the clinical commissioning group'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 in order 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, but due to COVID-19 pandemic, the CCG Governing Body agreed to focus its attention during 2020/21 on the Board Assurance Framework, to assist it in both navigating a very challenging environment but to also conserve valuable staff resources.

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 wherever possible will prevent risk arising, by the application of 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 advice, information governance advice, human resources advice) and internal audit. The CCG will also employ 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 to manage 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 board and the strategy outlines the processes for maintaining and monitoring the Board Assurance Framework and the Executive 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 health care 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 risk 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 Datix 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 (newly-introduced)
- 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 Datix
- 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 principle processes and the matrix described in these documents are applied to all risk registers, incident management and risk assessment activity across Telford and Wrekin CCG.

The following processes are used to identify risks:

- Retrospectively following the occurrence of an adverse incident
- Proactively by identifying of potential risks to service delivery
- During development of new activities.

It is acknowledged that risks may be shared with other organisations that the CCG works with jointly to deliver services. Consequently, the Board Assurance Framework is discussed with risk

management leads and reflects the identified strategic risks of these organisations where appropriate.

The following details are recorded for each risk recorded 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 is as follows:

Leadership is given to the risk management process by the Chief Officer whose role is to own the Board Assurance Framework. The Board Assurance Framework which documents the principle risks to the CCG's objectives not being delivered, is underpinned by the Executive Risk Register. This outlines the lower level risks to each executive lead not meeting the 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 Executive 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.

In November 2020, the CCG together with Shropshire CCG agreed to create a joint interim Board Assurance Framework in order to support the newly-appointed joint governing body members on both Governing Bodies to focus on the strategic risks facing both CCGs during a pandemic situation. A summary of the major risks identified in this interim joint Board Assurance Framework is set out below and the actions being taken to mitigate the risks. The major risks to the CCG have been reviewed and revised where necessary every quarter and then presented to Audit Committees in Common and the CCG Governing Bodies.

Description of joint Interim major risks added to the Board Assurance Framework during 2020/21	Existing controls	Further actions
Underlying financial position is currently a 9.8 per cent deficit (compared to recurrent allocation): There is a risk that the CCGs fail to deliver their financial plans for 2020/21 and that the underlying position going forward significantly deteriorates.	Detailed 2020/21 financial year to date and forecast reporting in place. QIPP Programme Board meeting monthly to monitor delivery of savings and action plans. Constitution / Prime Financial policies etc. in place and communicated across organisation. Regular budget meetings with budget holders and both budget manager handbook and regular training programme in place.	CCG Financial Strategy accepted by NHSE/I for authorisation process and signed off by Finance Committee in January 2021. The strategy will now be updated going forward in line with the development of the System Financial Plan. Update on this to be taken to April Finance Committee. System Long Term Financial Sustainability Plan to be updated by 31 March 2021, to include implementation plans from programme boards to address priorities and inclusion of COVID-19 recovery trajectories. Awaiting detailed planning guidance for 2021/22 and plans and budgets to be developed in line with this for reporting to Board in March/ May 2021. Continuing Healthcare (CHC) Action Plan in place and discussed with CFO and AO. Action plan is progressing and CHC team are reviewing QIPP plans for 2021/22 although the COVID-19 pandemic is still posting a risk. The recent internal audit report notes progress and evaluation scheduled for April 2021.
Quality and Safety: If the CCGs fail to commission safe, quality, services for their populations then there is a risk that patients will come to harm, that regulatory action or commissioning decisions will result in closure of services, with our population having to access services out of county, and a risk of adverse publicity.	1. CCG attendance at all providers quality and contract monthly meetings. RAP in key areas of concern including emergency departments, maternity, ophthalmology, diagnostics, neurology, cancer waits, referral to treatment, mental health, Looked After Children. 2. Monthly Serious Incident Review Group (SIRG) for each provider. 3. Monthly internal CCG SIRG. 4. Quality visit schedules for all providers, primary care	Continue to monitor workforce plans and risks at provider Certified Quantitative Risk Management (CQRM). 2, 3, 6, 7, 8, 9 – undertake themed reviews for both individual providers and system quality concerns and issues. Maintain a schedule of quality assurance visits, with triangulation of data from a variety of sources, including increased inclusion of patient experience elements. Further develop the maternity metrics dashboard by May 2021. Evidence to support maternity Clinical Negligence Scheme for Trusts (CNST) submission to be reviewed and validated by CCG by July 2021. Implement / embed a system-wide approach to

	and care homes Currently on hold due to COVID pandemic. 5. Infection prevention and control (IPC) health economy meetings and attendance at IPC committees and outbreak meetings. 6. NHSE/I Oversight and Assurance process in place with agreed support. 7. Regular monitoring re workforce including mandatory training, supervision, sickness, absence and vacancy rates for all providers. 8. CCG Quality Strategy and associated delivery programme.	quality improvements – Quality Surveillance Group, Patient Safety Group, Medicines Safety Group, which aligns to NHSE requirements (when published) to allow shared view of quality and appropriate escalation both within and external to system. By May 2021.
NHS Constitution Performance Targets: There is a risk that the CCGs fail to meet the NHS Constitution performance targets consistently.	CCG attendance at: Monthly Planned Care Working Groups – temporarily stood down due to COVID. Fortnightly Urgent and Emergency Care (UEC) Delivery Group. Fortnightly SaTH Cancer Performance meeting. Monthly provider contract meetings – temporarily stood down due to COVID.	Team staffing update – did not recruit to Deputy post – looking for interim while go out to external add in March. Analysts in post now and one performance assurance manager in post for elective and cancer. Agree key elements of A&E improvement plan at UEC Delivery Group by end March (delayed due to COVID wave 3). Working across system to get single performance framework and single reporting through system PMO delayed due to COVID wave 3. MLCSU supporting integrated performance reporting from March until system solution in place. Maximising use of all available system capacity for cancer and urgent elective care through to the end of March 2021 and beyond as required. Performance assurance manager doing deep dives into performance by tumour site to support delivery of 62-day referral to treatment. Already supported recovery in two-week breast cancer. Minimal improvement in referral to treatment times this year due to COVID, so mitigation is not sufficient to improve overall risk score this financial year – listed mitigation should slightly improve A&E performance and help maintain

		cancer performance and deliver required improvement in two-week measure by year-end.
COVID 19 Emergency Preparedness Resilience and Response (EPRR): There is a risk that the CCGs fail to manage with partner organisations the local health system response to COVID-19 second wave.	Gold Command Silver Command COVID-19 workstream Task and Finish Groups	Full programme in place to address all elements of COVID-19 response. System incident response structure in place and operational. Continued system approach to managing the incident as it evolves. Ongoing demand and capacity work to track impact in real time and inform decision making. Continued evaluation of surge planning. Ongoing discussions across region regarding mutual aid as well as with the Independent sector. Memorandum of Understanding in place to support re-deployment of staff. Prevalence rates now declining significantly and hospital admissions also continuing to decline. De-escalation plan in place and enacted relating to exit from third COVID wave.
Restoration of health services following COVID-19 third wave: There is a risk that the CCGs fail to take account of best practice and learning during COVID 19 response in the planning for future health needs.	Gold Command Silver Command COVID-19 workstream Task and Finish Groups System Transformation Delivery Group System Planning and Performance Group Use of Microsoft Teams as repository for all COVID-19 related information	Commitment via Gold and Silver Command to embrace new ways of working and where possible encourage the implementation of innovative ideas and solutions. Learning outputs presented to Silver and Gold as and when appropriate. Full debrief will be carried out following stepping down of incident response as part of usual EPRR process. System Improvement Plan developed and in implementation stage. To be addressed as part of single strategic commissioner organisational development work as well as through programme to develop the ICS. Prioritisation of critical tasks at height of pandemic will inevitably mean that change will focus on the immediate and necessary tasks to manage patient care and learning will be captured as a reflective piece at a later date. De-escalation plan enacted and repatriation of staff taking place and/or planned. Modelling work underway for restoration of services alongside mapping of staff resource required for delivery. Likely that restoration will present significant capacity issues.
Patient and public involvement: There is a risk that	Communications and Engagement (C&E) Strategies.	Draft communications strategy submitted to NHSE/I by 25 January 2021 deadline, no further comments received. Further final version to be

the CCGs fail 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.	C&E teams working jointly across both CCGs providing expertise in planning and delivery. Reports to Governing bodies/Committees require section completing on patient involvement. Decisions at STP level on restore of services require equality and engagement plans to be completed. Presence of Healthwatch for both areas at Governing body meetings/JSCC and Quality Committees. Joint Lay Member for PPI and Joint Associate Lay Member for PPI – Equalities, Diversity and Inclusion in place on Governing Bodies to act as specific check and balance. Patient engagement events delivered January 2020, December 2020 and March 2021 as per single strategic commissioner C&E Plan. Interim Director of C&E appointed for ICS/CCG to provide strategic direction and development whilst recruitment of substantive role is undertaken.	submitted 31 March 2021. Management of Change (MOC) for staff due to complete in March 2021. Band 7 vacancy now filled, Admin role still awaiting MOC to be finalised before any external recruitment can begin. Interim ICS/CCG Director of C&E will lead piece of work to review STP team work coming over to CCG team. Recruiting to an ICS/CCG Director of Communications and Engagement.
Single strategic commissioner: There is a risk that the CCGs fail to provide system leadership and the delivery of system transformation.	ICS Shadow Board Chief Executives Group STP Programme Boards CCG Directors weekly meeting Commissioning Strategy Operating Model Project plans for delivering required changes Agreement from system to have single leadership model	Recruitment of a single Accountable Officer for CCG and STP by March 2021. PMO programme management website to be updated with comprehensive project plans for all STP priorities by November 2020. Full ICS Development Plan finalised. Development of appropriate accountability framework that accommodate whole system and place-based commissioning.

