NHS
Cannock Chase
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS

2021/22

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Chair's introduction

Another year has come and gone and it has been a year unlike any other. Of course the COVID-19 pandemic has dominated much of what the NHS has been doing and been able to do, but there has much more going on besides.

I have to mention the COVID-19 vaccination programme because it really has required colossal effort, and that effort is still taking place. Most of the programme has been carried out by primary care, with GP surgeries working collectively through our Primary Care Networks (PCNs). So whether you have received your vaccination in a church hall or a hotel, it is your GP surgeries that have been putting in much of the effort.

The programme has involved a huge amount of teamwork and everyone involved needs to be thanked, not least the army of volunteers who have come forward to help. Some were clinically qualified staff who returned from retirement, and others simply volunteered to do invaluable tasks such as marshalling.

We've also worked closely with our other NHS colleagues, the councils have provided invaluable assistance, and we've even had logistical support from the Fire Service.

Just a reminder that COVID-19 isn't over – community transmission continues, and new strains are likely. All clinical workplaces are still needing to take infection prevention and control measures, and staff absence is still a real issue that has an impact on capacity.

The pandemic also has not left us where we want to be, with waiting lists being far higher than we would want. The number of people facing 104-week waits isn't acceptable, and we are working collectively to address the backlog.

The other area we are working hard to address is GP access. During the pandemic we took much of our consultations online or, more often, over the telephone. For some patients this works well, but we know it isn't appropriate or preferable for everyone. We are working hard to ensure we get the balance right. We want to tailor access to the needs of each patient wherever we can and to give patients an element of choice.

That brings me on to the workforce diversification that is taking place. It is progressing, although maybe not at the pace I would wish to see. A GP is not necessarily the best person to see in general practice on every occasion. If you have a musculoskeletal (MSK) condition, you may get more out of an appointment with a physiotherapist. They will probably be able to spend more time with you, and have specific skills and training that a GP does not. Physios can prescribe in some areas of Staffordshire, and they will in and around Cannock Chase shortly.

Widening the picture, we are actively looking to deliver a service to people seeking asylum, and recent events in Afghanistan and Ukraine have brought into focus who urgently this positive move is needed.

Locally there is going to be a lot of activity in the near future. As we speak we are looking at ways at restoring the service that was provided by the Minor Injuries Unit (MIU) at Cannock Chase Hospital.

But we are also engaging on a number of really important developments. These include engagements on the need to create urgent treatment centres (UTCs) and community diagnostic hubs (CDH). The UTC aim to offer an enhanced and far more unform level of service than we currently get from the county's patchwork of MIU and walk-in centres.

Meanwhile the diagnostic hubs have the potential to help us get the tests we need such blood tests, X-rays or scans closer to home, with reduced trips to hospital, and shorter waits. When you get a chance, I would encourage you all to have a say on the options.

Finally, I have to acknowledge that this will almost certainly be the last annual report from Cannock Chase Clinical Commissioning Group, as we shall shortly be superseded by the Staffordshire and Stoke-on-Trent Integrated Care System, Together We're Better.

This isn't sudden, and we've been working towards it for some time through Together We're Better in its previous guise as a Sustainability and Transformation Partnership (STP) bringing together all NHS partners, our local councils responsible for care services and elements of the voluntary sector.

I'd like to thank everyone who has been involved with Cannock Chase CCG through its decade of providing clinical commissioning for our population.

Dr Gary Free

Chair

NHS Cannock Chase CCG

22 June 2022

Performance Report

Performance overview

This overview provides information about the CCG including its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

A statement from the Accountable Officer

It's been another year of immense significance for the NHS both locally and nationally. I would suggest that for many of us working in the NHS and across the health and care sector, it has been the most difficult two years of our careers.

And as this is the last Annual Report in which I'll be able to do so, I want to say a huge thank you to all the staff of the six Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs). Thank you for everything you have done and achieved in the most challenging of circumstances.

It's the last time of course, because the CCGs have reached the end of their journey as NHS statutory organisations. The CCGs will be replaced by the Staffordshire and Stoke-on-Trent Integrated Care Board on 1 July 2022, as we complete our transition to a new Integrated Care System.

CCGs were established in April 2011 and authorised as statutory bodies on 1 April 2013. Over the last 10 years or so there have been many changes in leadership and staff, but CCG governing body members, clinicians and staff have never, ever failed to live up to the many challenges we have faced.

However, the last two years in particular have been the most challenging of all, and you have all been incredible.

Our initial response as the system came together to battle the first wave of the COVID-19 pandemic and each subsequent wave has been an astonishing achievement. The last year has been the second of the pandemic and we've had to go and go again. Once you've completed a marathon you know how to do it. That doesn't make getting up the next day and running another one any easier.

Responding to the pandemic whilst supporting the urgent and emergency care system, maintaining cancer and urgent elective care, keeping the doors of primary care open, recovering elective waiting lists, achieving financial balance and delivering the largest mass vaccination programme the NHS has ever delivered has been monumental. And exhausting.

All whilst implementing the latest NHS reorganisation with all the added uncertainty that brings. A reorganisation big enough to see from space. A reorganisation that will leave the NHS that emerges from the pandemic very different to the NHS before COVID-19.

Your resilience through all of this has been nothing short of phenomenal. Not just those of you working in the CCGs, but everyone working across the entire health and care system. You have kept going through it all, no matter what was thrown at you.

I try to be a compassionate leader, and I often ask myself whether we could have done more to support you. The honest answer is that I think it's virtually impossible to do enough for everyone, but we have done what we can and I sincerely hope it has helped in some way.

This Annual Report – the last we will produce as a CCG – sets out our achievements over the last year. There is much to be proud of and celebrate and a valuable legacy to hand over to the ICB on 1 July.

The vast majority of CCG staff will find a new home in the ICB. They will TUPE transfer (Transfer of Undertakings – Protection of Employment) on 1 July as part of the NHS continued employment commitment. Whilst they will have a job, many governing body colleagues will not.

Thank you to all of my clinical chairs, lay members, clinical leaders and executive colleagues for all you have contributed on our journey together and your support to me as your Accountable Officer. For those of you who have secured positions in the ICB my best wishes. For those for whom 1 July marks the end of this chapter in our lives and careers – my best wishes for whatever you choose to do in the future.

Thank you also to our GP memberships across the six CCGs. Whilst it has not always been smooth sailing – and it would be remiss of me not to acknowledge that there have been tensions along the way – we have generally worked through our differences and achieved some great things for the people we serve. General practice, the bedrock of the NHS, never closed during the pandemic and you delivered over two thirds of the vaccinations against COVID-19. Thank you for your continued endeavours and support.

So, that's me done. I have been the Accountable Officer for the six CCGs since 1 November 2017 and have immensely enjoyed my time at the helm, as challenging and difficult as it has been at times. Above all, I have enjoyed the privilege of working with you all. As I too transition to the next stage in my career, a final thank you once more to everyone who has worked with me in the CCGs, our stakeholders and the patients we have been proud to serve. It's been a blast!

Marcus Warnes

Accountable Officer

NHS Cannock Chase CCG

22 June 2022

Purpose and activities of the organisation

NHS Clinical Commissioning Groups (CCGs) have been responsible for planning and buying local healthcare services since April 2013. CCGs combine the expertise of clinicians including family doctors (GPs), nurses and NHS managers.

CCGs are here to make a difference to people's lives through improving the health and wellbeing of individuals and their families and taking action to reduce the inequalities in health that exist across Staffordshire and Stoke-on-Trent. Staffordshire and Stoke-on-Trent has a diverse healthcare system, comprising both rural and urban areas, as well as extremes of affluence and deprivation.

In Cannock Chase, we have a population of 135,845 – compared to 1,166,953 in Staffordshire and Stoke-on-Trent (figures as at October 2021).

We need to consider the following factors:

- An ageing population – this puts more pressure on our health and care services
- People's health varies – with different levels of poverty, deprivation and health inequalities
- A diverse population – 8.8% of people in Staffordshire and 17.8% in Stoke-on-Trent identify themselves as non-White British[1]
- Lifestyle factors that lead to health needs – more people have diabetes, strokes or heart disease than the national average[2], and obesity is also significantly worse than the national average
- Long-term conditions – the number of people with long-term conditions is increasing, with more than half of over-65s having two or more long-term conditions
- Early deaths – for example, people in Stoke-on-Trent have a lower life expectancy than in other parts of the country. More people under the age of 75 die from cancer than the national average

[1] ONS Data / Population characteristics research tables: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationcharacteristicsresearchtables

[2] Quality and Outcomes Framework, 2019/20 – NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20

- Deprived and ethnic minority communities are at a greater risk of exposure to COVID-19 and are more likely to have poorer outcomes due to existing poor health and adverse lifestyle factors. The control measures that have been implemented during the pandemic such as lockdown, social distancing and changes to routine care have resulted in disproportionately worse economic, social and health impacts on disadvantaged populations.

Our membership is made up of GP practices – as GPs are best placed to understand what services their patients need. This means that health professionals with current patient experience are leading the decisions we make. Our GP practices are organised into groups known as primary care networks (PCNs), which work together with a range of local providers, including those across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations.

To support these aims, 25 PCNs are already established across Staffordshire and Stoke-on-Trent, and three across Cannock Chase CCG, with five clinical directors appointed. Find out more about our members on our website.

The CCG is the delegated commissioner of general medical services, which means the organisation is responsible for managing the national General Medical Services (GMS) / Personal Medical Services (PMS) contracts with GP practices.

There are 145 general practices across the whole of Staffordshire and Stoke-on-Trent, and 22 in Cannock Chase CCG. We commission healthcare and work with a number of providers, including the following.

- Acute trusts including University Hospitals of North Midlands NHS Trust (UHNM), University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and The Royal Wolverhampton NHS Trust (RWT)
- Mental health trusts including Midlands Partnership NHS Foundation Trust (MPFT)
- NHS community trusts, including UHDB and MPFT
- Vocare (urgent care services)
- West Midlands Ambulance Service University NHS Foundation Trust (WMAS)
- For the south and east of Staffordshire, there are patients treated at a number of trusts in Derbyshire and the Black Country and West Birmingham
- NHS elective services provided to the local population by non-NHS providers
- Voluntary, community and social enterprise (VCSE) partners
- A diverse market of nursing, residential home and domiciliary care providers.

We work closely with our partners and providers to prevent poor health, improve wellbeing and involve and empower our population. Across Staffordshire and Stoke-on-Trent, the local authorities are Stoke-on-Trent City Council (a unitary authority) and Staffordshire County Council, which is split into eight districts and boroughs: Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands and Tamworth.

Our objectives and strategies

Staffordshire and Stoke-on-Trent Integrated Care System (ICS)

Cannock Chase CCG is a key partner in the local Integrated Care System (ICS) along with other neighbouring NHS organisations, local authorities, and the voluntary sector. The partners have a clear shared ambition to work with local people, communities, and staff to improve the health and wellbeing of individuals and to use their collective resources more effectively.

The key four aims of all ICSs are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS to support broader social and economic development.

The Staffordshire and Stoke-on-Trent ICS Board has agreed that their vision is “to make Staffordshire and Stoke-on-Trent the healthiest places to live and work”.

For local people, this means:

- more joined-up and better care – as we work together to bridge gaps between services
- everyone has access to high-quality services wherever they live – helping to reduce inequalities
- being empowered and supported to take an active role in their health and wellbeing – as we put an emphasis on prevention
- being put at the heart of decisions made about health and care services
- services brought closer to the people who use them
- being helped to live independent and healthy lives – as we promote community-centred care
- health and social care professionals have access to more data and technology to inform decisions
- one system with one strategy – to connect everyone who uses, delivers and manages health and care services
- the best use of money and resources – as we work closely as a health and care system.

System partners recognise that not one organisation working in isolation can solve the demand pressures that the system is currently facing. Stark health inequality challenges remain across the system and there is an urgent need to improve outcomes for our population whilst living within our collective resources.

The NHS Long Term Plan (2019) set out key ambitions for the next 10 years and the main commitments are to making sure everyone gets the best start in life, delivering

world-class care for major health problems, and supporting our population to age well.

The government published the Health and Care Bill in July 2021, which sets out the way forward for ICSs and is currently under parliamentary review. The proposals in the Bill are intended to deliver better and more joined-up care across the health and social care system.

The impact of COVID-19 has meant that all the plans and ways of working have needed to be reviewed and updated to ensure that they remain relevant and appropriate for the challenges that we face. The pandemic has accelerated our partnership working and some of our priorities such as increased use of digital services and technology.

During 2021/22 partners have continued to work on the ICS Development Plan that has been reviewed by NHS England and NHS Improvement. We aim to publish this plan in 2022/23. The ICS Development Plan describes how the ICS will continue to collaborate and deepen its approach to partnership working to tackle the challenges, while continuing to respond to the COVID-19 pandemic.

This year has been a transitional year for the ICS in anticipation of new legislation (the Health and Care Bill). All parts of the ICS have been working in partnership to streamline the commissioning approach, to develop system-wide strategic commissioning across health and care, which will align, and for some services be integrated, with social care commissioners.

The move to put ICSs on a statutory footing was delayed from 1 April 2022 to 1 July 2022 due to the parliamentary timetable of the Bill. This has provided Staffordshire and Stoke-on-Trent ICS with an opportunity to prepare and operate in shadow form with as much of the new infrastructure, arrangements, and meetings as possible.

Subject to legislation, on 1 July 2022 the anticipated Staffordshire and Stoke-on-Trent NHS Integrated Care Board (ICB) will form as a statutory organisation and the clinical commissioning groups (CCGs) will be abolished. The ICB will take over the CCGs' responsibilities for buying and monitoring healthcare services.

Earlier this year, a Designate Chair and Interim Chief Executive Officer were appointed to lead and develop the anticipated ICB. Over the past few months, five non-executive directors and six executive directors have been appointed. Recruitment is underway for other key executives for the ICB. Read about the appointments on the ICS website.

The Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP) is a statutory committee responsible for the quality of health and social care services. The ICP is also responsible for the overall strategy for how the ICS delivers services. The Integrated Care Strategy is in development. This outlines the systems' long-term priorities and will be published by March 2023.

National guidance indicates that an ICP and an ICB are a core component of all integrated care systems.

We are championing the need for local delegation and are supporting the development of locality Place-Based Partnerships that will plan and deliver services to meet the needs of local communities.

Principal risks and issues

In view of the COVID-19 pandemic, the CCG decided to 'mothball' its business-as-usual corporate risk register and created a COVID-19 risk register to enable the CCG to focus on the work and risks of the pandemic.

Details of these risks can be found in the Governance Statement section.

Financial review

Summary of 2021/22 financial performance

Throughout the financial year, we have operated under temporary financial arrangements. Consequently, the annual funding allocation to spend on healthcare services for our population was replaced by a framework designed to reimburse the cost of delivering services including COVID-related expenditure.

The six Staffordshire and Stoke-on-Trent CCGs ended the year with a total allocation to spend on healthcare of £2,189 million including allocations to meet the costs of COVID-19. Included in this allocation is a separate financial allocation to spend on running costs (employing staff, running the organisation and buying support services). The running costs allocation was determined as approximately £19 per head of CCG population – or £22.2 million for the Staffordshire and Stoke-on-Trent CCGs.

The financial rules set by NHS England for CCGs are such that:

- We must not over-spend our total allocation, as this would be a breach of our statutory duty under the Health and Social Care Act 2012
- We are expected to under-spend our total allocation (healthcare allocation plus running costs allocation)
- We can use any under-spend on our running costs allocation to fund expenditure on healthcare
- We cannot use an under-spend on our healthcare to over-spend on running costs.

As an individual CCG, our actual financial performance for 2021/22 is summarised in the following table.

Summary 2021/22 financial performance

Area of expenditure	Budget £'000	Actual £'000	Over/under spend £'000
Patient services	230,396	230,374	22
Corporate / running costs	2,607	2,553	54
TOTAL	**233,003**	**232,927**	**76**

The highlights from our financial performance are as follows:

- The actual position we have reported at the end of the financial year is a cumulative under-spend or surplus of £0.08 million
- The actual spend on running costs was within the allocation.

Overall, financial performance this year has been effective and leaves us well placed to manage our financial performance in future years.

Historic expenditure by area of healthcare expenditure

Area of expenditure	2019/20 £'000	2020/21 £'000	2021/22 £'000
Acute	110,401	103,404	109,816
Mental health	18,631	19,837	19,832
Community	21,015	23,366	25,804
Prescribing	24,226	25,257	25,112
Primary care other	2,284	4,483	5,270
Primary care co-commissioning	18,383	19,165	20,280
Continuing care and funded nursing care	19,601	20,676	22,312
Other programme services	535	2,235	1,948
Corporate / running costs	2,535	2,598	2,553
TOTAL	**217,610**	**221,022**	**232,927**

The highlights from our historic expenditure are as follows:

- During 2021/22, the COVID-19 pandemic led to the suspension of local contract provisions and payments to providers were set centrally to maintain services which compares to the payment by results activity based contract values in prior years
- Growth in continuing care and prescribing has continued to be greater than consumer price inflation.

Our financial statements for 2021/22 are set out on pages 1-4 of the annual accounts. These have been prepared in accordance with a direction issued by NHS England, under the National Health Service Act 2006.

Our Statement of Financial Position is set out on page 2 of the annual accounts. The main assets and liabilities at 31 March 2022 are short-term receivables (amounts owed to the CCG by third parties) and short-term payables (amounts owed by the CCG, mainly to other NHS organisations). We do not own any significant operational assets (e.g. land, buildings or equipment). Nor do we have any interests in finance leases or private finance initiative schemes.

Note 19 to our financial statements discloses our performance in 2021/22 against our statutory financial duties. This confirms that all statutory duties have been met.

Future financial plans

After two years of working under a temporary financial regime as a result of the COVID-19 pandemic the NHS has issued planning guidance for 2022/23 that sets out our priorities and the financial regime for the year ahead. This guidance reconfirms the ongoing need to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the pandemic.

The Staffordshire and Stoke-on-Trent ICS estimated an underlying deficit of circa £200m before the pandemic. Over the past year the system has implemented a financial strategy which has started the process of financial improvement, and the latest estimate of the underlying deficit is £133m at the end of 2021/22. The system financial strategy has helped contain activity growth which has supported this improvement.

Achieving financial sustainability continues to be a significant control issue currently facing the CCG (ICB) in the short term, and we are working collaboratively with system partners to manage this by continuing with the system strategy to contain activity growth and reduce the underlying deficit further. In addition, the system will work to maximise the significant opportunities for productivity improvements across all areas, which will be used to drive out the remaining deficit over the next three years. Whilst these medium-term strategies are delivered to achieve a sustainable financial position the system will use short term, non-recurrent measures to mitigate the underlying deficits.

Subject to the Health and Social Care Bill progressing through parliament, the six Staffordshire and Stoke-on-Trent CCGs will be abolished on 30 June 2022. They will be succeeded by the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) from 1 July 2022.

Overview analysis of COVID-19 expenditure

As a result of the COVID-19 pandemic, the CCG received additional funding to combat the disease. The table below provides a summary breakdown of what the CCG used the additional funding to procure within the financial year 2021/22.

COVID-19 expenditure by type 2021/22

CCG COVID allocation and expenditure breakdown	Cannock Chase CCG £000's
Hospital discharge programme	£1,058
Support to primary care (excluding PPE)	£269
Other COVID-19 support costs	£102
TOTAL CCG COVID-19 EXPENDITURE	**£1,429**

Mental Health Investment Standard

NHS Cannock Chase CCG considers that it has complied with the requirements of the mental health investment standard for 2021/22. The 2021/22 target spend was £17.80 million and actual spend was £17.81 million.

Going concern

We have undertaken an assessment of our status as a going concern. In conjunction with the ICS (STP), we and our providers across the system have produced a financial strategy and are currently working on the development of a medium-term financial recovery plan that is targeted with the objective of returning the system to an in-year financial balance.

This is based upon having established an Integrated Care Board supported by local Places and Provider Collaboratives, which enables all of the system partners within the health economy to focus upon delivering a collaborative transformation plan.

This has been supported by strengthened system governance measures, including the establishment of a System Transformation and Savings Group, to enable the CCG and system to make progress with their journey to a position of financial sustainability.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021 and received Royal Assent on the 28 April 2022. The Bill allows for the establishment of Integrated Care Boards (ICBs) across England, and will abolish NHS clinical commissioning groups (CCGs). ICBs will take on the commissioning functions and will have transferred across to them all of the assets and liabilities of the CCGs.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

Performance overview

As a statutory body, we recognise the importance of providing assurance to our stakeholders and the public so that they have confidence in our ability to commission safe, high-quality and sustainable services within the resources that we have available.

The COVID-19 pandemic has continued to impact a number of our normal key performance measures this year. We are working hard to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs

that are a direct consequence of the pandemic. The health and care system will continue to go through a process of recovering from the impact of COVID-19 on patients and performance. There has been and will continue to be increased demand for services within acute, community and mental health providers.

As part of our process of assurance, NHS England and NHS Improvement (NHSE/I) regularly assess our operational effectiveness. Our performance is assessed against a wide range of indicators that reflect whether standards set out in the NHS Constitution and the NHS Oversight Framework (NHS OF) are being delivered and whether health outcomes are improving for local people.

Annual Assessment

As part of the oversight process, each CCG is assessed annually against five key domains in the NHS Oversight Framework.

This year, considering the different circumstances and challenges CCGs have faced in managing the NHS response to COVID-19, the assessment process was simplified. Due to the impact of the pandemic, it has not been possible to apply the established methodology and therefore no CCGs have been given an overall CCG rating for 2020/21.

The six CCGs in Staffordshire and Stoke-on-Trent remain separate commissioning organisations, however as part of the expectations set out in the Health and Care Bill we are in the process of becoming an Integrated Care Board as part of the wider Integrated Care System (ICS). In light of this, NHS England and NHS Improvement carried out a thematic review of performance for the ICS as a whole.

The five key domains are to:

- improve the quality of services
- reduce health inequalities
- involve and consult the public
- comply with financial duties
- leadership and governance.

Locally we have shown significant progress in a number of domains which also reflect the changes in our health and care landscape. The system has been recognised for:

- demonstrating strong leadership and excellent cross-system collaboration
- robust arrangements for performance, assurance, and financial oversight
- making improvements in health inequalities data and linking clinical, social care and population datasets
- examples of strong community engagement and capturing of patient experiences
- rolling-out the COVID-19 vaccination programme, in particular for our focus on improving uptake in vulnerable communities and minority groups.

Overall, we believe this reflects how well, as a system, we have adapted to the circumstances we have found ourselves in. We have seen some truly remarkable achievements which reflects the agility and willingness to adapt of our staff.

As our system transforms, the way we are assessed will also need to change and we're currently developing a memorandum of understanding with NHS England on how we will be regulated as a system.

COVID-19 impact on performance

The COVID-19 pandemic has continued to evolve and present significant challenges across the system. COVID-19 has and continues to test our health and care services across Staffordshire and Stoke-on-Trent.

At the start of the financial year, COVID-19 cases were falling and the vaccination programme was well underway with the majority of vulnerable and elderly people having received at least one dose. As legal restrictions were eased, non-COVID-19 patient demand started to rise. Our primary care teams are seeing an increase in the number of people requesting appointments, while our community and domiciliary teams, nursing, and residential home staff, mental health care, ambulance crews and other vital services have also seen significant demand. Emergency departments have seen high numbers, including other illnesses as well as COVID-19.

Acute trusts have been required to continue delivering elective care, however waiting lists for surgery and treatment have grown. This is partly due to the backlog from the previous year when elective services were suspended, but operational capacity and productivity has also been affected by the introduction of infection prevention and control measures.

In November 2021, the first case of the Omicron variant of COVID-19 was detected in the UK. The new strain has been described as being milder, however it has proved to be more infectious and case numbers rose rapidly between November 2021 and January 2022. Hospital admissions and deaths did not rise at the same rate, although the number of people in hospital for both COVID-19 and non-COVID care remains high. The increased prevalence of COVID-19 has led to an increase in staff absence due to sickness and self-isolation across all partners, which has contributed significant pressures across health and care services.

This has been particularly challenging for Staffordshire and Stoke-on-Trent, as COVID-19 cases were higher than the national average. Although the number of confirmed cases across the area has decreased overall following the peak in January 2022 it remains higher than the rate for England.

The CCG has contributed extensively towards working in an integrated way, leading and providing support to addressing the continuing pressures across all care pathways.

The Staffordshire and Stoke-on-Trent ICS winter function has been established to ensure communication and system reporting from November 2021 through to March 2022 and to ensure cross-system decision making.

The six Staffordshire and Stoke-on-Trent CCGs lead the ICS Clinical and Care Risk meeting which continues to meet twice a week to ensure that the most significant

risks to patient safety are understood across the system, allowing appropriate allocation of resource and support and escalation as required.

The CCG continues to work collaboratively with system partners across Staffordshire and Stoke-on-Trent to deliver solutions to support immediate and longer-term workforce needs. A system-wide workforce cell has been in place since March 2020 and functions as a hub to support workforce challenges and recruit staff to deploy where needed across the system.

Restoration and recovery

The priorities and operational planning guidance for 2021/22 set out by NHS England and Improvement focused on restoring services and recovering elective activity. Accelerating the restoration of elective and cancer care and managing the increasing demand on mental health services were key priorities.

Systems were asked to develop plans to bring activity back to pre-COVID levels while meeting new care demands and reducing the backlogs that were a direct consequence of the pandemic. Supporting staff recovery and addressing inequalities in access, experience and outcomes were highlighted as key enablers.

The six CCGs across Staffordshire and Stoke-on-Trent worked with partner organisations to produce activity, workforce and finance plans to maximise service delivery and support recovery. It is to be noted however, that this was against a backdrop of the continued existence of COVID-19. Infection prevention and control measures to protect staff, patients and the public remained in place, which restricted available capacity for outpatient clinics and diagnostic and planned procedures.

The NHS as a whole is taking the opportunity to use what we have learned from the pandemic to work differently and better. The requirement to provide services remotely has highlighted numerous opportunities to roll out digital technologies in patient care. Examples include virtual wards to monitor patients' conditions at home, outpatient appointments delivered via video call and the NHS app. Across Staffordshire and Stoke-on-Trent, GP practices have been supported to utilise digital support methods for appointments and prescriptions including patient access, Electronic Prescribing Service (EPS) and the NHS app.

The ICS has significantly strengthened its system wide intelligence approach during 2020/21, and has established forums for analytical colleagues to input to and share expertise. A system-wide intelligence cell has been launched in response to the COVID-19 challenges. This brought together specialists from across the system to collectively look at data available and develop 'real time' data sets to enable the system to proactively support the system. The outputs of this work are evidenced through the growing sophistication of local COVID-19 winter demand modelling.

As part of manging the urgent care and recovery pressures we are working to understand the diverse needs of our population and target interventions to reduce health inequalities. Access to meaningful data is key to achieving this – we have worked with our partners closer than ever before to pool and analyse our data utilising digital population health management tools.

The focus for 2022/23 will continue to be the restoration of services and where possible exceeding activity delivery against the 2019/20 pre-COVID baseline. Systems are encouraged to work collaboratively to further transform service delivery making use of innovation and technology to develop new models of care which supports the population to live well and stay healthy.

Constitutional Standards

During 2021/22, a number of Constitutional Standards were not achieved, due to the continued impact of COVID-19 on health and care services locally and nationally.