	for ICS and CCG	
Population needs: There is a risk that the CCGs fail to understand their populations needs that contribute to health inequalities across the county.	Population Health Management (PHM) portfolio priority for Director of Planning. Partnerships and relationships developing with key stakeholders. JSNA for Shropshire, Telford and Wrekin. Health inequalities system strategy overseen by Director of Partnerships and feeds into governance of Care Closer to Home Programme Board. Links with patient, parent and carer groups to embed specific groups i.e. SEND, children's, mental health into strategies.	MLCSU Strategy Unit undertaking system review of BI capacity and capability to provide recommendations on future system model for BI including PHM. 2 x PHM posts in new CCG structure, each to be a joint post with our two local authorities Engagement strategies being developed with the Shropshire Care Closer to Home and TWIPP boards. Joint posts with local authority to develop partnership and place based working to deliver the needs of the population. Assurance. PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. Funding requirement linked to output of the MLCSU Strategy Unit review.
ICS development: There is a risk that the CCGs fail to support and lead the development of ICS/ICP which then compromises the capacity and capability of a new single CCG in the future.	CCG AO is interim ICS Lead Director.	ICS Plan to gain authorisation has been developed. Checkpoint meetings with NHSE/I. Monitoring through the ICS Shadow Board.
Sustainable services: If CCGs fail to maintain sustainable acute services within the county, there is a risk that patients will have to receive healthcare outside of the county. There is a risk of clinical safety associated with longer travel times. There is a risk	1. Current contract and quality monitoring arrangements including: CQRM (including workforce reports) QA visits SI reporting and meetings monthly Monitoring of NHS to NHS concerns. Staff survey.	Robust monitoring of workforce modelling – recruitment and retention plans. The People Board continues to identify and plan for the workforce gaps across the STP footprint. The CCG is an active part of this process. Escalate to NHSE/I, Board, PSG, as appropriate. Ongoing Local QSG in development to ensure a system approach to quality and demand issues by May 2021. System Planning and Performance Group now in place.

of adverse publicity.	Friends and Family Test. Patient experiences and stories. 2. Fortnightly ED/ SaTH Assurance call with Exec / SMT leads. 3. Monthly Shrewsbury and Telford NHS Hospital Trust Oversight and Assurance Group (SOAG) meetings to drive system approach to support in relieving the pressure at the front and back door of SaTH. 4. During COVID, the quality team have been working with the Trust's quality team, joining Exemplar visits. 5. Informal drop-in / ad-hoc visits take place as required based on horizon scanning of soft intelligence, data, SIs, NHS to NHS concerns, complaints etc.	Continue to attend SOAG and gain assurances required in relation to all ED concerns. Ongoing. Both CCGs, via the current control mechanisms, will continue to robustly encourage SaTH to make improvements across the trust to achieve improvements on all quality key indicators. Continue with enhanced monitoring and surveillance as per quality assurance framework. Oversight of quality management processes at the Trust continues via CQRM. Agree system quality matrix, Triangulation with CQC and NHS Improvement. Continuously review the assurance calls template/ data capture to provide assurances that the Emergency Departments are providing safe care and are appropriately staffed. Continue to support and challenge implementation of CQC action plans. The CCG is working closely with the Trust, NHSE/I, emergency care improvement support team (ECIST) and partners to provide support and challenge in driving forward the measures required to improve. The CCGs continues to offer direct support to SATH's safeguarding governance and operational processes. This has involved embedding the CCG named nurse for adult safeguarding within the Trust and this work is progressing positively. All actions ongoing.
EU Exit: There is a risk that the CCGs fail to manage the impact of EU Exit on the adequacy of patient care.	1. CCG attendance at all regional and national pharmacy leads briefings. 2. National planning and stockpile of medicines to ensure supply over first stages of EU Exit. 3. National shortage supply protocols implemented. 4. Medicines team will support practices with information and to respond to shortages. 5. Prescription Ordering	System EU Exit Lead in place and organisation integrated care communities in place to receive communications and directives from NHSE/I. System Procurement and Supply Chain Task and Finish Group meeting regularly and providing updated to Silver Command twice a week as well as a weekly SitRep. System will continue to monitor the position as it develops and request input / flag issues as required. No issues experienced locally and minimal nationally. Daily EU Exit SitReps now stood down at weekends for CCGs.

	Department can be utilised to shorten prescribing duration to ensure stock is equitable distributed. 6. Financial impact on NCSO and Cat M price changes are monitored monthly. 7.System EU Exit Lead identified. 8. Engagement with NHSE/I on EU Exit planning. 9. System procurement and supply chain Task and Finish Group in place.	

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 2020/21 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 Policy 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:

- Constitution
- Risk management
- 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 Board and its committees / sub-committees
- Safeguarding Annual Report
- Emergency and Business Continuity Planning / core standards
- External regulator reports on providers.

Annual audit of conflicts of interest management

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 significant assurance, with no recommendations for further action.

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 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, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG other organisations and to individuals that personal information is dealt with legally, securely,

efficiently and effectively. Telford and Wrekin CCG is compliant with the standards set out in the IG Toolkit for 2020/21.

The CCG places high importance on ensuring there are robust information governance 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 IG toolkit. 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 investigation of serious incidents. We have reported a total of five incidents during 20/20/21. The scoring for IG breaches changed from 0-2 to Reportable or Non reportable, All of 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 NHS Midlands and Lancashire CSU. This enables us to receive a full specialised service which as a small organisation we could no reproduce in-house. A work programme has been undertaken by MLCSU in order 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.

During 2021/22, the CCG will continue to move towards having a fully embedded information risk culture throughout the organisation and retaining its IG compliance in preparation for transition to an ICS in 2022.

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 be shared with the Analytical Oversight Committee.

Third party assurances

Third party assurances are received annually from MLCSU for particular financial functions which are part of a Service Level Agreement. Processes are in place to ensure that the CSU Internal Audit function shares its own audit findings of these functions with the CCG's internal auditor who includes a precis of the findings in the Head of Internal Audit Opinion which is part of this statement. There have been no limited findings from last year's reports which would require remedial action.

Raising Concerns – Whistleblowing

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 2020/21. The Audit Committee gets an annual report on any concerns raised and action taken protecting anonymity where required. The new single CCG has appointed a Speak Up Guardian at Board level to support staff to raise concerns under the policy moving forward.

Control issues

The significant control issues that have materialised during 2020/21 that would require reporting in this Annual Governance Statement are as follows:

1. Financial Deficit

Due to the COVID-19 pandemic, the financial regime for 2020-21 has been very different to any normal year. In the first six months of 2020/21, the CCG was given a budget to operate within based on 2019/20 spend with a small uplift, any variances from this budget for either COVID or non COVID expenditure were then funded retrospectively so that for the first six months of the year the CCG reported a break even position. In the second six months of 2020/21, the CCG was again given a budget to operate within based on 2019/20 spend plus a small uplift plus an additional allocation assuming that non COVID overspends in the first six months of the year would continue into the second six months. The CCGs were also given system level funds to support COVID expenditure and any growth across the system. There was a clear expectation that organisations and systems would manage within this funding and report a break even position.

The CCG has ended the year with a £1.3m deficit against the budget allocated. This deficit will take the cumulative deficit carried into 2021/22 to a total of £7.4m.

As the CCGs come together to become a single commissioning organisation, the focus for both the CCG and the wider system is addressing the underlying financial position. The current assessment of the underlying financial deficit for the newly combined CCG in 2020/21 is £71m deficit. The system is currently working together to develop a sustainable financial plan that delivers stabilisation during 2021/22 and then improvement through transformation schemes from 2022/23 onwards.

Running costs have exceeded its resource limit this year due to non-recurrent costs relating to the development of a single commissioner. In working towards the creation of a single strategic commissioning organisation with Telford and Wrekin CCG, a new staffing structure has been implemented and is in the final stages of the management of change process so that for 2021/22, the CCG is intending to operate within its new lower running cost allocation. In addition, the CCG has all but eliminated the use of interim staff.

2. Quality issues at local providers

The CCG continues to work with the trust to manage significant performance and quality issues in year in relation to its acute provider, which is in special measures for quality, particularly relating to ED, maternity care and more recently care of children and young people presenting with mental health conditions, and is assessed as inadequate for leadership at organisational level, which includes quality governance concerns.

The CCG has a range of inputs to the provider to aid improvement and will be implementing revised system quality governance arrangements during the next reporting period, including strengthening the role of our Local Maternity and Neonatal System (LMNS) to have oversight of perinatal mortality and safety.

A&E performance continues to be poor, with associated issues relating to 12-hour breaches and ambulance delays over one hour. These have been made worse by additional pressures of the COVID-19 pandemic including the reduced bed base as a result of infection, prevention and control and cohorting challenges. Also as a result of the pandemic, the local cancer and 18-week referral to treatment performance has been affected. The CCG now has a number of patients waiting longer than 52 weeks, which prior to the pandemic was zero. The CCG is working with all providers to ensure patients waiting are kept under regular clinical review and clinically prioritised at a system level. Detailed improvement plans are being worked on with providers in preparation for the end of the pandemic and the start of the recovery period and these will be reported through the CCG's Quality and Performance Committee and the emerging ICS governance structure to ensure a more coordinated approach to performance. The work around performance continues to be supported by NHSE/I.

3. COVID-19 pandemic

A further significant control issue is that 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 and which is still in place.

The CCG in partnership with NHS Shropshire CCG and other key stakeholders continues to lead the local health resilience partnership (LHRP) response to the emergency across Shropshire and Telford and Wrekin. Some clinical staff continue to be redeployed to frontline services to support the significant challenge that COVID-19 has had. Non-clinical CCG staff also continue to be redeployed into identified critical services or have been trained to provide back-up to these services to cover any staff shortages. The CCG has led on the restoration of services following the first national lockdown.

Review of economy, efficiency and effectiveness of the use of resources

The Finance Committee and Quality and Performance Committee gives 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 Programme Management Sub-committee, performance against central management costs and efficiency controls. Both committees report to the Governing Body via a Chair's exception report on a monthly basis.

The Governing Body in addition receives summary financial reporting at each meeting.

The internal audit plan also provides reports to 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 of 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 Counter Fraud Specialist, contracted to undertake counter fraud work proportionate to the CCG's identified risks.

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

The 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.

Head of Internal Audit (HOIA) opinion

The purpose of my annual HOIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This opinion will in turn assist the Governing Body in the completion of its Annual Governance Statement.

My **overall opinion** is that:

Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

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

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes

2. An assessment of the range of individual opinions arising from risk based audit assignments, contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses

3. Any reliance that is being placed upon third party assurances.

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

The design and operation of the Assurance Framework and associated processes

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

created a joint BAF with Shropshire CCG which should help establish controls and risk management in the new commissioning organisation. Whilst broader control arrangements were in place the BAF was not always fully updated and 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 2020/21 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The system of internal control based on internal audit work undertaken

My opinion also takes into account the range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. A revised internal audit plan for 2020/21 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:

Significant Assurance	• Financial Governance (Covid19) • Financial Systems (Debtors, Ledger and Payroll) • Conflicts of Interest Management • Primary Care Commissioning (Finance) • Financial Systems (Accounts Payable)

- Data Protection and Security Toolkit (the CCG plan to submit in June 2021 – Moderate Confidence based on DPST guidance)
- Board Assurance Framework – Level A – with recommendations for improvement including to keep updated
- Governance Arrangements – COVID-19 in support of the Head of Internal Audit Opinion
- Organisational Preparedness – Committees of the Board Effectiveness.

Other

COVID-19 Governance

In order to help issue the Head of Internal Audit Opinion without extensive limitations in this extraordinary year, an additional high-level review of the governance around some of the key controls was undertaken. The review was designed to help provide the required assurance for the organisation whilst minimising inputs from key staff who are likely to be actively engaged in managing the impacts of the pandemic, it did not therefore provide an assurance level for each area considered.

The CCG has responded well to the challenge of achieving governance during the pandemic. We noted the development and implementation of a robust incident management structure with Shropshire CCG which has been subject to internal review and revision during the course of the pandemic – particularly in light of the second wave. We were advised by the Director of Planning on 11 February 2021 that there have been no significant weaknesses specific to the CCG for which we would need to be made aware of with regard to the response.

We noted a clear process was established to support the completion of staff risk assessments in order to ensure that appropriate mitigations were put in place for staff who are unable to work from home during the pandemic and for those identified as 'at risk'.

We noted that appropriate governance arrangements were maintained during the course of the pandemic with regular meetings of the Governing Body and Committees of the Board continuing to be held for the period reviewed, with key areas being reported on at each meeting. SitRep arrangements were also considered to be appropriate.

We confirmed as part of our Financial Governance review completed in July that no changes were made to the CCG's Standing Financial Instructions, Scheme of Delegation/Delegated limits and this was reported to the Audit Committee in June 2020. Our review noted a paper on 'Review of Governance Arrangements in Response to COVID-19' was presented to the Governing Body meetings of both Shropshire CCG and Telford and Wrekin CCG in May 2020. The paper proposed the stepping down a number of committees to a different regularity and to move to virtual meetings in response to COVID-19. Governing Body meetings were to remain as bi-monthly but with a reduced agenda focussing on assurance from committees, COVID-19 response updates, Governing Body Assurance Framework and strategic or investment decisions that need to be made in the period. The proposed arrangements were agreed at the May Governing Body meetings and in July, following a further update paper presented to both meetings it was agreed for governance arrangements to be reverted back from August.

Financial position

There is an underlying significant system deficit which predominantly sits with the neighbouring Shropshire CCG and its main provider SaTH. This position is recognised in the STP in their System Operational Plan of April 2019 which will support the development of the Integrated Care System.

The financial position in 2020/21 for both Telford and Wrekin CCG and Shropshire CCG is particularly complicated with significant non recurrent funds received to operate a break even process during Months 1-6 and significant system non recurrent pass through allocations in Months 7-12. The CCGs (Shropshire CCG and Telford and Wrekin CCG) reported that the underlying position reported to the system was calculated at Month 7 as a £78m underlying deficit (2019/20: £65.3m) which mostly related to Shropshire CCG. It was reported that if this was adjusted for prescribing and individual commissioning Month 8 FOT improvements, the joint position showed a £74.3m underlying deficit. The underlying position was still being reviewed both internally and in discussions at a system level with providers. There was particular focus on whether all COVID spend is non-recurrent.

Following up of actions arising from our work

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

The Audit Committee is proactive in monitoring actions and during the year there has been good progress in relation to implementing recommendations that the Audit Committee are responsible for overseeing.

Reliance on third party assurances

At the time of providing this opinion we have not received third party assurances in relation to outsourced services provided by NHS Shared Business Services and NHS Midlands and Lancashire Commissioning Support Unit. I therefore reserve the right to revise my overall opinion in the event that these reviews identify any significant control failings that would impact on the CCG.

There are a number of significant and persistent quality challenges that the system has struggled to see significant traction and sustained improvement in. These challenges have included amongst others A&E, 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. Shropshire CCG has been the main commissioner for Shrewsbury and Telford Hospital NHS Trust (SaTH). On 8 April 2020, the CQC published their report on Shrewsbury and Telford Hospital NHS Trust (SaTH).

The ‘inadequate’ rating was assessed as remaining in place with no assessment areas improving and two areas rated by CQC worse than the last inspection. The first part of the Ockenden Report (Maternity Services) has been issued which highlights local actions for learning and immediate and essential actions. The second report is expected next year. The CCG have advised (November 2020) that the CQC have confirmed to SaTH that sustained improvements have resulted in the two S31 conditions relating to maternity services being lifted and reporting requirements reduced. The future single commissioning organisation will have plenty to focus on as part of system reconfiguration.

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 clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

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 review / assurance mechanisms.

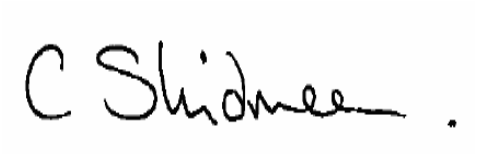
This has been a challenging year for the CCG; leading the system response to the COVID 19 pandemic, preparing the CCG for its transition into a newly-created CCG on 1 April 2021, addressing the significant financial issues across our system and the continuing quality challenges of some of our providers.

I have put in place a series of actions to address these issues which are discussed in more detail in the body of the Annual Report.

Conclusion

In conclusion, although the CCG still maintains a generally sound system of internal control, designed to meet the organisation's objectives, and controls are generally being applied consistently, during 2020/21 the CCG has continued to see significant financial challenges which has resulted in the CCG being unable to meet its duty to breakeven for 2020/21.

The CCG is taking steps with its partners and supported by NHS England and NHS Improvement to develop a system finance plan which will seek to address the total system financial deficit over the next five years.



Claire Skidmore
Interim Accountable Officer
14 June 2021

REMUNERATION AND STAFF REPORT

Remuneration Report

Remuneration Committee

The Remuneration Committee was established by 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 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.

NHS Midlands and Lancashire Commissioning Support Unit provide independent advice and support to the CCG and the Remuneration Committee in relation to employment and remuneration matters.

Remuneration report tables – pension and salary (subject to audit)

Salaries and allowances 2020/2021

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	0-5	-	-	-	-	0-5
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

* Not in the NHS Pension scheme in this employment

Note on exit packages

The following Board Members received the following redundancy payments in 2020/21 due to a restructuring of the Governing Body in preparation for the creation of a single commissioning organisation on 1st April 2021:

J Cooke £20k

These payments are not included in the values disclosed in these tables and exclude any applicable employers NI costs. Details of exit packages (including employers NI costs), are disclosed in Note 4.3 of the annual accounts.

Explanation of Joint Arrangements with Shropshire CCG

During 2020/21 Telford & Wrekin CCG and Shropshire CCG undertook a management of change process in preparation for the creation of one single commissioning organisation with effect from 1st April 2021. Part of this process was the formulation of a joint Governing Body and all Director roles became joint posts across the 2 CCGs with effect from 1st April 2020. The remaining Governing Body roles became joint points with effect from 1st August 2020.

The total cost of remuneration across both CCGs is shown below. This is in respect of the period of joint working only (where applicable):

SURNAME	FIRST NAME	POST	TOTAL REMUNERATION (Bands of £5,000)
Ahmed	Ash	Lay Member - Joint post with Telford & Wrekin CCG wef 01/08/20	5-10
Allen	Martin	Secondary doctor member - Joint post with Telford & Wrekin CCG wef 01/08/20	5-10
Braden	Geoff	Lay Member - Governance & Audit - Joint post with Telford & Wrekin CCG wef 01/08/20	5-10
Bryceland	Rachel	GP Governing Body Member - Joint post with Telford & Wrekin CCG wef 01/08/20	20-25
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG	105-110
Evans	David	Accountable Officer - Joint post with Telford & Wrekin CCG	145-150
James	Stephen	Interim Chief Clinical Information Officer - Joint post with Telford & Wrekin CCG	55-60
Macarthur	Donna	Lay Member - Joint post with Telford & Wrekin CCG wef 01/10/20	0-5
Matthee	Michael	GP Governing Body Member - Joint post with Telford & Wrekin CCG wef 01/08/20	15-20
McCabe	Julie	Nurse Member - Joint post with Telford & Wrekin CCG 01/08/20-31/01/21	0-5
Parker	Claire	Director of Partnerships - Joint post with Telford & Wrekin CCG	100-105
Pepper	John	GP Governing Body Member - Joint post with Telford & Wrekin CCG wef 01/08/20	15-20
Povey	Julian	Chair (Clinical) - Joint post with Telford & Wrekin CCG wef 01/08/20	60-65
Pringle	Adam	GP Governing Body Member - Joint post with Telford & Wrekin CCG wef 01/08/20	15-20
Shepherd	Deborah	Medical Director - Joint post with Telford & Wrekin CCG wef 01/08/20	45-50
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG	130-135
Smith	Alison	Director of Corporate Affairs - Joint post with Telford & Wrekin CCG	105-110
Smith	Fiona (Danella)	GP/Healthcare Professional Member - Joint post with Telford & Wrekin CCG wef 01/08/20	15-20
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG	105-110
Timmis	Keith (Andrew)	Lay Member - Governance & Audit - Joint post with Telford & Wrekin CCG wef 01/08/20	5-10
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CCG	120-125
Turner	Gary	Lay Member - Joint post with Telford & Wrekin CCG 01/08/20-30/08/20	0-5
Vivian	Meredith	Lay Member - Patient & Public Involvement - Joint post with Telford & Wrekin CCG wef 01/08/20	10-15
Young	Zena	Executive Director of Quality - Joint post with Telford & Wrekin CCG	115-120