Cannock Chase CCG has a number of main acute providers. These include Royal Wolverhampton NHS Trust (RWT), University Hospitals of North Midlands NHS Trust (UHNM), University Hospitals of Derby and Burton NHS Foundation (UHDB), University Hospitals of Birmingham NHS Foundation Trust (UHB), Dudley Group NHS Foundation Trust (DGFT) and Walsall Healthcare NHS Trust (WHT). Performance by these providers largely determines our ability to meet NHS Constitutional Standards.

The CCG is also an associate commissioner for various other providers in the area. This report highlights those providers relevant to the area.

Key Performance Indicators

The table below summarises Cannock Chase CCG's performance against the NHS Constitutional Standards during 2021/22.

Cannock Chase CCG

Indicators	Target	Year to date	Q1	Q2	Q3	Q4
Healthcare acquired infections						
MRSA	0	1	0	1	0	0
C. difficile	28/20/37	36	8	14	8	6
Referral to treatment times						
RTT admitted	N/A	63.68%	60.34%	67.99%	67.66%	57.45%
RTT non-admitted	N/A	80.43%	81.20%	83.61%	79.87%	77.66%
RTT incompletes	92%	68.77%	70.67%	71.19%	68.77%	64.80%
RTT 52 week+ waiters	0	7,532	1,836	1,721	1,970	2,005
Diagnostic test waiting times						

Diagnostics 6 weeks+	99%	74.89%	76.00%	73.91%	74.63%	75.07%
Cancer waits						
Cancer 2 week wait	93%	77.38%	79.69%	81.20%	76.36%	72.82%
Cancer breast symptoms 2 week wait	93%	42.08%	13.24%	61.90%	59.74%	38.89%
Cancer 31 day first definitive treatment	96%	86.75%	90.55%	88.44%	83.25%	84.69%
Cancer 31 day subsequent treatment – surgery	94%	73.13%	80.56%	88.89%	61.11%	65.71%
Cancer 31 day subsequent treatment – drug	98%	94.47%	98.46%	95.15%	98.39%	85.94%
Cancer 31 day subsequent treatment – radiotherapy	94%	87.63%	88.89%	83.54%	91.67%	86.76%
Cancer 62 day standard	85%	53.27%	64.42%	54.81%	52.38%	42.61%
Cancer 62 day screening	90%	47.37%	46.15%	64.29%	42.11%	36.36%
Cancer 62 day upgrade	0%	76.92%	79.71%	81.25%	65.31%	78.46%
Mixed sex accommodation breaches						
Mixed sex accommodation breaches	0	1	-	-	1	0

A&E providers

University Hospitals of North Midlands NHS Trust

2021/22	Target	Year to date	Q1	Q2	Q3	Q4
A&E 4-hour trolley target	95%	66.87%	72.75%	67.23%	64.31%	62.59%
12-hour trolley breaches	0	3,854	2	149	1,259	2,444

University Hospitals of Derby and Burton NHS Foundation Trust

2021/22	Target	Year to date	Q1	Q2	Q3	Q4
A&E 4-hour trolley target	95%	68.29%	75.16%	69.39%	65.12%	63.28%
12-hour trolley breaches	0	971	9	66	302	594

The Royal Wolverhampton NHS Trust

2021/22	Target	Year to date	Q1	Q2	Q3	Q4
A&E 4-hour trolley target	95%	80.25%	82.42%	80.21%	79.17%	79.16%
12-hour trolley breaches	0	485	4	19	173	289

University Hospitals Birmingham NHS Foundation Trust

2021/22	Target	Year to date	Q1	Q2	Q3	Q4
A&E 4-hour trolley target	95%	56.99%	65.50%	55.17%	53.55%	53.27%
12-hour trolley breaches	0	1,033	5	87	391	550

The Dudley Group NHS Foundation Trust

2021/22	Target	Year to date	Q1	Q2	Q3	Q4
A&E 4-hour trolley target	95%	77.97%	83.00%	77.04%	76.73%	74.61%
12-hour trolley breaches	0	257	0	68	77	112

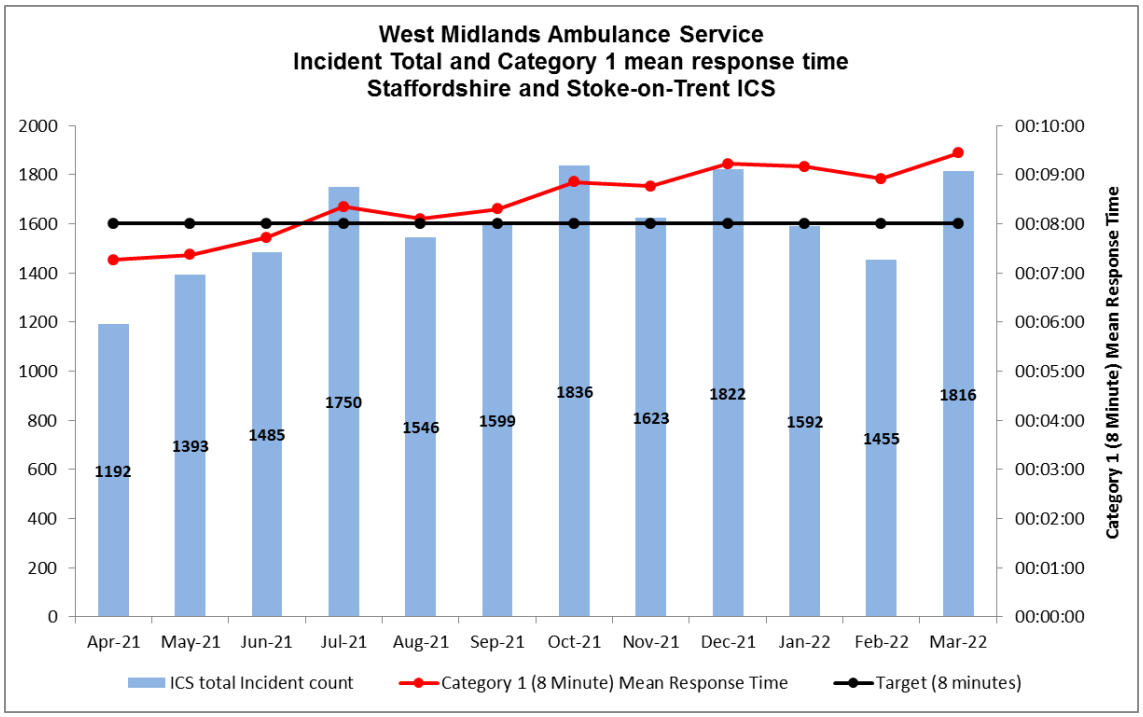
Walsall Healthcare NHS Trust

2021/22	Target	Year to date	Q1	Q2	Q3	Q4
A&E 4-hour trolley target	95%	81.44%	90.75%	80.55%	77.86%	76.71%
12-hour trolley breaches	0	33	5	12	7	9

West Midlands Ambulance Service

Ambulance services are measured by the time it takes from receiving a 999 call to a vehicle arriving at the patient's location.

The chart below shows the average (mean) response times in minutes to Category 1 (life-threatening) ambulance calls across the Staffordshire and Stoke-on-Trent ICS. The number of calls is also shown. The target response time is eight minutes.



From July 2021, response times have exceeded eight minutes. This coincides with an increase in the number of calls.

Further details on performance against the Constitutional Standards and other key targets are outlined in the Performance analysis section.

Performance analysis

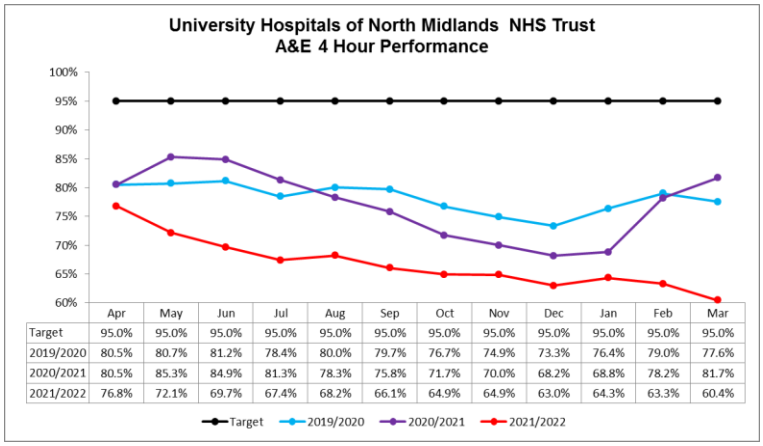
Urgent and emergency care

In 2020/21, numbers of emergency department attendances were close to pre-COVID-19 levels. Although the number of COVID-19 patients in hospital has been lower than 2020/21, the flow of patients through the hospitals has been affected. This is due to the longer length of stay for COVID-19 positive patients and restrictions on discharge of positive patients to care homes and community services.

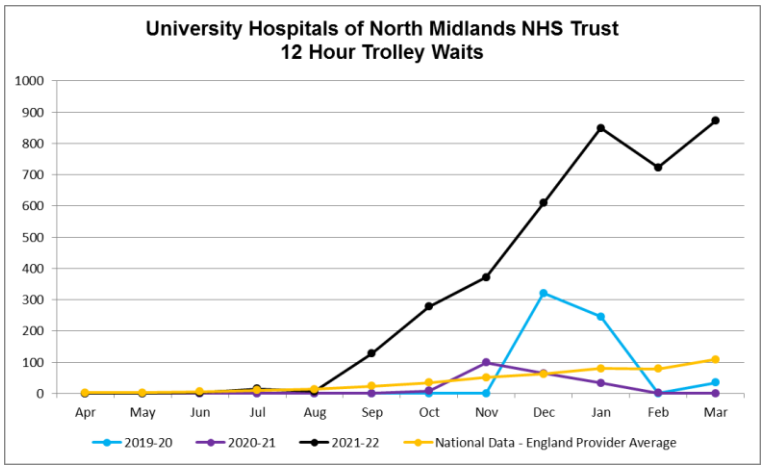
These unprecedented challenges are reflected in the performance against the urgent care constitutional standards – the proportion of emergency department patients seen within four hours of arrival, and the number of patients waiting on a trolley for 12 hours or more.

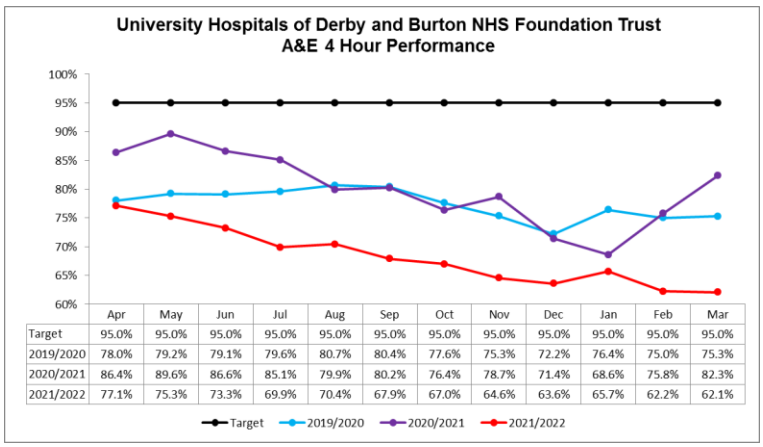
A&E performance is reported at provider trust level, rather than CCG.

All six of Cannock Chase CCG's acute core providers have seen an increase in 12-hour trolley breaches. Performance against the four-hour A&E standard (four hours from booking into A&E to being admitted, discharged or transferred to another facility) has continued to prove challenging. The target of seeing 95% of patients within four hours was not achieved during 2021/22.

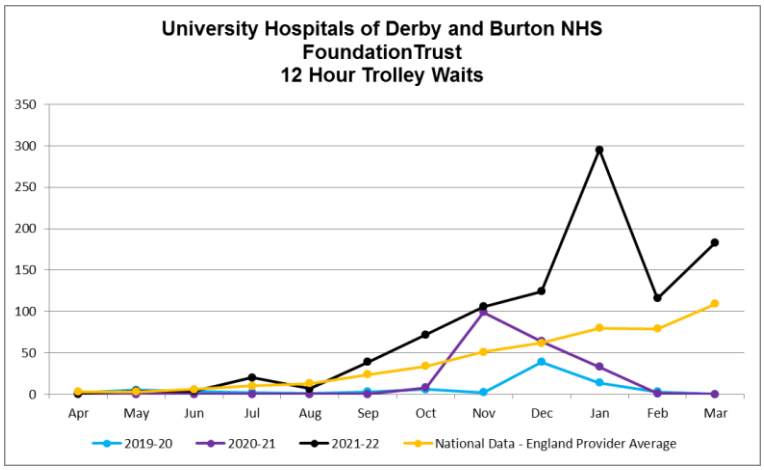


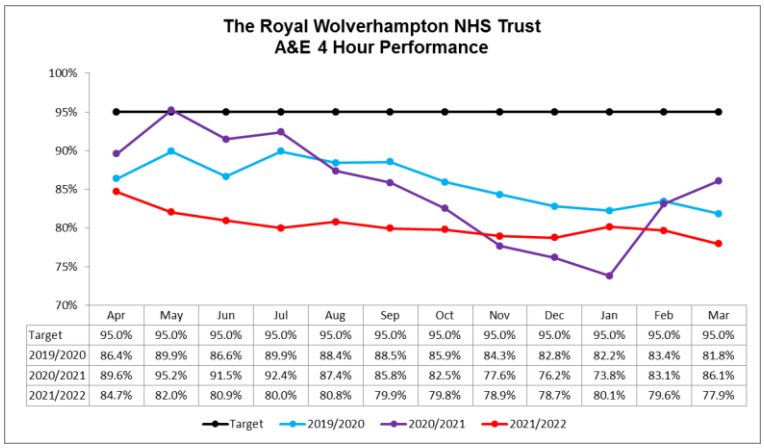
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2019/2020	80.5%	80.7%	81.2%	78.4%	80.0%	79.7%	76.7%	74.9%	73.3%	76.4%	79.0%	77.6%
2020/2021	80.5%	85.3%	84.9%	81.3%	78.3%	75.8%	71.7%	70.0%	68.2%	68.8%	78.2%	81.7%
2021/2022	76.8%	72.1%	69.7%	67.4%	68.2%	66.1%	64.9%	64.9%	63.0%	64.3%	63.3%	60.4%