Salaries and allowances 2019/2020

2019/20									
	Name	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments taxable (bands of £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
	Jon Cooke	Chief Finance Officer	01/04/19 to 31/12/19	75-80	0	0	0	0	75-80
	Jon Cooke	Interim Director	01/01/20 to 31/03/20	25-30	0	0	0	0	25-30
	Claire Skidmore	Executive Director of Finance	01/01/20 to 31/03/20	15-20	0	0	0	10.0-12.5	25-30
	David Evans	Accountable Officer	01/04/19 to 30/09/19	60-65	0	0	0	0.0-2.5	60-65
	David Evans	Accountable Officer - Joint post with Shropshire CCG	01/10/19 to 31/03/20	35-40	0	0	0	0.0-2.5	35-40
	Fran Beck	Executive Lead Commissioning	01/04/19 to 31/12/19	70-75	0	0	0	17.5-20.0	85-90
	Fran Beck	Interim Director - Joint post with Shropshire CCG	01/01/20 to 31/03/20	10-15	0	0	0	2.5-5.0	10-15
	Julie Davies	Director of Performance - Joint post with Shropshire CCG	01/01/20 to 31/03/20	10-15	0	0	0	7.5-10.0	20-25
	Christine Morris	Executive Nurse Director	01/04/19 to 31/05/19	15-20	0	0	0	15.0-17.5	30-35
	Christine Morris	Executive Nurse Director - Joint post with Shropshire CCG	01/06/19 to 31/12/19	30-35	0	0	0	27.5-30.0	60-65
	Christine Morris	Interim Executive Director of Quality - Joint post with Shropshire CCG	01/01/20 to 31/03/20	10-15	0	0	0	10.0-12.5	25-30
	Alison Smith	Director of Corporate Affairs	01/04/19 to 31/12/19	70-75	0	0	0	17.5-20.0	90-95
	Alison Smith	Director of Corporate Affairs - Joint post with Shropshire CCG	01/01/20 to 31/03/20	10-15	0	0	0	2.5-5.0	15-20
	Jessica Sokolov	Executive Director of Transformation - Joint post with Shropshire CCG	01/01/20 to 15/03/20	10-15	0	0	0	2.5-5.0	15-20
	Samantha Tilley	Director of Planning - Joint post with Shropshire CCG	01/01/20 to 31/03/20	10-15	0	0	0	20.0-22.5	30-35
	Steven Trenchard	Interim Executive Director of Transformation - Joint post with Shropshire CCG	16/03/20 to 31/03/20	0-5	0	0	0	0.0-2.5	0-5
	Dr Martin Allen	Board Secondary Care Clinician	01/04/19 to 31/03/20	5-10	0	0	0	0	5-10
	Mr Geoff Braden	Board Lay Member Governance	01/04/19 to 31/03/20	5-10	0	0	0	0	5-10
	Dr Rachael Bryceland	Board Member Primary Healthcare Professional	01/04/19 to 31/03/20	35-40	0	0	0	272.5-275.0	305-310
	Dr Kwok Chan	Board GP Member	01/04/19 to 31/03/20	35-40	0	0	0	147.5-150.0	185-190
	Dr Jo Leahy	Chair	01/04/19 to 31/03/20	90-95	0	0	0	0	90-95
	Tracey Slater	Board Secondary Care Nurse	01/04/19 to 31/08/19	5-10	0	0	0	0	5-10
	Peter Easthaugh	Board Lay Member - Primary Care	01/04/19 to 31/03/20	5-10	0	0	0	0	5-10
	Carolyn Fenton-West	Board Member Primary Healthcare Professional	01/04/19 to 31/03/20	30-35	0	0	0	0.0-2.5	30-35
	Neil Maybury	Board Lay Member - PPI	01/04/19 to 31/03/20	5-10	0	0	0	0	5-10
	Dr Adam Pringle	Board GP Member	01/04/19 to 31/03/20	35-40	0	0	0	60.0-62.5	95-100

Pension benefits (subject to audit)

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

Pension Entitlements of Senior Managers 2020/21

Surname	Forename		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021 £'000	Cash Equivalent Transfer Value at 1 April 2020 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Bryceland	Rachel	GP Governing Body Member	0-2.5	(25)-(27.5)	15-20	25-30	238	366	-135	0
Bryceland	Rachel	GP Governing Body Member - Joint post with Shropshire CCG								
Chan	Kwok	GP Governing Body Member	0-2.5	0-2.5	10-15	0-5	129	122	5	0
Cooke	Jonathan	Interim Director	15-17.5	37.5-40	40-45	85-90	733	421	305	0
Fenton West	Carolyn	GP Governing Body Member	0-2.5	(25)-(27.5)	10-15	20-25	259	394	-142	0
Parker	Claire	Director of Partnerships - Joint post with Shropshire CCG	0-2.5	(5)-(7.5)	25-30	40-45	483	475	-0	0
Pringle	Adam	GP Governing Body Member	0-2.5	0-2.5	10-15	30-35	249	235	10	0
Pringle	Adam	GP Governing Body Member - Joint post with Shropshire CCG								
Smith	Alison	Director of Corporate Affairs - Joint post with Shropshire CCG	2.5-5	0-2.5	35-40	0-5	529	453	68	0
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Shropshire CCG	0-2.5	0-2.5	15-20	0-5	229	234	-9	0
Young	Zena	Executive Director of Quality - Joint post with Shropshire CCG	10-12.5	32.5-35	45-50	145-150	1,146	845	286	0

2019/20								
Name and Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age(bands of £2,500) £'000	Total accrued pension at pension age 31 March 2020 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2019 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2020 £'000	Employers contribution to stakeholder pension
Jon Cooke - Chief Finance Officer	(7.5)-(10.0)	(32.5)-(35.0)	20-25	45-50	594	0	421	0
Jon Cooke - Interim Director								
David Evans - Accountable Officer	0.0-2.5	0.0-2.5	40-45	125-130	0	191	191	0
David Evans - Accountable Officer - Joint post with Shropshire CCG								
Fran Beck - Executive Lead Commissioning	0.0-2.5	10.0-12.5	40-45	130-135	0	0	0	0
Fran Beck - Interim Director								
Christine Morris - Executive Nurse Director	5.0-7.5	15.0-17.5	40-45	125-130	803	135	956	0
Christine Morris - Executive Nurse Director - Joint post with Shropshire CCG								
Christine Morris - Interim Executive Director of Quality - Joint post with Shropshire CCG								
Alison Smith - Director of Corporate Affairs	0.0-2.5	0	30-35	0	407	36	453	0
Alison Smith - Director of Corporate Affairs - Joint post with Shropshire CCG								
Carolyn Fenton West - Board Member Primary Healthcare Professional	0.0-2.5	(0.0)-(2.5)	15-20	45-50	372	13	394	0
Dr Adam Pringle - GP Board Member	2.5-5.0	5.0-7.5	10-15	25-30	167	64	235	0
Dr Rachael Bryceland - Board Member Primary Healthcare Professional	10.0-12.5	32.5-35.0	20-25	55-60	150	213	366	0
Dr Kwok Chan - Board GP Member	7.5-10.0	0	10-15	0	34	87	122	0

Compensation on early retirement or for loss of office (subject to audit)

Telford and Wrekin CCG does not have any to report during 2020/21, (nil in 2019/20).

Payment to past members (subject to audit)

Telford and Wrekin CCG does not have any to report during 2020/21, (nil in 2019/20).

Pay multiples (subject to audit)

This section of the annual report is subject to audit and will be referred to in the audit opinion.

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

The banded remuneration of the highest paid Member in the organisation in the financial year 2020-21 was £146,495 (2019-20, £145,000). This was 3.51 times (2019-20, 3.89) the median remuneration of the workforce, which was £41,723 (2019-20, £37,267). The movement in the ratio compared to 2019-20 is due to an increase in the number of staff on higher banded agenda for change payscales in 2020/21.

In 2020-21, 0 (2019-20, 0) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £19k to £146k, (2019-20 £18k- £145k).

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

Redeployment of staff for COVID work

The following categories of CCG staff were redeployed for COVID work during 2020/21:

1.00wte Band 5 (Administrative/managerial support) – duration three months

1.00wte Band 7 (Administrative/managerial support) – duration four months

These were short-term redeployments and the average duration was 3.5 months.

Staff Report (subject to audit)

The CCG has employed a headcount of 116 staff during 2020/21. This is equivalent to 82.69 WTE.

Staff Analysis by Gender as at 31.03.21 (Headcount)

Staff Analysis by Gender (based on staffing at 31.03.2021 - Extracted from ESR 19.04.2021)

	Headcount by Gender			% by Gender	
Staff Grouping	**Female**	**Male**	**Totals**	**Female**	**Male**
Governing Body	10	11	**21**	47.6%	52.4%
Other Senior Management (Band 8C+)	13	5	**18**	72.2%	27.8%
All Other Employees	65	12	**77**	84.4%	15.6%
Grand Total	**88**	**28**	**116**	**75.86%**	**24.14%**

Staff Analysis by Gender as at 31.03.21 (FTE)

Staff Analysis by Gender (based on staffing at 31.03.2021 - Extracted from ESR 19.04.2021)

	FTE by Gender			% by Gender	
Staff Grouping	**Female**	**Male**	**Totals**	**Female**	**Male**
Governing Body	3.52	2.59	**6.11**	57.6%	42.4%
Other Senior Management (Band 8C+)	8.95	0.45	**9.40**	95.2%	4.8%
All Other Employees	56.11	11.08	**67.19**	83.5%	16.5%
Grand Total	**68.57**	**14.12**	**82.69**	**82.92%**	**17.08%**

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

Staff composition by pay band

Staff Analysis by Band as at 31.03.21 (Headcount)

Senior Staff Analysis by Band (based on staffing at 31.03.2021 - Extracted from ESR 19.04.2021)

Pay Band	Headcount
Apprentice	0
Band 1	0
Band 2	1
Band 3	20
Band 4	8
Band 5	8
Band 6	13
Band 7	10
Band 8 - Range A	11
Band 8 - Range B	6
Band 8 - Range C	4
Band 8 - Range D	3
Band 9	0
Medical	20
VSM	12
Gov Body (off payroll)	0
Grand Total	**116**

Staff Analysis by Band as at 31.03.21 – (FTE)

Senior Staff Analysis by Band (based on staffing at 31.03.2021 - Extracted from ESR 19.04.2021)

Pay Band	FTE
Apprentice	0.00
Band 1	0.00
Band 2	0.57
Band 3	15.84
Band 4	7.33
Band 5	7.25
Band 6	12.21
Band 7	8.70
Band 8 - Range A	10.50
Band 8 - Range B	4.78
Band 8 - Range C	4.00

Band 8 - Range D	3.00
Band 9	0.00
Medical	2.33
VSM	6.17
Gov Body (off payroll)	0.00
Grand Total	**82.69**

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

Employee benefits (subject to audit)

Employee benefits and staff numbers

Employee benefits 2020-21

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,498	142	**3,640**
Social security costs	365	0	**365**
Employer Contributions to NHS Pension scheme	671	0	**671**
Other pension costs	0	0	**0**
Apprenticeship Levy	5	0	**5**
Other post-employment benefits	0	0	**0**
Other employment benefits	0	0	**0**
Termination benefits	0	0	**0**
Gross employee benefits expenditure	4,539	142	**4,681**
Less recoveries in respect of employee benefits	0	0	**0**
Total - Net admin employee benefits including capitalised costs	4,539	142	**4,681**
Less: Employee costs capitalised	0	0	**0**
Net employee benefits excluding capitalised costs	4,539	142	**4,681**

The costs above include £72k for COVID-19 related costs.

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20 & 2020/21, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in the accounts and further detail explaining the reason for this increase can be found in Note 4.5 of the accounts.

Employee benefits 2019-20

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,419	161	3,580
Social security costs	364	-	364
Employer Contributions to NHS Pension scheme	620	-	620
Other pension costs	-	-	-
Apprenticeship Levy	5	-	5
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	160	-	160
Gross employee benefits expenditure	4,567	161	4,728
Less recoveries in respect of employee benefits	-	-	-
Total - Net admin employee benefits including capitalised costs	4,567	161	4,728
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	4,567	161	4,728

Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in 2020/21,(nil in 2019/20).

Sickness absence data

The sickness absence data for the CCG in 2020/21 was whole time equivalent (WTE) days available of 19919.97 and WTE days lost to sickness absence of 762.12 and average working days lost per employee was 8.61 which was managed through the absence management policy.

Staff sickness absence 2020	2020 Number
Total Days Lost	762.12
Total Staff Years	88.53
Average Working Days Lost	8.61

Staff turnover data

The CCG Staff Turnover Rate for 2020-21 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 18.18. The CCG's Average FTE Staff in Post during the year was 85.6.

The CCG Staff Turnover Rate for the year was 21.24%.

CCG Staff Turnover 2020-21	2020-21 Number
Average FTE Employed 2020-21	85.60
Total FTE Leavers 2020-21	18.18
Turnover Rate	21.24%

Other employee matters

The CCG recognises that discrimination and victimisation is unacceptable and that it is in the interests of the organisation and its employees to utilise the skills of the total workforce. It is the aim of the organisation to ensure that no employee or job applicant receives less favourable facilities or treatment (either directly or indirectly) in recruitment training/career progression or employment on grounds of age, disability, gender/gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex, or sexual orientation.

To support this commitment and to ensure we comply with both the Equality Act 2010 and the Human Rights Act 1998, the CCG requires all of 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, staff newsletters. We are part of our regional Joint Staff Consultative Committee (JSCC), which provides a forum for Trade Union staff representatives to meet and contribute to service change and development and for issues to be discussed. During the COVID-19 pandemic when the

majority of our staff have been working from home, we have run weekly “huddle” meetings via Microsoft Teams. These are hosted by the Accountable Officer and Directors and all staff to share information, receive updates on key areas of development with the pandemic and other priority areas. These huddles have also been shared with Shropshire CCG as a way of bringing together the two CCGs in preparation for the transition to a single CCG in April 2021.

The CCG has a recruitment policy which is based on NHS best practice and we use the recruitment service of NHS Midlands and Lancashire Commissioning Support Unit 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 an equal opportunity and access to training and development that their role requires through identification with their managers in appraisals and regular one-to-one meetings.

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 on people with disabilities.

Trade union facility time

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
0	0

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0

1-50%	0
51-99%	0
100%	0

Percentage of pay bill spent on facility time

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

Paid trade union activities

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

Expenditure on consultancy

Telford and Wrekin CCG spent £57k on consultancy services in 2020/21. The majority of this related to Organisational Development support during the transition to one single commissioning organisation.

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 table below shows the existing arrangements as of 31 March 2021:

Off-payroll engagements longer than six months

For all off-payroll engagements as at 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	0
Of which, the 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 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

New off-payroll engagements

For all new off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Total number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
Of which….	
Number assessed caught by IR35	0
Number assessed as NOT caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements/senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2020 and 31st March 2021:

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

Exit packages and severance payments (subject to audit)

Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	6,805	2	7,724	3	14,529
£10,001 to £25,000	1	20,000	1	24,492	2	44,492
£25,001 to £50,000	-	-	1	45,753	1	45,753
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**26,805**	**4**	**77,969**	**6**	**104,774**

Compulsory redundancies include £20k paid to Board members as disclosed in the salary and pension benefits information on page 118.

Analysis of Other Agreed Departures

	2020-21 Other agreed departures	
	Number	**£**
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	4	77,969
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
Total	**4**	**77,969**

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 & Conditions of Service Handbook and a Mutually Agreed Resignation Scheme (MARS)

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

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

Health and safety

The CCG takes health and safety of its employees very seriously and we have a policy in place to help ensure staff carry out their functions in a safe way. The policy requires staff to report health and safety incidents via an electronic system, which are then investigated, and action taken to help mitigate incidents reoccurring.

During 2020/21 due to the COVID-19 pandemic, the majority of CCG staff have been working from home, but with a small number of staff having to work in the office environment due to the nature of the roles they undertake. In order to ensure that the safety of staff was paramount during this time, we have assessed the risk to all staff having to work from the office and put protocols for mask-wearing, social distancing and cleaning processes in place to allow them to do this safely. Some staff identified as having a greater risk 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 is supporting 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, that there is no relevant audit information of which the CCG's external auditor is unaware; and, that the member has taken all steps that they ought to have as a member in order to make them self-aware of any relevant audit information and to establish that the CCG's auditor is aware of the information.

Parliamentary Accountability and Audit Report

Telford and Wrekin 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.

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 2020/21 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, Colmore Plaza, 20, Colmore Circus, Birmingham B4 6AT. The contract value was £42k excl 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 / the financial statements and notes

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31st March 2021	137
Statement of Financial Position as at 31st March 2021	138
Statement of Changes in Taxpayers' Equity for the year ended 31st March 2021	139
Statement of Cash Flows for the year ended 31st March 2021	140

Notes to the Accounts:

Accounting policies	141-146
Other operating revenue	147
Revenue	148
Employee benefits and staff numbers	149-151
Operating expenses	152
Better payment practice code	153
Other gains and losses	154
Net gain/(loss) on transfer by absorption	155
Operating leases	155
Property, plant and equipment	156-157
Trade and other receivables	158
Cash and cash equivalents	159
Analysis of impairments and reversals	160
Trade and other payables	161
Provisions	162
Contingencies	163
Financial instruments	163-164
Operating segments	164
Joint arrangements - interests in joint operations	165
Related party transactions	166
Events after the end of the reporting period	167
Financial performance targets	167

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	2	(1)	-
Other operating income	2	18	(808)
Total operating income		**17**	**(808)**
Staff costs	4	4,681	4,728
Purchase of goods and services	5	285,165	271,375
Depreciation and impairment charges	5	90	59
Provision expense	5	540	407
Other Operating Expenditure	5	262	321
Total operating expenditure		**290,738**	**276,889**
Net Operating Expenditure		**290,755**	**276,081**
Finance income		-	-
Finance expense	7	39	-
Net expenditure for the Year		**290,794**	**276,081**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**290,794**	**276,081**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**290,794**	**276,081**

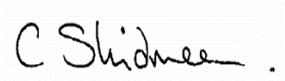
The CCG's planned in-year deficit was £3.6m, and has concluded the year with an in-year deficit of £1.3m.
The cumulative deficit is £7.4m, following the application of the cumulative deficit brought forward from previous years of £6.1 million. The External Auditors have made a referral to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 in this respect.

The Clinical Commissioning Group has a residual cash balance of £73k on 31 March 2021 that is within the tolerance required by NHS England. This balance can be seen in the Statement of Cash Flows.