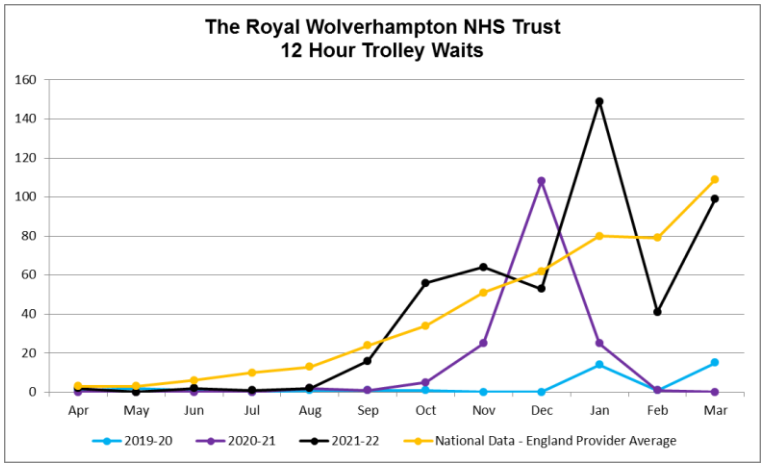


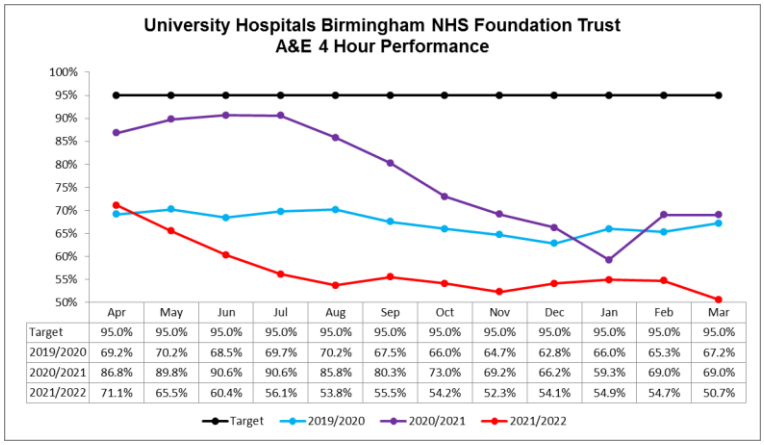
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2019/2020	78.0%	79.2%	79.1%	79.6%	80.7%	80.4%	77.6%	75.3%	72.2%	76.4%	75.0%	75.3%
2020/2021	86.4%	89.6%	86.6%	85.1%	79.9%	80.2%	76.4%	78.7%	71.4%	68.6%	75.8%	82.3%
2021/2022	77.1%	75.3%	73.3%	69.9%	70.4%	67.9%	67.0%	64.6%	63.6%	65.7%	62.2%	62.1%



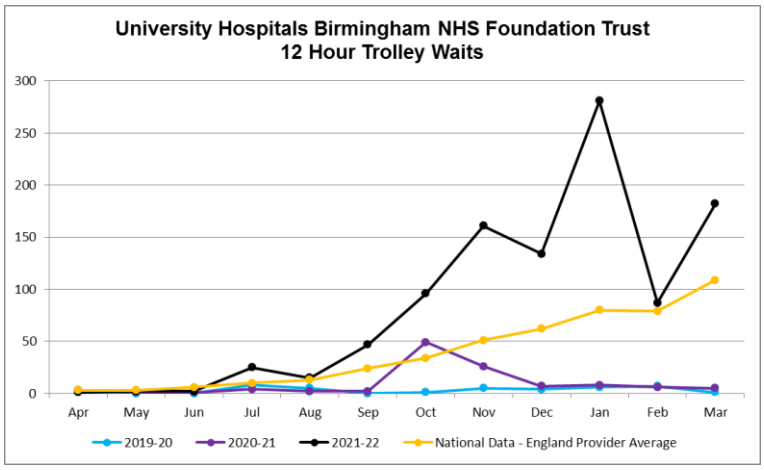


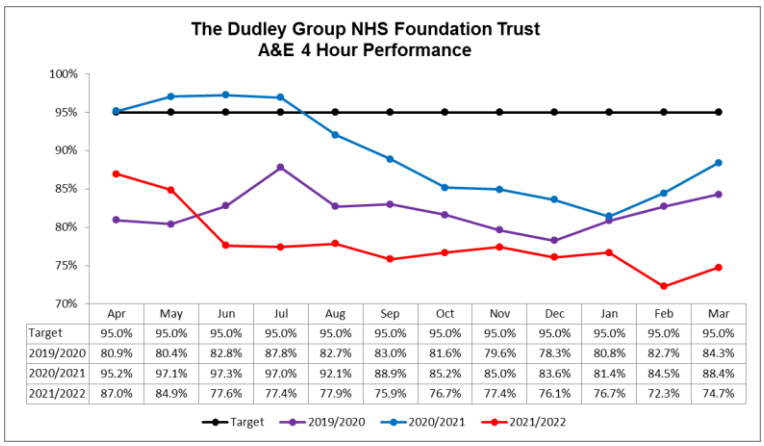
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2019/2020	86.4%	89.9%	86.6%	89.9%	88.4%	88.5%	85.9%	84.3%	82.8%	82.2%	83.4%	81.8%
2020/2021	89.6%	95.2%	91.5%	92.4%	87.4%	85.8%	82.5%	77.6%	76.2%	73.8%	83.1%	86.1%
2021/2022	84.7%	82.0%	80.9%	80.0%	80.8%	79.9%	79.8%	78.9%	78.7%	80.1%	79.6%	77.9%



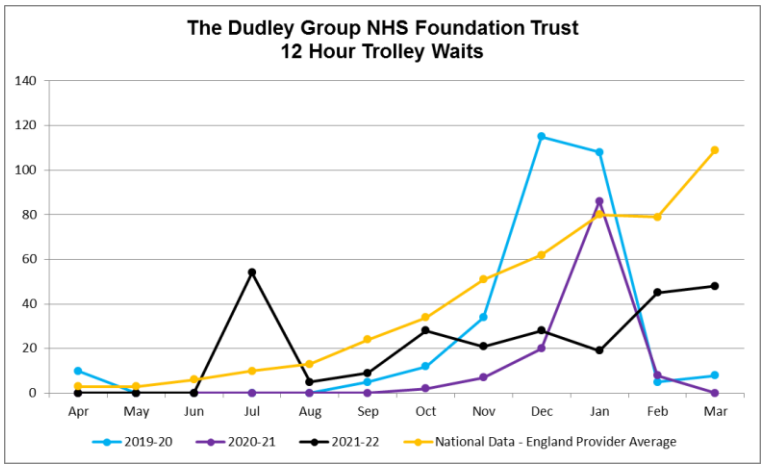


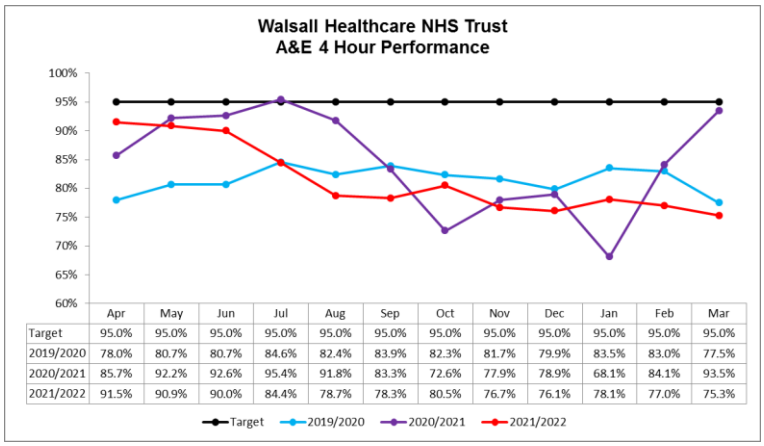
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2019/2020	69.2%	70.2%	68.5%	69.7%	70.2%	67.5%	66.0%	64.7%	62.8%	66.0%	65.3%	67.2%
2020/2021	86.8%	89.8%	90.6%	90.6%	85.8%	80.3%	73.0%	69.2%	66.2%	59.3%	69.0%	69.0%
2021/2022	71.1%	65.5%	60.4%	56.1%	53.8%	55.5%	54.2%	52.3%	54.1%	54.9%	54.7%	50.7%



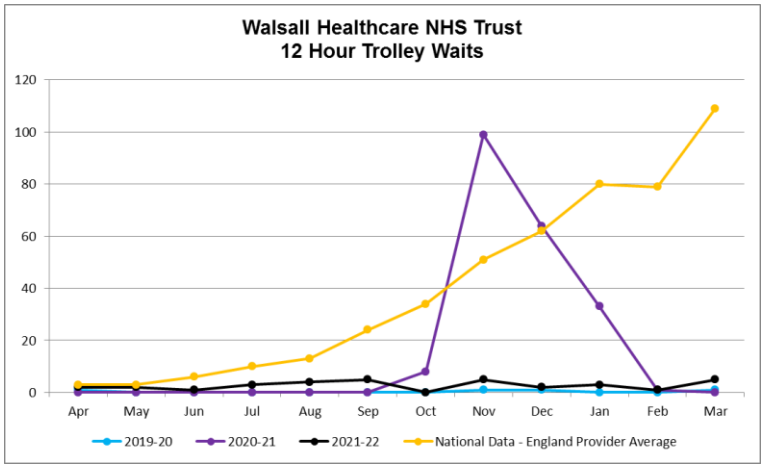


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2019/2020	80.9%	80.4%	82.8%	87.8%	82.7%	83.0%	81.6%	79.6%	78.3%	80.8%	82.7%	84.3%
2020/2021	95.2%	97.1%	97.3%	97.0%	92.1%	88.9%	85.2%	85.0%	83.6%	81.4%	84.5%	88.4%
2021/2022	87.0%	84.9%	77.6%	77.4%	77.9%	75.9%	76.7%	77.4%	76.1%	76.7%	72.3%	74.7%





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2019/2020	78.0%	80.7%	80.7%	84.6%	82.4%	83.9%	82.3%	81.7%	79.9%	83.5%	83.0%	77.5%
2020/2021	85.7%	92.2%	92.6%	95.4%	91.8%	83.3%	72.6%	77.9%	78.9%	68.1%	84.1%	93.5%
2021/2022	91.5%	90.9%	90.0%	84.4%	78.7%	78.3%	80.5%	76.7%	76.1%	78.1%	77.0%	75.3%



The CCGs' Quality and Safety Committees in Common (QSCC) meet throughout the year to monitor and review all quality and safety risks.

The ICS Clinical and Care Risk meeting continues to meet twice a week to ensure that the most significant risks to patient safety are understood across the system, allowing appropriate allocation of resources and support escalation as required.

Elective care

The key focus for the NHS in 2021/22 was the restoration of elective care services, as set out in the NHS operational planning guidance. Providers have worked hard to step up elective capacity and tackle backlogs, however pressures on our health and care services across Staffordshire and Stoke-on-Trent due to COVID-19 have continued to impact on recovery of activity to pre-pandemic levels.

COVID-19 has had a significant impact on plans to recover planned care activity. During the lockdowns in 2019/20 fewer patients were seeing their GP and being referred to secondary care for treatment. These patients are now starting to come forward. There are existing backlogs on hospital waiting lists resulting from the postponement of elective surgery and some outpatient consultations during the same period.

The significant increase in COVID-19 from November 2021 meant that COVID-19 patients were occupying over 7% of acute beds in January 2022, rising to 10% in March 2022. Bed occupancy at UHNM was at 15.8%, UHDB was at 18.9% and RWT was at 9.9%. Total urgent care demand for beds has impacted on theatre and ward capacity to support elective care patients.

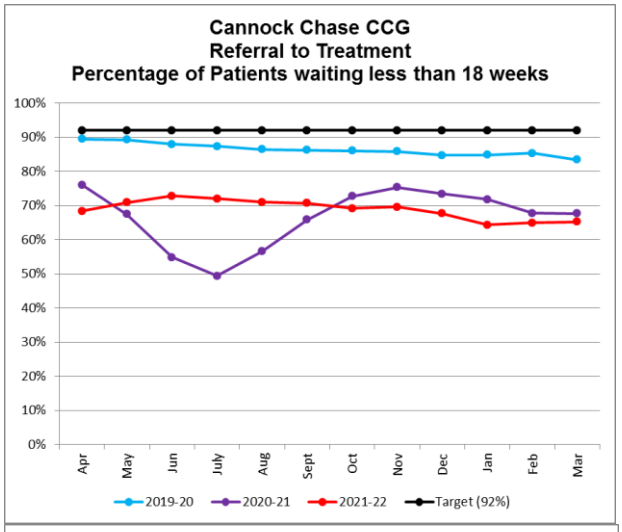
The above factors, along with staffing pressures and infection control measures, has meant that our patients are having to wait significantly longer for treatment in 2021/22. This has also meant that our acute providers have failed to meet the referral to treatment standards this year.