Statement of Financial Position as at 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment	10	(0)	129
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		(0)	129
Current assets:			
Inventories		-	-
Trade and other receivables	11	1,702	1,287
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	12	73	47
Total current assets		**1,775**	1,333
Non-current assets held for sale		-	-
Total current assets		**1,775**	1,333
Total assets		**1,775**	1,462
Current liabilities			
Trade and other payables	14	(23,784)	(19,944)
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions	15	(842)	(407)
Total current liabilities		**(24,626)**	(20,350)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(22,851)**	(18,888)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions		-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(22,851)**	(18,888)
Financed by Taxpayers' Equity			
General fund		(22,851)	(18,888)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(22,851)**	(18,888)

The financial statements on pages 136 to 168 were approved by the Governing Body on 9th June and signed on its behalf by:



Claire Skidmore
Interim Accountable Officer

31 March 2021

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	(18,888)	-	-	**(18,888)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	**(18,888)**	**-**	**-**	**(18,888)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating expenditure for the financial year	(290,794)	-	-	**(290,794)**
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets	-	-	-	**-**
Net gain/(loss) on revaluation of financial assets	-	-	-	**-**
Total revaluations against revaluation reserve	**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets	-	-	-	**-**
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			-	**-**
Net gain (loss) on revaluation of assets held for sale	-	-	-	**-**
Impairments and reversals	-	-	-	**-**
Net actuarial gain (loss) on pensions	-	-	-	**-**
Movements in other reserves	-	-	-	**-**
Transfers between reserves	-	-	-	**-**
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	**-**
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	**-**
Transfers by absorption to (from) other bodies	-	-	-	**-**
Reserves eliminated on dissolution	-	-	-	**-**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(290,794)**	**-**	**-**	**(290,794)**
Net funding	286,831	-	-	**286,831**
Balance at 31 March 2021	**(22,851)**	**-**	**-**	**(22,851)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(12,521)	-	-	**(12,521)**
Transfer of assets and liabilities from closed NHS bodies	-	-	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	**(12,521)**	**-**	**-**	**(12,521)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating costs for the financial year	(276,081)	-	-	(276,081)
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets	-	-	-	**-**
Net gain/(loss) on revaluation of financial assets	-	-	-	**-**
Total revaluations against revaluation reserve	-	-	-	**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	-	-	-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(276,081)**	**-**	**-**	**(276,081)**
Net funding	269,714	-	-	269,714
Balance at 31 March 2020	**(18,888)**	**-**	**-**	**(18,888)**

Statement of Cash Flows for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(290,794)	(276,081)
Depreciation and amortisation	5	74	59
Impairments and reversals	5	16	-
Non-cash movements arising on application of new accounting standards		-	-
Movement due to transfer by Modified Absorption		-	-
Other gains (losses) on foreign exchange		-	-
Donated assets received credited to revenue but non-cash		-	-
Government granted assets received credited to revenue but non-cash		-	-
Interest paid		-	-
Release of PFI deferred credit		-	-
Other Gains & Losses	7	39	-
Finance Costs		-	-
Unwinding of Discounts		-	-
(Increase)/decrease in inventories		-	-
(Increase)/decrease in trade & other receivables	11	(416)	1,110
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	14	3,840	4,722
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	15	(105)	-
Increase/(decrease) in provisions	15	540	407
Net Cash Inflow (Outflow) from Operating Activities		**(286,805)**	(269,784)
Cash Flows from Investing Activities			
Interest received		-	-
(Payments) for property, plant and equipment		-	-
(Payments) for intangible assets		-	-
(Payments) for investments with the Department of Health		-	-
(Payments) for other financial assets		-	-
(Payments) for financial assets (LIFT)		-	-
Proceeds from disposal of assets held for sale: property, plant and equipment		-	-
Proceeds from disposal of assets held for sale: intangible assets		-	-
Proceeds from disposal of investments with the Department of Health		-	-
Proceeds from disposal of other financial assets		-	-
Proceeds from disposal of financial assets (LIFT)		-	-
Non-cash movements arising on application of new accounting standards		-	-
Loans made in respect of LIFT		-	-
Loans repaid in respect of LIFT		-	-
Rental revenue		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(286,805)**	(269,784)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		286,831	269,714
Other loans received		-	-
Other loans repaid		-	-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-	-
Capital grants and other capital receipts		-	-
Capital receipts surrendered		-	-
Non-cash movements arising on application of new accounting standards		-	-
Net Cash Inflow (Outflow) from Financing Activities		**286,831**	269,714
Net Increase (Decrease) in Cash & Cash Equivalents		**26**	(70)
Cash & Cash Equivalents at the Beginning of the Financial Year		47	117
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	12	**73**	47

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

The CCG ended the financial year with an in-year deficit of £1.3m and a cumulative deficit position of £7.4m. This is in the context of a temporary financial framework being in operation in 2020/21 due to COVID-19. In the first 6 months of 2020/21, the CCG was given a budget to operate within and any variances from this budget for either COVID or non COVID expenditure were then funded retrospectively so that for the first 6 months of the year the CCG reported a break even position. Further funding was provided for the latter 6 months of the year which included funding for estimated COVID costs and there was a clear expectation that organisations would manage within this funding and report a break even position.

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 however it is recognised that there has been a significant impact on how we operate. Our assessment of going concern is made on the basis that Government support is available to the NHS for all COVID-19 related costs and the CCG is fully participating in all financial returns and reviews.

The CCG have taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt are not materially impacted. These steps include securing remote access to financial systems for all finance staff and budget holders, and working with our 3rd party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected. 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 indicates some uncertainty over the its finances, the Governing body, having made appropriate enquiries, have reasonable expectations over the continuity of services and the adequacy of resources to continue in operational existence for the foreseeable future (in its merged form with Shropshire CCG). As directed by the Group Accounting Manual 2020/21, the Governing Body have prepared the financial statements on a going concern basis as they consider that the services currently provided by the CCG will continue to be provided in the foreseeable future.

On 1st April 2021 the CCG will form one single commissioning group with Shropshire CCG to become 'Shropshire, Telford and Wrekin Clinical Commissioning Group'. The formation of this new organisation has been approved by both sets of Governing Bodies and NHS England and the services currently provided by the CCG will transfer entirely to the new organisation together with its assets and liabilities.

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

1.2 Accounting Convention

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

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

The clinical commissioning group has entered into two pooled budget arrangements with Telford and Wrekin Local Authority, (in accordance with section 75 of the NHS Act 2006). Under the arrangements, funds are pooled for the Better Care Fund and the Transforming Care Programme and note 19 to the accounts provides details of the income and expenditure.

The TCP pool is hosted by the Local Authority and the BCF pool is jointly hosted. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

Notes to the financial statements

1.6 **Revenue**

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

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

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The Clinical Commissioning Group, as a commissioning organisation, does not receive any significant revenue from contracts. The majority of the CCG's revenue is from Departmental funding which is recognised within the year it is received as Grant in Aid funding as reflected in the Statement of Changes in Taxpayers Equity.

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

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

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

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

1.8 **Other Expenses**

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

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:
- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Notes to the financial statements

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

1.9.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

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

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

During 2020/21 the CCG undertook a review of assets and asset lives as part of the due diligence process in transitioning to a new single commissioning organisation. This has resulted in additional depreciation being charged in the year and the net book value of IT assets is now nil. In addition, the review highlighted a piece of plant & machinery which had become obsolete and this has therefore been disposed of at nil value.

1.10 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.
NHS Telford and Wrekin CCG only holds leases with NHS Property Services.

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

Notes to the financial statements

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

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

1.15 **Contingent liabilities and contingent assets**

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

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

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

Notes to the financial statements

1.16 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.16.1 **Financial Assets at Amortised cost**

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

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

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

The CCG did not hold any such assets as at 31st March 2021.

1.16.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

The CCG did not hold any such assets as at 31st March 2021.

1.16.4 **Impairment**

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

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

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

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

1.17 **Financial Liabilities**

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

1.17.1 **Financial Guarantee Contract Liabilities**

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

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

The CCG did not take financial guarantee contracts during 2020/21.

1.17.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

The CCG did not hold any financial liabilities at fair value through profit and loss during 2020/21.

1.17.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest

1.18 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Notes to the financial statements

1.19 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 **Critical accounting judgements in applying accounting policies**

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

1.20.2 **Sources of estimation uncertainty**

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

Provisions: Estimates used to calculate potential provisions are based on expert advice from solicitors and other external professional agents combined with the experience of CCG managers. The redundancy provision is based on the number of staff deemed at risk following a management of change process and the estimated costs have been calculated using an average cost for all staff. The actual costs will vary dependant upon the grade of staff and their number of years service but an average cost is deemed appropriate given the uncertainity at this point in time.
The continuing health care provision reflects the cost of appeals outstanding as at 31st March 2021. The cost has been calculated using an average weekly rate and assumes that all of the appeals will be successful.

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

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

1.21 **Gifts**

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

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.
Work carried out to date has identified that the CCG currently has 1 operating lease with NHS Property Services which will be re-classified as a finance lease. Current calculations estimate that this would have the effect on the Statement of Financial Position of increasing non-current assets by £404k and increasing financial liabilities by £404k. The current estimated impact on expenditure is an annual increase of £104k representing depreciation and interest costs and guidance is awaited from NHSE/I regarding the funding of this.

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

Other Operating Revenue

	2020-21 Total	2019-20 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	-
Non-patient care services to other bodies	**-**	-
Patient transport services	**-**	-
Prescription fees and charges	**-**	-
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**1**	-
Recoveries in respect of employee benefits	**-**	-
Total Income from sale of goods and services	**1**	**-**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**-**	-
Other non contract revenue	**(18)**	808
Total Other operating income	**(18)**	**808**
Total Operating Income	**(17)**	**808**

Other contract income relates to royalties received in respect of the sale of Aska Maternity Movement bracelets.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the Clinical Commissioning Group and credited to the General Fund.

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

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	-	-	-	-	-	-	-
Non NHS	-	-	-	-	-	-	1	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**1**	**-**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	-	-	-	-	-	-	1	-
Over time	-	-	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**1**	**-**

3.2 Transaction price to remaining contract performance obligations

The CCG did not have any contract revenue in 2020/21 expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2020-21

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,498	142	**3,640**
Social security costs	365	0	**365**
Employer Contributions to NHS Pension scheme	671	0	**671**
Other pension costs	0	0	**0**
Apprenticeship Levy	5	0	**5**
Other post-employment benefits	0	0	**0**
Other employment benefits	0	0	**0**
Termination benefits	0	0	**0**
Gross employee benefits expenditure	4,539	142	**4,681**
Less recoveries in respect of employee benefits (note 4.1.3)	0	0	**0**
Total - Net admin employee benefits including capitalised costs	4,539	142	**4,681**
Less: Employee costs capitalised	0	0	**0**
Net employee benefits excluding capitalised costs	4,539	142	**4,681**

The costs above include £72k for COVID-19 related costs.

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20 & 2020/21, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.5.

4.1.2 Employee benefits 2019-20

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,419	161	3,580
Social security costs	364	-	364
Employer Contributions to NHS Pension scheme	620	-	620
Other pension costs	-	-	-
Apprenticeship Levy	5	-	5
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	160	-	160
Gross employee benefits expenditure	4,567	161	4,728
Less recoveries in respect of employee benefits (note 4.1.3)	-	-	-
Total - Net admin employee benefits including capitalised costs	4,567	161	4,728
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	4,567	161	4,728

4.1.3 Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in 2020/21,(nil in 2019/20).