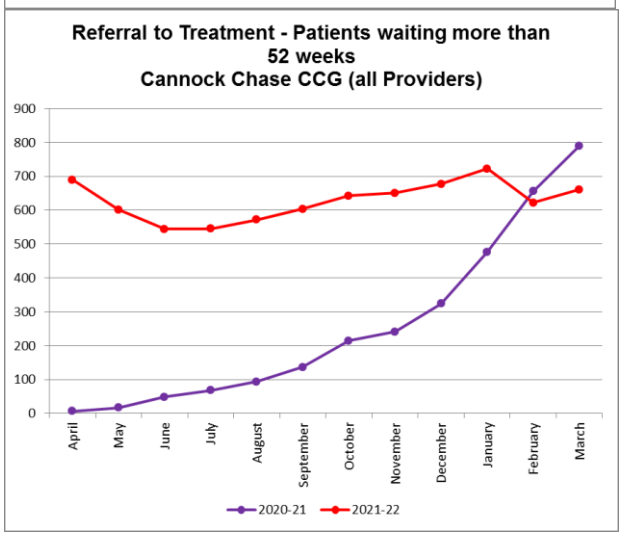
The Referral to Treatment (RTT) standard is part of the NHS Constitution and requires that 92% of patients should wait no more than 18 weeks from referral to the start of their treatment and that no patients should wait over 52 weeks for treatment.

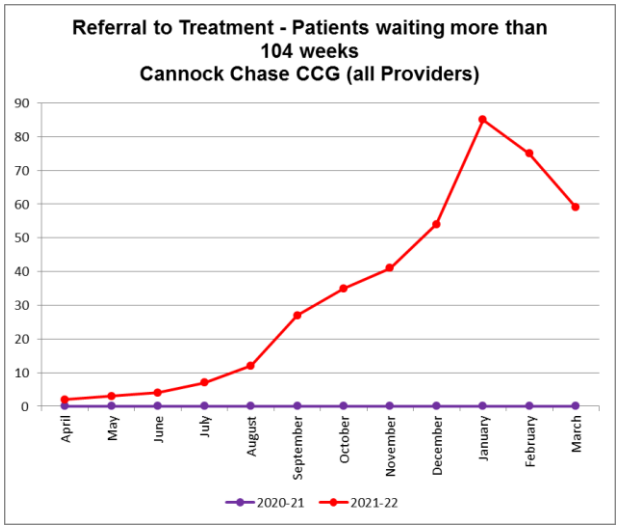
The graphs below demonstrate that the proportion of patients waiting more than 18 weeks and 52 weeks for treatment has increased significantly throughout the year, and there has been significant growth in the number of people waiting more than 52 weeks, and a number of patients are now waiting 104 weeks (two years) or more. Long waits are much higher in comparison to last year however the number of patients waiting over 104 weeks has started to fall from February due to a concentrated effort from providers to focus on eliminating these very long waits.

In March 2022, a total of 661 patients were waiting over 52 weeks for Cannock Chase CCG and 59 were waiting over 104 weeks.

Referral to Treatment – Total percentage of Cannock Chase CCG patients seen within 18 weeks, 52 weeks and 104 weeks







All breaches of 52 and 104 weeks are subject to a harm review by the provider and a meeting is held which the CCG Quality team attends, to identify if any harm has occurred, and any learning and improvement are needed to patient pathways.

Providers continue to ensure that patients who have already had an extended wait for treatment can be prioritised alongside more urgent patients.

The sustainability and further improvement in reducing the numbers of beds occupied by patients who are medically fit for discharge (MFFD) is a key component of elective recovery, as well as of COVID-19 and winter resilience. Work is ongoing to ensure full system capacity is being utilised.

Outpatient services

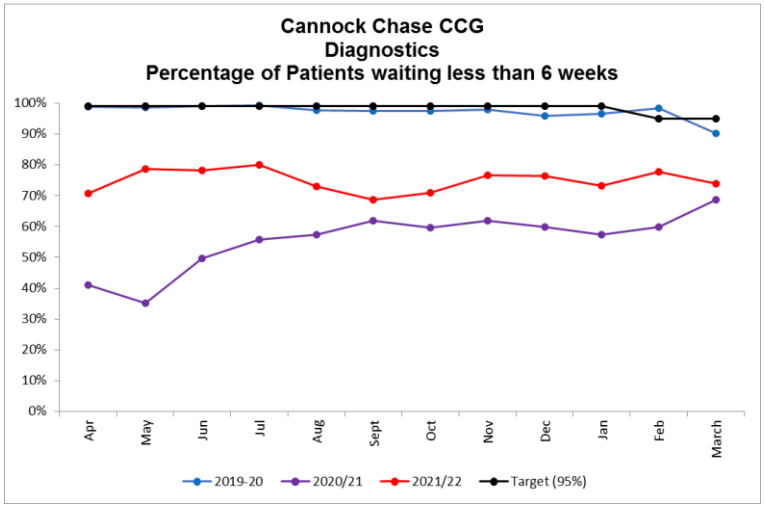
The system and providers are working collectively to transform outpatient services and reduce waiting times. For example, many outpatient consultations were held via video call so patients do not always have to travel to hospital.

Work is underway to reduce the number of unnecessary follow-up appointments. For example, in certain services patients with long-term conditions are being empowered to contact the hospital when they experience a flare-up in their condition and receive an appointment quickly.

Diagnostic services

Diagnostic services have been affected throughout the year by the continued impact of COVID-19, particularly in terms of staffing and infection control measures, as tests must be delivered in person by a trained operative.

The diagnostics standard is for patients to wait fewer than six weeks for a diagnostic test. The target was 99% up to January 2022, then the target was amended to 95% from February onwards. For Cannock Chase CCG, performance for Quarter 4 (January to March 2022) was 75.1%.



As with other activity diagnostic capacity has been affected by recent pressures, particularly since October 2021 due to rising levels of COVID-19 in the community.

Cannock Chase CCG is working intensely with our core acute providers to support them to manage pressures in elective care with a focus on reducing harm to patients. Fortnightly meetings are held with trusts to review those patients waiting the longest, and providers continue to ensure that patients who have already had extended wait for treatment can be prioritised alongside more urgent patients.

Our independent sector partners have also supported us in providing additional capacity to treat patients. Patients currently sitting on acute NHS trust waiting lists are being offered the opportunity to receive care in those facilities.

We are working with our providers to plan for increasing elective activity in 2022/23 to levels above those seen in pre-pandemic years across all pathways in order to bring down waiting times for our patients.

Cancer

Performance in cancer standards across Cannock Chase CCG has been variable throughout 2021/22. Relatively small patient numbers in some standards can lead to large fluctuations in performance month-on-month.

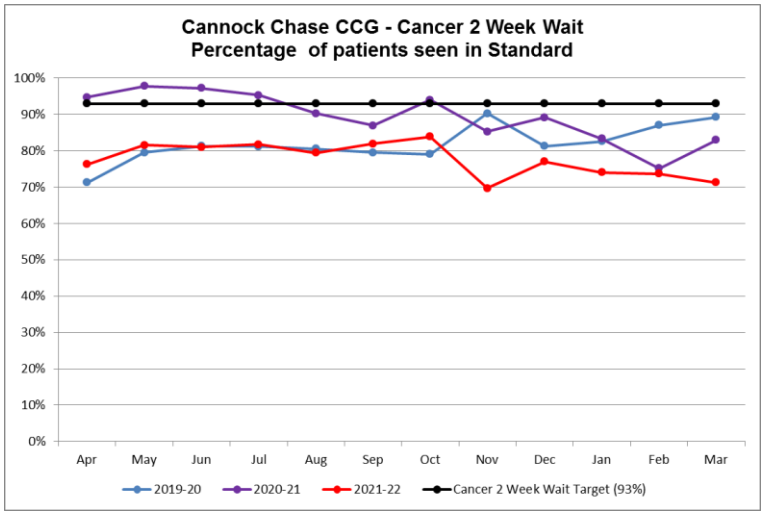
All cancer services have remained open throughout 2021/22, and have continued as a priority. However, the cancer pathway has been affected by staff sickness, in particular the need to self-isolate to protect this vulnerable group of patients. Cancer patients need access to diagnostics and specialist treatments, which have in turn been affected by COVID-19 pressures.

The overall number of patients attending their GP practice has returned to pre-COVID-19 levels and is starting to exceed levels seen in 2019. This has led to increased numbers of two-week wait referrals and patients attending screening.

Total number of Cannock Chase CCG patients seen as part of the two-week wait cancer standard by all providers

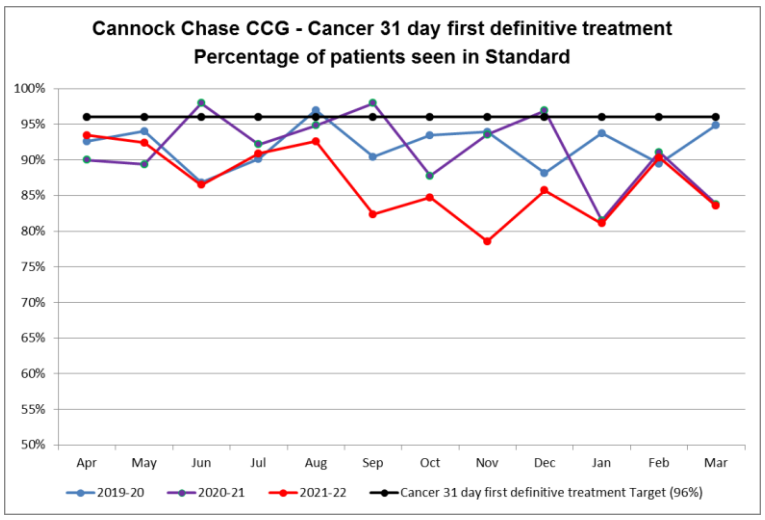
This standard covers patients seen by a specialist in secondary care following an urgent GP referral for suspected cancer. The standard states that 93% of patients should be seen within 14 days of the referral.

Although the target has not been met in 2021/22, performance has recovered to 2019/20 levels.



Total number of Cannock Chase CCG patients seen as part of the 31-day decision-to-treat to first treatment standard by all providers

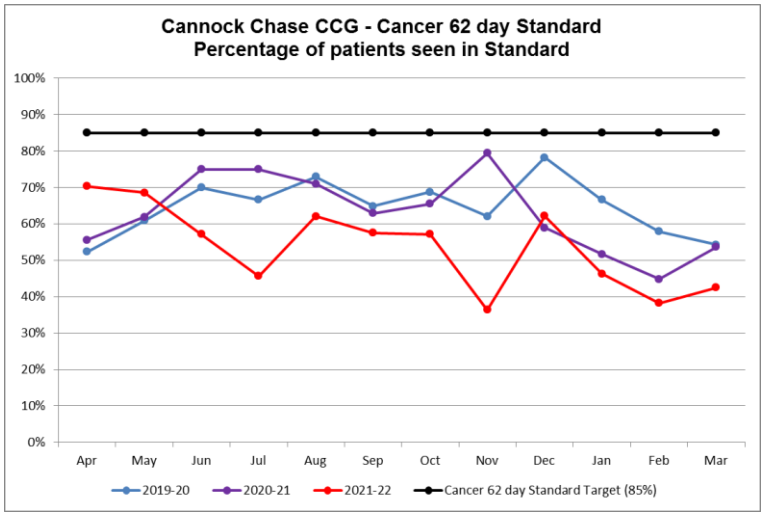
The standard covers patients starting a first definitive treatment for a new primary cancer within one month of a cancer diagnosis. The standard states that 96% of patients should receive a first definitive anti-cancer treatment within 31 days of the diagnosis date.



Performance against the 31-day decision to treat to first treatment standard has been variable since the pandemic started in 2020, although providers have been able to retain a position much closer to the 96% standard throughout. As at March 2022, UHNM reported 90% performance against the 96% standard. UHDB reported 91%, with RWT at 82%. The Dudley Group and Walsall Healthcare has largely been able to maintain a 100% position throughout the pandemic.

Total number of Cannock Chase CCG patients seen as part of the 62 day cancer standard by all providers

The standard covers patients starting a first definitive treatment for a new primary cancer following an urgent GP referral for suspected cancer. The standard states that 85% of patients should receive a first definitive anti-cancer treatment within 62 days of the urgent referral date.



Performance has been variable across the six core providers for the 62 day urgent referral to first treatment standard since the first lockdown in April 2020. In 2021/22, none of the main providers achieved the 85% target against this standard.

Total number of Cannock Chase CCG patients seen as part of the 62 day cancer screening standard by all providers

The standard states that 90% of patients should receive a first definitive anti-cancer treatment within 62 days following referral from an NHS cancer screening programme (breast, cervical or bowel).

Performance against this target has been affected by the build-up of demand from when screening programmes were paused during the height of the pandemic in 2019/20. For 2021/22, the numbers of patients added to the 62 day pathway each month are at similar levels as seen in 2019/20.

28 Day Faster Diagnosis

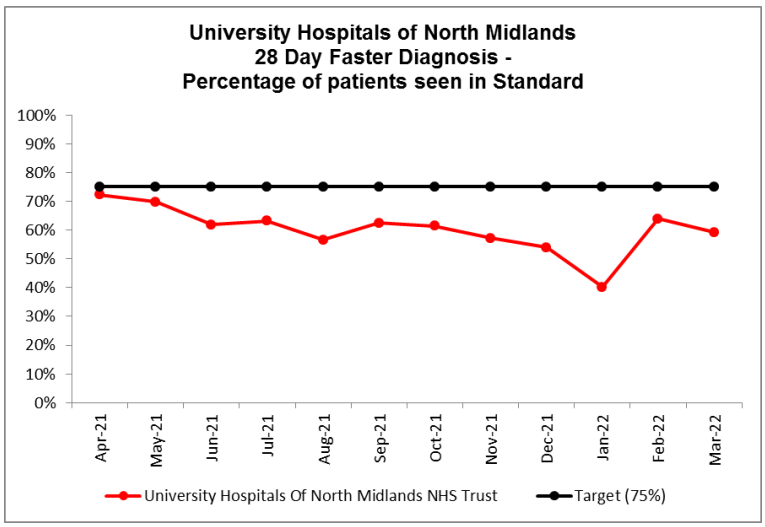
The Faster Diagnosis Standard (FDS) is a new performance standard to ensure patients who are referred for suspected cancer have a timely diagnosis. The standard was introduced in April 2020, and from October 2021 at least three quarters (75%) of patients should be told whether or not they have cancer within 28 days of an urgent referral from their GP or a cancer screening programme.

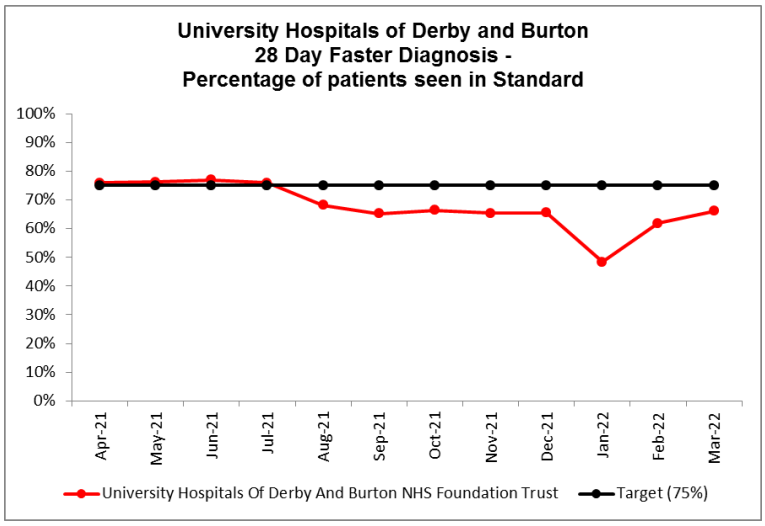
Total number of UHNM, UHDB, RWT, DGFT, UHB and Walsall Healthcare NHS Trust patients seen as part of the 28 day Faster Diagnosis standard

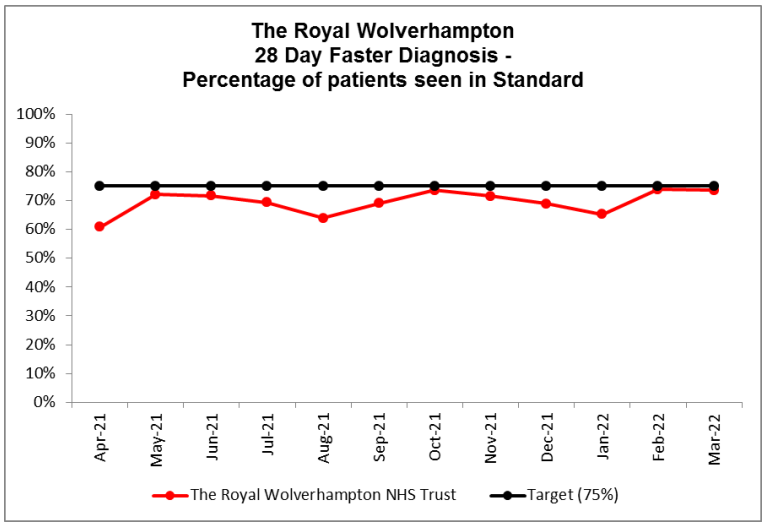
Please note that this data is currently reported at provider level.

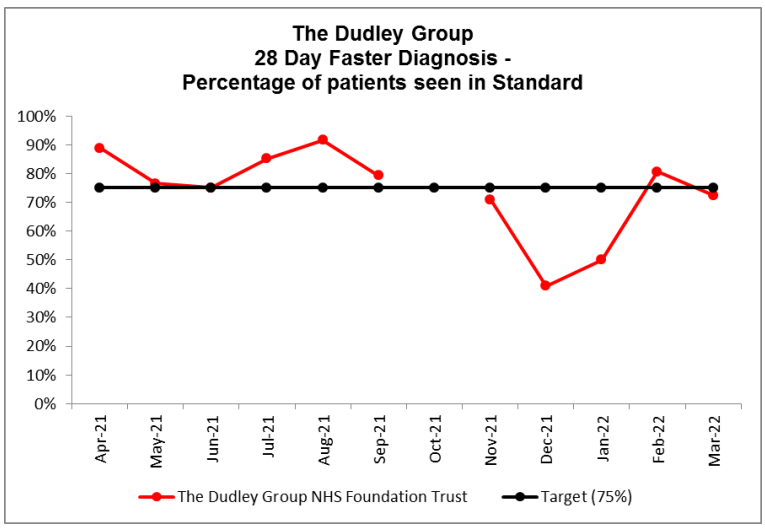
Performance for the 28 day faster diagnosis standard has remained variable across the six main providers. There has been a decline in performance across all providers in recent months. As of December 2021 all providers are below the 75% target.

The University Hospitals of Derby and Burton NHS Foundation Trust, The Royal Wolverhampton NHS Trust and The Dudley Group NHS Foundation Trust are close to achieving this target.




University Hospitals of Derby and Burton
28 Day Faster Diagnosis -
Percentage of patients seen in Standard
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
University Hospitals Of Derby And Burton NHS Foundation Trust
Target (75%)


The Royal Wolverhampton
28 Day Faster Diagnosis -
Percentage of patients seen in Standard
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
The Royal Wolverhampton NHS Trust
Target (75%)


The Dudley Group
28 Day Faster Diagnosis -
Percentage of patients seen in Standard
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-21
May-21
Jun-21
Jul-21
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Nov-21
Dec-21
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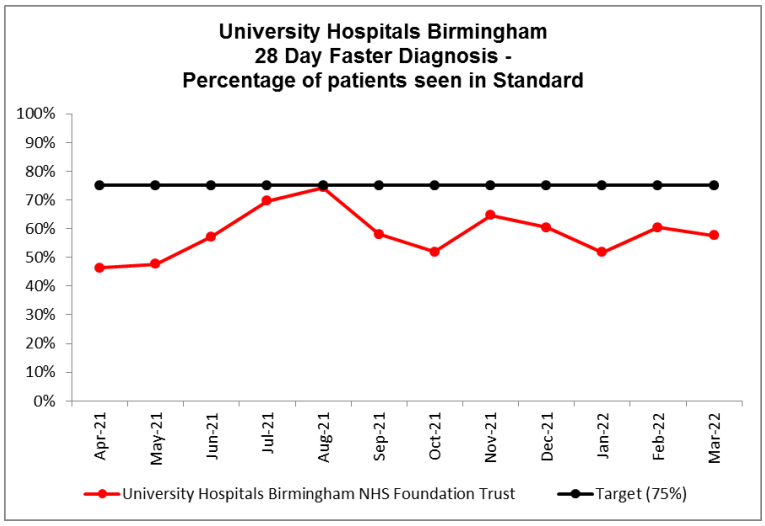
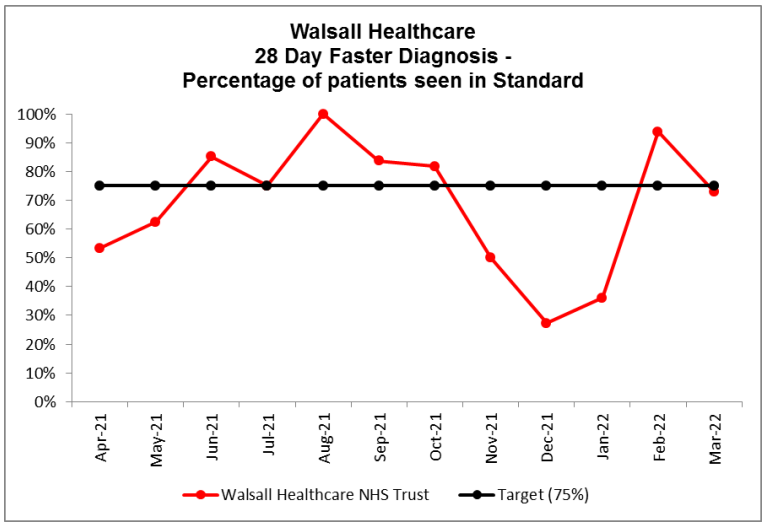
Feb-22
Mar-22
The Dudley Group NHS Foundation Trust
Target (75%)





Mental health

While the main focus has been around acute hospitals recovery, it is important to acknowledge the challenges and pressures which mental health, learning disabilities and autism services have faced, and also to acknowledge the achievements that have been made. NHS trusts providing mental health and learning disability services have and will continue to play a critical role, both to maintain services and to respond to COVID-19 and winter pressures. The main provider for Cannock Chase CCG is Midlands Partnership NHS Foundation Trust.

Demand continues to increase in primary and secondary care for mental health services which has had some effect on service delivery. However, notable

improvements have been made in performance across our main providers (MPFT and North Staffordshire Combined Healthcare NHS Trust).

Access rates for many adult and children's mental health services have improved. For example, for adults, waiting times for Early Intervention in Psychosis have been steadily improving, in January 2022 (the latest available data) the ICS as a whole achieved 77.6% of people with a first episode starting treatment within two weeks of referral, exceeding the national ambition of 60% and above the Midlands average.

COVID-19 has had a significant impact on workforce and also capacity across inpatient wards. All wards have been affected by both staff and patient outbreaks with most being closed at some point. Guidance was utilised to ensure that where it's clinically the only option patients can be admitted to wards. Despite these challenges, people have not been placed inappropriately out of area. Out of area placements fell steadily throughout the second half of the year – Cannock Chase CCG had zero patients placed out of area during 2021/22.

Improving Access to Psychological Therapies (IAPT) referrals remain below target due to the impact of COVID-19, but there has been a significant increase in referrals. Pathways are established with long-COVID clinics, and training of all IAPT staff on assessment and treatment of long-COVID.

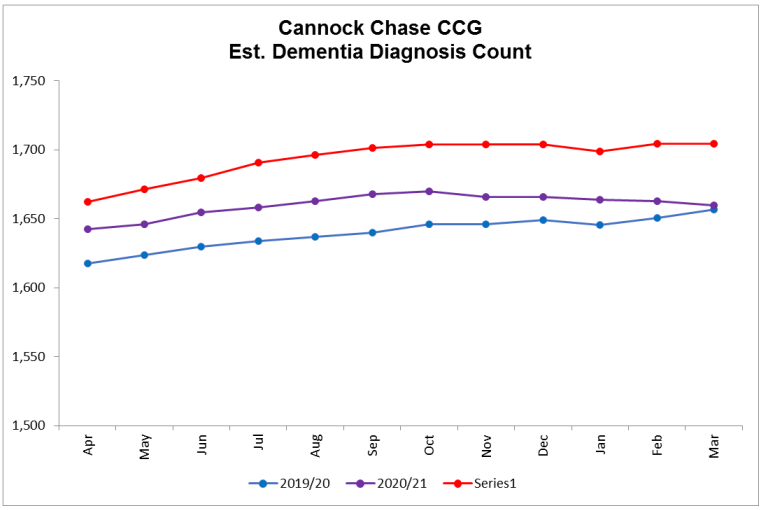
Dementia diagnosis

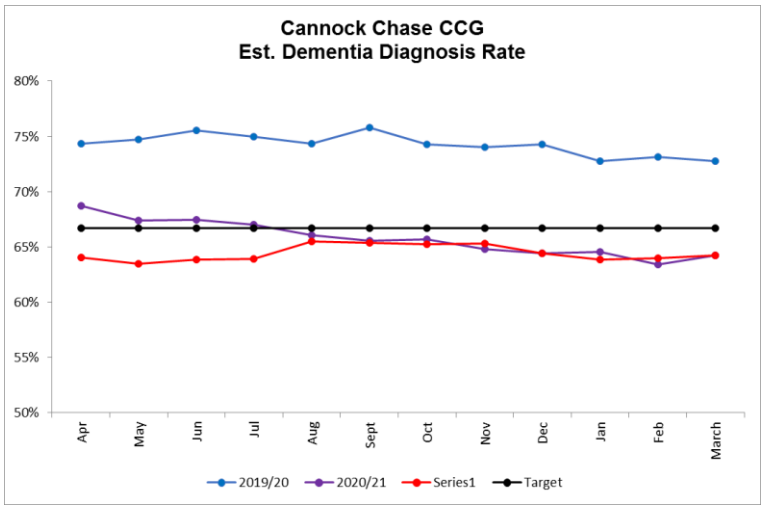
Across Staffordshire and Stoke-on-Trent, the dementia diagnosis rate has improved slightly throughout the year, although rates remain below pre-pandemic levels. The estimated diagnosis rate remains around 65% for the ICS.

The overall number of patients receiving a dementia diagnosis in the CCG are rising, which has resulted in an increase in demand for local services.

The charts below show the number of dementia diagnoses made and the rate. The diagnosis rate is calculated as the number of patients aged 65+ diagnosed as a percentage of the estimated dementia diagnosis count.

Cannock Chase CCG has not yet met the 66.7% target, however performance has improved from the middle of the year.





The six CCGs in Staffordshire and Stoke-on-Trent have enhanced the Hospital Avoidance Function that currently has been successful in supporting people with dementia staying out of a mental health hospital and receiving their care and treatment at home or in their usual place of residence.

Children and young people (CYP)

The ICS as a whole is on track to achieve the CYP access target. The target for 2021/22 is for 14,364 children and young people with a diagnosable mental health condition to have at least one contact with an NHS funded community mental health service. According to the most recent data available at the time of publication (January 2022), 13,952 children and young people have been seen.

Learning disabilities and autism

People with a learning disability often have poorer physical and mental health than other people. An annual health check can improve people's health by spotting problems earlier. Despite pressures, GP practices have delivered more health checks and increased the number of people on the Learning Disability (LD) register.