4.2 Average number of people employed

	2020-21			2019-20		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**85.84**	**2.60**	**88.44**	92.03	2.52	94.55
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		**2020-21 Other agreed departures**		**2020-21 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	1	6,805	2	7,724	3	14,529
£10,001 to £25,000	1	20,000	1	24,492	2	44,492
£25,001 to £50,000	-	-	1	45,753	1	45,753
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**26,805**	**4**	**77,969**	**6**	**104,774**

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	2	160,000	2	160,000
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**2**	**160,000**	**2**	**160,000**

	2020-21 Departures where special payments have been made		2019-20 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

4.4 Analysis of Other Agreed Departures

	2020-21 Other agreed departures		2019-20 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	4	77,969	2	160,000
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**4**	**77,969**	**2**	**160,000**

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 & Conditions of Service Handbook and a Mutually Agreed Resignation Scheme (MARS)

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

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension Costs

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

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

5. Operating expenses

	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	2,900	2,697
Services from foundation trusts	36,937	36,929
Services from other NHS trusts	139,060	135,688
Provider Sustainability Fund	-	-
Services from Other WGA bodies	0	0
Purchase of healthcare from non-NHS bodies	44,255	36,370
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	30,350	28,950
Pharmaceutical services	-	-
General Ophthalmic services	168	290
GPMS/APMS and PCTMS	27,519	25,341
Supplies and services – clinical	808	1,234
Supplies and services – general	145	762
Consultancy services	57	625
Establishment	2,085	916
Transport	23	8
Premises	320	566
Audit fees	54	48
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	10	10
Other professional fees	336	718
Legal fees	141	32
Education, training and conferences	(4)	190
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**285,165**	**271,375**
Depreciation and impairment charges		
Depreciation	74	59
Amortisation	-	-
Impairments and reversals of property, plant and equipment	16	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**90**	**59**
Provision expense		
Change in discount rate	-	-
Provisions	540	407
Total Provision expense	**540**	**407**
Other Operating Expenditure		
Chair and Non Executive Members	267	315
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	(5)	5
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	0	1
Total Other Operating Expenditure	**262**	**321**
Total operating expenditure	**286,057**	**272,161**

The above includes expenditure dealt with under the pooled budget arrangement for the Better Care Fund as set out in Note 19.

COVID-19 costs included in the above figures total £8.5m. The majority of these costs fall under Services from other NHS Trusts and Purchase of Healthcare from non-NHS bodies. COVID-19 pay costs are shown in Note 4.1.

Health care expenditure includes (£224k) representing a reduction in the assessment of partially completed spells. In line with latest NHSE guidance, partially completed spells have been settled in full in 2020/21.

Internal audit and counter fraud services are provided by CW Audit who are part of a Foundation Trust. The cost of these services was £30k in 2020/21, (included within other professional fees).

External Audit Fees are inclusive of VAT and comprise:

Statutory audit fee 2020/21	£50k
Unaccrued element of 2019/20 statutory audit fee	£4k
Total External Audit Fees incurred in 2020/21	£54k

The auditor's liability for external audit work carried out for the financial year 2020/21 is limited to £2 million.

6.1 Better Payment Practice Code

Measure of compliance	**2020-21 Number**	**2020-21 £'000**	2019-20 Number	2019-20 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	11,875	73,628	11,810	65,391
Total Non-NHS Trade Invoices paid within target	11,814	72,809	11,689	63,099
Percentage of Non-NHS Trade invoices paid within target	**99.49%**	**98.89%**	98.98%	96.49%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	875	185,179	2,512	184,400
Total NHS Trade Invoices Paid within target	869	185,172	2,492	184,028
Percentage of NHS Trade Invoices paid within target	**99.31%**	**100.00%**	99.20%	99.80%

The Better Payment Practice Code requires the clinical commissioning group to pay valid invoices by their due date or within 30 days of receipt of the invoices, whichever is the later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2020-21 £'000**	2019-20 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7. Other gains and losses

	2020-21	2019-20
	£'000	£'000
(Gain)/loss on disposal of property, plant and equipment assets other than by sale	39	-
(Gain)/loss on disposal of intangible assets other than by sale	-	-
(Gain)/loss on disposal of financial assets other than held for sale	-	-
(Gain)/loss on disposal of assets held for sale	-	-
(Gain)/loss on foreign exchange	-	-
Change in fair value of financial assets carried at fair value through the statement of comprehensive net expenditure	-	-
Change in fair value of financial liabilities carried at fair value through the statement of comprehensive net expenditure	-	-
Change in fair value of investment property	-	-
Recycling of (gain)/loss from equity on disposal of financial assets held for sale	-	-
Total	**39**	**-**

The loss on disposal relates to the disposal of an item of medical equipment which had become obsolete.

8. Net gain/(loss) on transfer by absorption

Telford and Wrekin CCG does not have any to report in 2020/21 or any reported during 2019/20.

9. Operating Leases

9.1 As lessee

9.1.1 Payments recognised as an expense

	2020-21				2019-20			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	-	147	-	**147**	-	176	-	176
Contingent rents	-	-	-	**-**	-	-	-	-
Sub-lease payments	-	-	-	**-**	-	-	-	-
Total	**-**	**147**	**-**	**147**	-	176	-	176

Buildings lease payments relate to expenditure with NHS Property Services Ltd for the rental of office accommodation.

9.1.2 Future minimum lease payments

	2020-21				2019-20			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	-	-	-	**-**	-	-	-	-
Between one and five years	-	-	-	**-**	-	-	-	-
After five years	-	-	-	**-**	-	-	-	-
Total	**-**	**-**	**-**	**-**	-	-	-	-

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

9.2 As lessor

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

10 Property, plant and equipment

	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2020	-	-	-	-	**99**	**-**	**361**	**39**	**499**
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	(99)	-	-	-	(99)
Upward revaluation gains	-	-	-	-	-	-	-	0	0
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2021	**-**	**-**	**-**	**-**	**0**	**-**	**361**	**39**	**400**
Depreciation 01 April 2020	-	-	-	-	52	-	279	39	370
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	(60)	-	-	-	(60)
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	16	-	16
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	8	-	66	-	74
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**0**	**-**	**361**	**39**	**400**
Net Book Value at 31 March 2021	**-**	**-**	**-**	**-**	**(0)**	**-**	**-**	**-**	**-**
Purchased	-	-	-	-	(0)	-	(0)	-	(0)
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2021	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**	**-**	**(0)**
Asset financing:									
Owned	-	-	-	-	(0)	-	(0)	-	(0)
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2021	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**	**-**	**(0)**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2020	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

10 Property, plant and equipment cont'd

10.1 Cost or valuation of fully depreciated assets

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

	2020-21	2019-20
	£'000	£'000
Land	-	-
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	166	87
Furniture & fittings	-	18
Total	**166**	**105**

10.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	5	15
Transport equipment	0	0
Information technology	2	3
Furniture & fittings	5	10

11 Trade and other receivables	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS receivables: Revenue	641	-	172	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	154	-	-	-
NHS accrued income	224	-	629	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	350	-	155	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	221	-	199	-
Non-NHS and Other WGA accrued income	35	-	87	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	(5)	-
VAT	65	-	40	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	13	-	8	-
Total Trade & other receivables	**1,702**	**-**	**1,287**	**-**
Total current and non current	**1,702**		**1,287**	
Included above:				
Prepaid pensions contributions	-		-	

11.1 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	**2020-21 Non DHSC Group Bodies £'000**	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	68	269	(72)	13
By three to six months	1	(3)	188	31
By more than six months	-	0	-	0
Total	**68**	**266**	116	44

11.2 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**	**Other financial assets £'000**	**Total £'000**
Balance at 01 April 2020	(5)	-	**(5)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	-	-	**-**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	5	-	**5**
Total	**-**	**-**	**-**

12 Cash and cash equivalents

	2020-21	2019-20
	£'000	£'000
Balance at 01 April 2020	47	117
Net change in year	26	(70)
Balance at 31 March 2021	**73**	47
Made up of:		
Cash with the Government Banking Service	73	46
Cash with Commercial banks	-	-
Cash in hand	-	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**73**	47
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	-
Balance at 31 March 2021	**73**	47

13 Analysis of impairments and reversals

	2020-21	2019-20
	£'000	£'000
Impairments and reversals charged to the statement of comprehensive net expenditure		
Loss or damage resulting from normal operations	(16)	-
Over-specification of assets	-	-
Abandonment of assets in the course of construction	-	-
Total charged to departmental expenditure limit	**(16)**	**-**
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Other	-	-
Change in market price	-	-
Total charged to annually managed expenditure	**-**	**-**
Total impairments and reversals charged to the statement of comprehensive net expenditure	**-**	**-**

Other impairments relate to a reassessment of asset lives in relation to IT equipment.

14 Trade and other payables	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	3,441	-	2,349	-
NHS payables: Capital	-	-	-	-
NHS accruals	310	-	1,385	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	1,583	-	2,079	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	15,151	-	13,471	-
Non-NHS and Other WGA deferred income	-	-	41	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	59	-	63	-
VAT	-	-	-	-
Tax	57	-	95	-
Payments received on account	-	-	-	-
Other payables and accruals	3,184	-	462	-
Total Trade & Other Payables	**23,784**	**-**	**19,944**	**-**
Total current and non-current	**23,784**		**19,944**	

NHS payables includes £935k in respect of an invoice received from Shrewsbury & Telford Hospitals NHS Trust for the settlement of partially completed spells and this has been paid in April 2021. In line with latest NHSE guidance, partially completed spells have been settled in full in 2020/21 and the remaining liability with other providers was settled in cash in March 2021, (the liability in respect of partially completed spells in 2019/20 was £1,221k).

Other payables include £229k outstanding pension contributions at 31 March 2021 (£200k in 2019/20).