Practice staff made reasonable adjustments to make sure people with a learning disability continued to have access to annual health checks. For example, health checks are offered by phone or video call, and where face-to-face was needed, made sure these were done in a COVID-safe way.

The six CCGs are focused on improving uptake of annual health checks to reduce health inequalities. We are working to increase the rate of health checks for people aged 14 and over on a GP LD register – towards the NHS Long Term Plan ambition to achieve 75% in 2023/24. Some of the CCGs are already achieving this, with the remainder on track to achieve 75% of all people with LD having had an annual health check during 2023/24.

Learning from Lives and Deaths (LeDeR)

The LeDeR programme was set up as a service improvement programme to look at why people with a learning disability or autism are dying, and the changes we can make to services to improve the health of people with a learning disability and reduce health inequalities. Partnership and collaborative working is taking place

across the system, and early data is demonstrating an improvement in life expectancy for people with a learning disability.

Transforming Care Partnership

The Staffordshire and Stoke-on-Trent Transforming Care Partnership (TCP) continues to progress the ambitions set out in the 'Building the Right Support' document. The last year has been particularly successful in progress towards the year-end trajectory. The TCP has been acknowledged for its significant improvement.

The number of autistic people and those with a learning disability in Staffordshire and Stoke-on-Trent who have been inpatients for a long period of time continues to decrease. There has, however, been an increase in admissions particularly for children and young people with autism who appear to be struggling mainly due to COVID-19 restrictions. This is not unique to the local system, and is being seen across the country.

For many of the people discharged, their lives have been completely transformed with many enjoying new experiences in the community with their families and friends. The TCP will continue to be committed to discharging patients from inpatient hospitals back into the community.

The Transforming Care team moved to North Staffordshire Combined Healthcare NHS Trust (NSCHT) on 1 April 2021. NSCHT continue to support the current programme while the CCGs concentrate their efforts on the delivery of the objectives set out in the NHS Long Term Plan.

Reducing health inequalities[3]

Cannock Chase CCG is strengthening the governance and reporting arrangements in place to ensure that reducing health inequalities is a central part of achieving better outcomes for our patients. There is an Executive Board-level responsibility for addressing health inequalities in each NHS organisation – including the CCG. Both health and social care services are held to account for health inequalities through the Health and Wellbeing Board.

[3] References for 'Reducing health inequalities' section

- https://fingertips.phe.org.uk/search/life%20expectancy
- https://fingertips.phe.org.uk/search/infant%20mortality
- https://fingertips.phe.org.uk/profile/wider-determinants
- Disparities in the risk and outcomes of COVID-19, PHE. August 2020. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf
- https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

There are significant health inequalities across Staffordshire and Stoke-on-Trent, with Stoke-on-Trent being the 13th most deprived upper tier local authority in England.

There are also differences in health outcomes based on socio-economic factors. The life expectancy of the most deprived residents in Staffordshire is about eight years lower than the least deprived residents, and for Stoke-on-Trent this difference is about nine years. Reducing this gap will have a major impact on health outcomes for the population and achieve a major reduction in the demand for health and care services.

Early childhood indicators are poor across Staffordshire and Stoke-on-Trent. For example, Stoke-on-Trent has amongst the highest infant mortality rates in England, while rates in Staffordshire are also significantly higher than that of England.

The Marmot Review, published in 2010, highlighted the role of wider determinants of health by emphasising the strong link between social inequalities and disparities in health outcomes.

The COVID-19 pandemic has brought health inequalities back into sharp focus and has exacerbated health inequalities that already existed within the population.

Evidence shows that there have been disparities in the risk and outcomes from COVID-19 based around: age, geography, deprivation, ethnicity, socially excluded groups occupation, and comorbidities.

Reducing the risk of worsening health inequalities

Staffordshire and Stoke-on-Trent have five key priorities to our approach to addressing health inequalities:

1. Restore NHS services inclusively
2. Mitigate against digital exclusion
3. Ensure datasets are complete and timely
4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Strengthen leadership and accountability.

Given the impact of COVID-19 on health inequalities, as we restore NHS performance to pre-COVID-19 levels we are ensuring that we do not worsen inequalities. We therefore continue to expand the use of linked data, so that we can take into account population risk and health inequalities in reaching our decisions about how services are delivered and restored.

Population management approach to addressing health inequalities

We are adopting a population health management (PHM) approach to ensure the right data and intelligence are used to identify and address existing health inequalities. This will allow system partners both to develop a shared understanding of population need and to plan targeted interventions that will meet people's needs and result in better health outcomes.

Accelerating preventative programmes

Proactively reducing health inequalities and supporting the recovery of services in the community will involve community and social engagement and interventions for:

- preventative measures for COVID-19 including social distancing and hand hygiene
- promoting the uptake of COVID-19 vaccinations by communities at greatest risk
- promoting the uptake of the seasonal flu vaccination, childhood immunisations and vaccinations and accessing health services appropriately
- cardiovascular disease (CVD) prevention programmes as a key component of the NHS Long Term Plan and associated risks with COVID-19
- promoting non-medical models to improve wellbeing
- smoking cessation and other brief intervention advice to improve health.

Update on preventative programmes

The acceleration of preventative programmes, which proactively engages those at greatest risk of poor health outcomes is a key ambition for the Staffordshire and Stoke-on-Trent ICS.

As part of our response to treating tobacco dependency in 2021/22, we have started to develop the initial building blocks which will support this work to implement the recommended models across all inpatient and maternity settings. This includes the development of a governance structure including a multiagency ICS Tobacco Steering Group and Tobacco Dependency Delivery Groups across providers which is chaired by the CCGs.

Non-financial information, including social matters, respect for human rights, anti-corruption and anti-bribery matters

There are no issues to report for this financial year. Further information regarding these matters can be found in this report's dedicated Governance Statement section, including reference to Modern Slavery Act requirements for the CCGs.

The six Staffordshire and Stoke-on-Trent CCGs follow a robust process for Equality Impact and Risk Assessments (EIRAs) which includes governance, monitoring, one-to-one and/or team training and support in completing relevant and proportionate assessments. The EIRA process includes assessing any potential Human Rights impacts and gives consideration to the Human Rights Act 1998. Information is contained on the CCG's website regarding other key equality legislation, such as Human Rights Act 1998 and Health and Social Care Act 2012.

We also produce an annual Equality and Inclusion Report which can be accessed on our website. In addition, we have an accredited Local Counter-Fraud Specialist (LCFS) in place to undertake counter-fraud work proportionate to identified risks and this service is provided by our internal auditors – RSM. Work has continued throughout 2021/22 with a detailed Counter Fraud work programme approved by the CCG Audit Committees, with regular updates to these on progression of those deliverables and an annual Counter Fraud Report covering issues across the year as a whole. We have also continued to receive regular LCFS alerts about specific instances of fraud activities, which are cascaded to all staff. There are also regular staff awareness and training sessions conducted throughout the year to enhance staff vigilance about fraud.

Finally, all officers of the CCG and relevant decision makers are required to sign a declarations of interest form stating any relationships with other colleagues and organisations and are required to adhere to the updated CCG's Standards of Business Conduct policy, which was agreed by the governing bodies in October 2021.

Sustainable development

As an NHS organisation spending 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 services. Sustainability means spending public money well, using natural resources smartly and efficiently, 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 costs of natural resources.

The CCG continues to demonstrate a commitment to actively promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner. We recognise that everything we do has an impact on the environment, which in turn affects people's health and wellbeing.

All six CCGs in Staffordshire and Stoke-on-Trent are working together to make the most efficient use of our resources, including the estate. We continue to maintain HQ locality offices in Edwin House, Burton, and Smithfield One in Hanley, albeit with reduced staff footfalls and energy consumption due to pandemic response, as noted below.

Due to the COVID-19 pandemic, all staff (bar one or two exceptions) have worked from home for most of the year – in line with HM Government requirements. We have conducted all business meetings through Microsoft Teams, significantly reducing our carbon footprint by removing the need to travel and use utilities in buildings. Costs have fallen accordingly, with only the most essential journeys undertaken in a few isolated cases where homeworking was impossible.

All our offices are situated in purpose-built office blocks, designed to high environmental standards to reduce the carbon footprint of the CCGs. Smithfield One has been built to a Building Research Establishment Environmental Assessment Method 'excellent' standard. Energy consumption, water consumption and waste are all monitored and the Energy Performance Certificate for the building shows a 'B' standard of performance.

All our sites operate the following:

- Travel and transport schemes – as noted above, fuel costs have been reduced to negligible amounts due to enforced homeworking during COVID. Instead, the exclusive use of tele-conferencing and improved access to mobile IT devices as part of our Agile Working Framework have helped to achieve paper-light or paperless working
- Waste management – due to COVID-19 homeworking patterns and the use of tele-conferencing for all business meetings, there has been very little paper to recycle and confidential shredding is all but non-existent
- Procurement and supply chain management – ensuring that procured / commissioned goods and services are as energy-efficient as possible and reduce carbon emissions (included within the CCG's procurement strategy); including the use of contractual provisions to ensure that providers adopt sustainable business practices and implement the carbon reduction strategy
- Managing system risk – taking a whole-systems approach to our commissioning work and actively looking to manage future risks
- Staff training and attitudes – actively engaging our staff in delivering our Sustainable Development Plan objectives through the Back to the Future

(Agile Working) programme. Staff cited environmental and business benefits as a positive reason to support changing people's base to their home (after consultation in summer 2020), effective as of 1 April 2021

- Quality Innovation Productivity and Prevention (QIPP) and transformation work – designing and implementing schemes that support the delivery of good quality healthcare, delivered at the right time and in the right place to the right person; to help reduce the use of resources and carbon and improve sustainability.

Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that the CCG will continue to meet the needs of our local population during such events, we have developed and implemented a number of policies and protocols in partnership with other local agencies. These are included within our Business Continuity and Emergency Resilience Response Plans.

The Staffordshire and Stoke-on-Trent CCGs continue to play a core role in the "Greener NHS" response. We are members with the other statutory agencies and partners in the Staffordshire and Stoke-on-Trent Greener NHS Programme Board, which feeds into the main ICS Partnership.

Through this, we are also well represented at the NHS Midlands Greener Delivery Board, helping to deliver the Greener NHS Programme across the Midlands and East region. Both Boards help us to contribute to making the required progress towards delivering a net zero NHS.

To support our collective net zero ambition, every NHS Trust needs to develop a board-approved, three-year Green Plan. These set out each organisation's strategy and ambitions to reduce emissions in line with the national trajectory.

By 31 March 2022, our ICS will have collected and developed its first consolidated system-wide strategy, to be submitted and reviewed regionally. We are following NHSE/I Green Plan guidance to create an integrated document that describes our journey, governance arrangements and core local ambitions towards national net zero targets. As part of the initial work towards this, every NHS organisation and our ICS have confirmed a board-level net zero lead with accountability for this work, with our NHSE/I regional team.

Through North Staffordshire Combined Healthcare NHS Trust (acting as lead co-ordinating agency across the ICS partnership acting under a joint Memorandum of Understanding: MOU), we have secured additional specialist support needed to help us develop and then deliver our joint ICS Green Plan. This work has involved establishing pan-organisation baseline data on individual aspirations for sustainability to facilitate a co-ordinated ICS approach to the interim NHS Green Plan requirements of:

- corporate approaches
- greenhouse gas emissions
- capital projects
- sustainable use of resources, care models and sustainable travel
- our people

- climate change adaptation
- our sustainable procurement programme
- green space and biodiversity.

The purpose of this MOU is to define the functions and actions of local partners and the Regional Greener NHS team, as well as our core deliverables for 2021/22, set out as the three priorities of our ICS programme:

1. Meeting the NHS's net zero targets:
    - An 80% reduction in the emissions we control directly (NHS Carbon Footprint) by 2028-32, and net zero by 2040
    - An 80% reduction in our entire emissions profile (NHS Carbon Footprint Plus) by 2036-39, and net zero by 2045
2. Improving health and patient care and reducing health inequalities
3. Building a more resilient healthcare system that understands and is responding to the direct and indirect threats posed by climate change.

Meeting these three outcomes will result in a wide range of ancillary benefits – from improved air quality to reductions in plastic waste, across a broad range of sustainability issues. Importantly, the success of the programme will be measured against the extent to which the three priorities above are met locally.

Statutory duties

The CCG has a number of statutory duties under section 14Z15(2)(a) of the Health and Social Care Act 2012 and section 116B(1)(b) of the Local Government and Public Involvement in Health Act relating to:

- improving the quality of services (Duty 14R)
- reducing inequalities (Duty 14T)
- public involvement and consultation (Duty 14Z2)
- contributing to the delivery of any joint health and wellbeing strategy
- section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

The CCG also has statutory duties relating to safeguarding adults and children which are as follows:

- the Children Act 1989
- the Children Act 2004
- the Adoption and Children Act 2002
- the Care Act 2014
- Working Together to Safeguard Children 2018.

The following sections of this report focus on quality, partnerships and public and patient involvement, and explain how the CCG has discharged its statutory duties in these areas during 2021/22.

The CCG certifies that we have complied with the statutory duties laid down in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Maintaining and improving the quality and safety of services

The Staffordshire and Stoke-on-Trent CCGs work closely together. This is reflected in the joint governance through Quality and Safety Committees in Common (QSCC). The committee continued to meet (virtually) throughout 2021/22. During February 2021, due to system pressures and to enable the focus on managing the COVID-19 pandemic to continue, the QSCC agenda was refocused to prioritise patient safety and areas of risk across the system.

Quality is everyone's business, and the patient journey today often involves multiple providers. It is therefore important that all organisations and individuals involved have strong relationships and work together in a systematic way to understand patients' needs and ensure that care is safe, effective and provides a positive experience. It is only when all strands of quality come together that high-quality care is achieved. We have well-established working relationships, and we continue to work proactively with our main providers via Clinical Quality Review Meetings (CQRMs), to ensure that our vision for quality patient care is delivered.