15 Provisions

	Current 2020-21 £'000	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	190	-
Redundancy	509	-	209	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	140	-	8	-
Continuing care	18	-	-	-
Other	175	-	-	-
Total	**842**	**-**	**407**	**-**
Total current and non-current	**842**		**407**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2020	**-**	**-**	**190**	**209**	**-**	**-**	**8**	**-**	**-**	**407**
Arising during the year	-	-	-	327	-	-	140	18	175	**659**
Utilised during the year	-	-	(78)	(27)	-	-	-	-	-	**(105)**
Reversed unused	-	-	(112)	-	-	-	(8)	-	-	**(120)**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2021	**-**	**-**	**-**	**509**	**-**	**-**	**140**	**18**	**175**	**842**
Expected timing of cash flows:										
Within one year	-	-	-	509	-	-	140	18	175	**842**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2021	**-**	**-**	**-**	**509**	**-**	**-**	**140**	**18**	**175**	**842**

The creation of one single commissioning organisation in Shropshire, Telford & Wrekin with effect from 1st April 2021 has involved a restructuring of roles & responsibilities and has had an impact on the associated staffing. The majority of this management of change work has been completed during 2020/21 but as at 31st March 2021 some staff were still awaiting an outcome. The redundancy provision reflects the estimated impact of this and it is expected that the process will be concluded early in the new financial year.

The legal claims provision relates to ongoing legal cases outstanding at 31/03/2021, with the estimated costs to conclusion provided by the CCG's legal advisors. The CCG has no claims currently lodged with NHS Resolution.

A continuing care provision has been created which reflects the estimated cost of continuing care appeals currently awaiting processing. The provision is based on the number of appeals outstanding at the 31st March 2021 and these are expected to be processed within the new financial year.

Other provisions include £163k in relation to ring-fenced funding received in 2020/21 which may need to be repaid in 2021/22 and £12k in relation to a claim against the CCG for lost revenue.

16 Contingencies

The CCG had no contingent assets or liabilities to disclose in 2020/21.

17 Financial instruments

17.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

17.1.1 Currency risk

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

17.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

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

17.1.4 Liquidity risk

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

17.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

17 Financial instruments cont'd

17.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	Equity Instruments designated at FVOCI 2020-21 £'000	Total 2020-21 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	815		815
Trade and other receivables with other DHSC group bodies	316		316
Trade and other receivables with external bodies	132		132
Other financial assets	-		-
Cash and cash equivalents	73		73
Total at 31 March 2021	**1,336**	**-**	**1,336**

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	Other 2020-21 £'000	Total 2020-21 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	446		**446**
Trade and other payables with other DHSC group bodies	9,072		**9,072**
Trade and other payables with external bodies	14,150		**14,150**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2021	**23,668**	**-**	**23,668**

18 Operating segments

As stated in IFRS8, the "Chief Operating Decision Maker" is responsible for allocating resources to and assessing the performance of the operating segments of an entity. At Telford and Wrekin clinical commissioning group this function is performed by the Governing Body. The clinical commissioning group considers it has a single operating segment; commissioning of healthcare services. Hence finance and performance information is reported to the Governing Body as one segment. These Statements are produced in accordance with this position.

19 Joint arrangements - interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2020-21 Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000	Amounts recognised in Entities books ONLY 2019-20 Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Better Care Fund Section 75 Arrangement	Telford and Wrekin CCG and Telford and Wrekin LA	The Better Care Fund promoting integrated working	0	0	0	13,191	0	0	0	13,189
Transforming Care Programme Section 75 Arrangement	Telford and Wrekin CCG and Telford and Wrekin LA	The Transforming Care Programme for people with a learning disability	0	0	0	1,204	0	0	0	1,384

Better Care Pooled Fund	**CCG Pays** £		**Accounting Treatment** £
Rehabilitation and Reablement	778,052		CCG pays full amount to LA.
Domiciliary Care	1,057,082		CCG pays full amount to LA.
Rehabilitation and Reablement Bed Usage	1,517,170		CCG pays full amount to LA.
Rehabilitation and Reablement Bed Usage - Others	94,010		CCG retains to pay others.
Assistive Technologies	610,487		CCG pays full amount to LA.
Preventative Services	1,874,567		CCG pays full amount to LA.
Carers	111,763		CCG pays full amount to LA.
Management Charges	65,161		CCG pays full amount to LA.
Shropshire Community Health Trust	3,650,154		CCG pays to SCHT via contract.
Shrewsbury and Telford Hospital	1,867,956		CCG pays to SaTH via contract.
Programme Management	138,917		CCG retains to pay staff.
Maintaining Eligibility	910,607		CCG pays full amount to LA.
Care Act Implementation	514,688		CCG pays full amount to LA.
Total:	**13,190,614**		

The CCG is party to the Telford and Wrekin Better Care Fund Pooled Budget established under Section 75 of the NHS Act 2006. The other party to the Section 75 Agreement is Telford and Wrekin Local Authority.

The CCG's total contribution to the Fund in 2020/21 was £13.191 million. The partners determine the nature of the programmes of work making up the Fund and in particular whether joint control is in operation for each programme for the purposes of IFRS 11.

In 2020/21 the CCG contributed £7.365 million to programmes on community based provision where the Council acted as Lead Commissioner. The CCG accounted for its share of expenditure on these schemes. The contributions to fund these programmes were fully expensed in the year.

In 2020/21 the CCG contributed £5.826 million to programmes on community based provision where the CCG retained sole control. The CCG accounted for its share of expenditure on these schemes. The contributions to fund these programmes were fully expensed in the year.

20 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr A Pringle - GP Member - Sessional work for Shropshire Doctors Cooperative Ltd	305	0	16	0
K Timmis Lay Member - Wife is an archivist for Shropshire Council	135	0	44	0

Note to related party transactions

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:
• NHS England;
• Shrewsbury and Telford Hospitals NHS Trust;
• Midlands Partnership NHS Foundation Trust;
• University Hospitals North Midlands NHS Trust;
• Shropshire Community Health NHS Trust;
• West Midlands Ambulance NHS Foundation Trust,
• Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust,
• NHS Shropshire CCG
• Telford and Wrekin Local Authority
• Midlands and Lancashire CSU
• NHS Property Services
• NHS Business Services Authority.

From the 1st April 2015 the CCG had delegated responsibility for Primary Care Co-Commissioning, we therefore class all of our member GP practices as related parties.

21 Events after the end of the reporting period

On 1st April 2021 Telford & Wrekin CCG joined with Shropshire CCG to create one single commissioning organisation, (Shropshire, Telford & Wrekin CCG). All of the services, assets and liabilities from both CCGs were transferred to the new organisation.

22 Financial performance targets

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

	2020-21 Target £'000	**2020-21 Performance £'000**	2019-20 Target £'000	2019-20 Performance £'000
Expenditure not to exceed income	289,484	290,777	263,831	276,889
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	289,501	290,794	263,023	276,081
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	3,595	4,734	3,993	4,859

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

NHS England set the CCG an in-year control total of break-even and the CCG is reporting an outturn of £1.3m deficit. The CCG brought forward a deficit of £6.1m and therefore the cumulative outturn is £7.4m deficit.

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

23 Losses and special payments

23.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2020-21 Number	**Total Value of Cases 2020-21 £'000**	Total Number of Cases 2019-20 Number	Total Value of Cases 2019-20 £'000
Administrative write-offs	10	16	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**10**	**16**	**-**	**-**

These losses relate to the impairment of a number of items of IT equipment. A review of the asset register as part of the due diligence work in moving to the new single commissioning organisation resulted in a reduction in their asset lives.

23.2 Special payments

The clinical commissioning group has made no special payments in 2020/21 (nil in 2019/20).

Independent auditor's report to the members of the Governing Body of NHS Shropshire, Telford & Wrekin CCG in respect of NHS Telford & Wrekin CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Telford & Wrekin CCG (the 'CCG') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that NHS Telford & Wrekin CCG merged with NHS Shropshire CCG to become NHS Shropshire, Telford & Wrekin CCG on 1st April 2021. The services provided by Telford & Wrekin CCG transferred entirely to NHS Shropshire, Telford & Wrekin CCG, together with its assets and liabilities.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported expenditure of £290.794 million against income of £286.831 million in its financial statements for the year ending 31 March 2021. The CCG also reported revenue resource use of £290.794 million against a target of £289.501 million and administration expenditure of £4.734 million against a target of £3.595 million in its financial statements for the year ended 31 March 2021. The CCG thereby breached three of its duties under the National Health Service Act 2006, as amended by paragraphs 223H, 223I and 223J of Section 27 of the Health and Social Care Act 2021, to ensure that annual expenditure does not exceed income, and to ensure that both revenue resource use and revenue resource use in a financial year which is attributable to administration do not exceed the amounts specified by direction of NHS England.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 14 June 2021 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the CCG's expenditure exceeding its income and the CCG's breach of its revenue resource limit and administration resource limit.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 76 to 77, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that

includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - journal entries that altered the CCG's financial performance for the year; and
  - potential management bias in determining accounting estimates.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on significant journals at the end of the financial year which impacted on the CCG's financial performance;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to prescribing accruals, continuing healthcare accruals, and provisions. On 14 June 2021 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the CCG's expenditure exceeding its income and the CCG's breach of its revenue resource limit and administration resource limit.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements –the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter except on 14 June 2021 we identified a significant weakness in how the CCG plans and manages its resources to ensure it can continue to deliver its services. This was in relation to the CCG's failure to develop plans during 2020/21 to address NHS Shropshire, Telford & Wrekin CCG's predicted deficit for 2021/22 and to achieve the efficiency target set for it by NHS England. We recommended that NHS Shropshire, Telford & Wrekin CCG reconsider its planned expenditure and the deliverability of its savings schemes and amends its financial plan as necessary to deliver a balanced financial position.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any further significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Telford & Wrekin CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of NHS Shropshire, Telford & Wrekin CCG, as a body, in respect of NHS Telford & Wrekin CCG, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of NHS Shropshire, Telford & Wrekin CCG those matters we are required to state to them in an auditor's report, in respect of NHS Telford & Wrekin CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Shropshire, Telford & Wrekin CCG and NHS Telford & Wrekin CCG, and the members of the Governing Bodies of both CCG's, as bodies, for our audit work, for this report, or for the opinions we have formed.

M C Stocks

Mark Stocks, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

14 June 2021