The quality team works in partnership with providers to identify emerging quality concerns and assist with prompt resolutions. These have taken the form of CQRMs or touch-point meetings with a clear focus on patient safety.

The CCGs are committed to continually working with all providers as we move into 2022/23 and through the transition into the Integrated Care System. We aspire to maintain and continue to improve the high levels of quality and safety of care provided for our local population. The CCGs recognise the importance of working together to achieve the best health and wellbeing outcomes for the people of Staffordshire and Stoke-on-Trent, building on the progress and work currently being undertaken.

General quality improvement

The Nursing and Quality Directorate in the CCG has continued to work tirelessly and in partnership to ensure the delivery of high-quality service provision for local people. We have continued to review the processes and mechanisms we use, and continued to build relationships with our respective stakeholders and providers of healthcare, which are:

- University Hospitals of North Midlands NHS Trust (UHNM)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- Midlands Partnership NHS Foundation Trust (MPFT)
- Vocare – Integrated Urgent Care

- Independent hospitals.

We also work with some out of area providers, detailed below.

The following summaries present an overview of the discussions that the quality team have had with key providers during the past year, and the identified quality improvements.

All Patient-Led Assessments of Care Environment (PLACE) scores for providers from which the CCG commissions services can be found on the NHS Digital website.

North Staffordshire Combined Healthcare Trust (NSCHT)

North Staffordshire Combined Healthcare Trust (NSCHT) have worked as a valued system partner during the COVID-19 major incident response. We recognise the impact the pandemic has had on staffing and services since mid-January 2020. NSCHT remains rated as 'outstanding' by the Care Quality Commission (CQC). The CCG continue to work alongside the Trust to support it to maintain its strong reputation.

With the support of the Trust and Healthwatch Stoke-on-Trent, the CCG continues to complete virtual quality visits to provide real-time assurance on the quality of services provided. Vacancy management has been a major factor for the provider over the last 12 months. The Trust has devised a number of innovative recruitment projects, working closely with other providers and local universities, including the co-production of a joint bid to recruit international nurses and the continuation of the Nurse Preceptee course.

The Trust launched a Regroup-Reflect-Recharge campaign in April 2021 to seek the views of staff. Five key themes were captured including agile and flexible working, health and wellbeing, a move away from the perceived 'always on' culture with protected time and rest breaks, staff engagement and away days, as well as an estates and facilities review. A number of actions have been taken in response.

Projects continued throughout the year including Project Chrysalis to deliver the eradication of dormitory style wards and anti-ligature work, the introduction of a co-produced Wellbeing College and commencement of the three-year Community Mental Health Transformation Programme, giving service users the opportunity to get involved in the transformation of community mental health services in Stoke-on-Trent and North Staffordshire.

Midlands Partnership NHS Foundation Trust (MPFT)

The Trust have encountered many more challenges over the past 12 months with the ongoing COVID-19 pandemic and the variations of the virus, which has meant that the Trust has had to react quickly to the demands on their services, ensuring patient safety remained a top priority. The Trust undertook a significant piece of work around learning from experience from the previous 12 months (2020/21), engaging with staff to understand what could be done differently to ensure that the right skill mix was in the right place and at the right time. Throughout this period, the CCG and Trust continued to hold bimonthly Clinical Quality Review Meetings. Or, where capacity was limited, either Touch Point meetings or Patient Safety Focus meetings, enabling continued assurance around the quality, safety and care for service users.

The Trust has continued to undertake a comprehensive Health Care Associated Infections (HCAI) programme of work relating to COVID-19 during 2021/22, managing outbreaks effectively even with the staffing challenges of COVID-related illness. The HCAI team have also worked as systems partners with regards to the vaccination programme with the Trust's Chief Executive Officer being the Senior Responsible Officer for the programme.

The Trust has undertaken a programme of virtual Quality Standards Assurance visits (QSAV), which have proved to be very successful and has enabled both the CCG and Trust the opportunity to have open and transparent discussions with staff from different care groups. The virtual QSAVs have given the Trust and CCG the opportunity to hear and gain assurance of the good work that has taken place across the service areas and support teams where there have been challenges.

The Trust were nationally recognised for their people and organisation development work and were shortlisted for two Healthcare People Management Association (HPMA) Excellence in People awards which recognise and celebrate the work of human resources (HR), organisational development (OD) and workforce professionals in healthcare across the UK. The first for the Capsticks Award for innovation in HR for the 'Big Shout Out', a virtual celebration and 'thank you' to staff for their efforts throughout 2020 and the challenges of the COVID-19 pandemic. The event included three virtual festival tents and over 40 hours of digital content, based on the themes of compassion, collaboration and celebration.

The second was for the Academi Wales Award for excellence in OD for an OD initiative or project that had significantly benefited the organisation through improved effectiveness or viability, for the Trust's innovative collaboration programme and hub, 'In Our Gift'. The programme aims to capture the art of the possible by harnessing the talents of staff from across the organisation. It uses a digital platform to enable colleagues to connect, influence and collaborate to improve the experiences of staff and service users.

The Trust were shortlisted for the Health Service Journal (HSJ) Mental Health Provider of the Year 2021, in recognition of the organisation's commitment to partnership and quality improvement alongside a strong focus on staff engagement and involvement in research.

University Hospitals of North Midlands NHS Trust (UHNM)

UHNM had a second very challenging year due to the COVID-19 pandemic dominating 2021/22. Throughout the year and following relaxation of government restrictions, UHNM has seen an increase in emergency department (ED) attendances and has received high volumes of referrals for patients with suspected cancer. The ED has had times throughout the year when the Trust were moved to escalation level 4 and they declared a major incident during mid-September 2021 and January 2022 due to the Omicron variant of COVID-19.

During these times of high demand, 12-hour trolley breaches occurred along with ambulance handover delays as seen nationally. The Trust has undertaken harm reviews for the affected patients and has held panels with the CCGs' Quality Leads in attendance. These have continued throughout the year. Due to the number of ambulance handover delays and in order to maintain safety, the Trust introduced a standard operating procedure to monitor patients and escalate into ED when

required. UHNM has worked with system partners to undertake initiatives to try to reduce ED attendances and improve hospital flow.

During the second COVID-19 surge in the first year of the pandemic, due to high inpatient numbers, a major incident was declared which resulted in further cancellations of elective work. This has inevitably led to significant backlogs. Throughout the pandemic, the Trust has prioritised cancer work and urgent patients with the triage of referrals and clinical prioritisation of waiting lists. The Trust has undertaken harm reviews for those patients who waited longer than 52 weeks to complete their treatment. The CCGs' Quality Leads attended panels to review cases by speciality. The Trust have continued to utilise the independent sector hospitals for suitable elective patients.

In January 2022, the UHNM workforce was significantly impacted by the Omicron variant, with high sickness levels across the Trust. Many staff were either testing positive or self-isolating due to being in contact with a positive case. The Trust redeployed staff from elective areas and had support from the army to ensure patient care and safety were maintained. The Trust's COVID-19 vaccination programme, led by the Infection Prevention and Control team, has (at the time of writing) administered around 8,379 booster vaccines to UHNM staff.

UHNM had a CQC inspection in August and October 2021, and the report was published in December 2021. The Trust received an overall rating of 'Requires Improvement' with rating changes for the 'Caring domain' from 'Good' to 'Outstanding'; and the 'Well Led domain' from 'Requires Improvement' to 'Good'.

Integrated urgent care

Urgent care centre and emergency department front door model

Vocare work as an active system partner alongside the urgent care centre (UCC) and the emergency department at Royal Stoke University Hospital, working collectively to ensure there is a robust model of care in place to meet the needs of patients. Members of a joint working group chaired by the CCG work together to improve patient flow and patient experience, ensuring the model of care is clinically safe and strive to resolve system problems to mitigate risk to patient safety.

A number of changes and improvements have been made over the last 12 months, including the introduction of a nurse navigator as a safety step which allows ambulatory patients to be immediately assessed and signposted to the most appropriate care setting. This includes sending patients direct to the UCC where they will be assessed as requiring primary care and ensuring patients are not transferred without appropriate clinical information being recorded on an appropriate auditable IT system.

NHS 111 kiosks have been installed at the front door of the accident and emergency department, which patients can use with the support of staff if required, to seek direction to the most appropriate care setting.

Independent hospitals

During 2021/22, the CCG continued close working with all the independent hospitals within the Staffordshire and Stoke-on-Trent footprint, as well as with key partners such as the CQC and NHSE/I. Work continued to strengthen and further develop

quality monitoring systems and processes for assurance for all stakeholders and service users.

On two occasions and with two of the independent hospitals, the CCG was required to have clear oversight and management of challenging situations for patients. Relocation was needed to be safely and appropriately facilitated by relevant placing commissioners.

In June 2021, a high dependency rehabilitation service was issued with an urgent notice of suspension of registration by the CQC with all patients required to be transferred within a six-week period. The CCG supported the provider of care and the placing commissioners in the safe management of closure and the safe relocation of 24 patients with complex needs. Following the closure, the CCG worked closely with NHSE/I in a debrief process to ensure clear lessons were learned and the learning shared appropriately. Unfortunately, those lessons were then required to be used soon after, to facilitate the closure of another independent mental health hospital, this time in Leek.

Following a poor CQC outcome, the CCG supported the hospital in Leek with their improvement plan, however the Board of Directors for the hospital made the decision to close the hospital, giving 12 weeks' notice. The CCG's Quality Team again supported the providers and placing commissioners in the safe management and safe relocation of all patients with complex needs, working closely with NHSE/I, the CQC and all system partners.

These events have led to the development and ongoing review of several processes, including clear oversight arrangements for CCG commissioned inpatient care for independent hospital review, a host commissioner escalation process and a Staffordshire system Memorandum of Understanding for failing independent hospitals.

As host commissioners, the CCGs continue to ensure appropriate communication processes are in place to share soft intelligence with meetings continuing throughout the year, despite pandemic pressures.

As was the situation last year due to the ongoing COVID-19 pandemic, several independent hospitals had COVID-19 outbreaks which were managed via a system-wide approach with assistance from key stakeholders as required, including NHSE/I and the UK Health Security Agency (previously Public Health England).

During 2021/22, the CCG continued with the quarterly meetings with independent hospitals and stakeholders, including NHSE/I, Healthwatch, Asist and safeguarding, to share intelligence, good practice and lessons learned.

As part of the quality improvement work planned for 2021/22, quality visits have occurred for all independent hospitals. Where required, action plans have been developed and monitored.

The CCG has also worked closely with NHSE/I to develop the national template used to support Safe and Well reviews for all children, young people and adults with a learning disability and autism. The 'Five Eye' review demonstrates the collective input and view of those involved with the individual. The aim is to ensure there is a system in place to receive intelligence and feedback regarding the quality of care from placing commissioners in decision making from provider service surveillance.

Out of area providers

A number of residents in Staffordshire and Stoke-on-Trent access services managed outside the area. In these instances, the six CCGs are associates to the contract held by another CCG (the lead commissioner) and work in partnership with the relevant trust and lead commissioner to support quality improvements for our residents.

The CQC inspected a number of these services throughout 2021/22, including:

The Dudley Group NHS Foundation Trust

The CQC carried out an unannounced focused inspection of the emergency department at Russells Hall Hospital in February 2021 (findings published April 2021). The inspection framework focused on key lines of enquiry under Safe, Responsive, and Well-Led domains and covered aspects of care that included care of the critically ill patient, infection prevention and control, patient flow, workforce, leadership, and culture. The CQC identified no 'must do' actions and four 'should do' actions to improve services. The full report is available on the CQC website.

University Hospitals of Birmingham NHS Foundation Trust (UHB)

UHB had an unannounced inspection from the CQC in April 2021. The inspection focused on urgent emergency care, medical care, cancer services and surgery as well as the Well-Led domain. The Trust's overall CQC rating and Safe and Responsive domains were all changed from 'Good' to 'Requires Improvement'. The CQC identified areas of outstanding practice within cancer services as well as areas for improvement. The full report is available on the CQC website.

University Hospitals Derby and Burton NHS Foundation Trust (UHDB)

UHDB had an announced focused inspection from the CQC in June 2021 to look at infection prevention and control. The inspection was not rated. The CQC identified one 'must do' action relating to the storage of equipment in patient bathrooms. The full report is available on the CQC website.

Walsall Healthcare NHS Trust (WHT)

The CQC carried out an unannounced focused inspection of the medical services at Manor Hospital in March 2021 (findings published May 2021). The inspection was in response to concerns around the safety and quality of services. Following the inspection, WHT were issued with a section 29a warning notice and the rating of the services changed to 'Inadequate'.

Further, the CQC carried out an unannounced focused inspection of the maternity service at the Manor Hospital in July 2021 (findings published October 2021). The inspection was in response to concerns around safety and governance. WHT were issued with two requirement notices.

The full reports are available on the CQC website. Black Country and West Birmingham CCGs have provided significant support to WHT and maintained oversight of the issues identified by the CQC.

General practice quality

The Primary Care team continue to monitor the quality and safety in general practices working closely with the CCGs' Quality team and other stakeholders including the Care Quality Commission.

Across Staffordshire and Stoke-on-Trent, 99% of practices are currently rated by the CQC as 'Good' or 'Outstanding', with work ongoing for those practices rated as 'Requires Improvement'. We currently have no practices rated 'Inadequate'.

A quality visit programme has taken place in 2021/22 as a two-way conversation on areas such as workforce and access. Themes and trends will be gathered once the programme is complete early in 2022/23 to share learning and identify any additional support for practices.

Incident investigation processes are supported also by the Quality team including the sharing of wider learning.

The General Practice Nurse Evidence Based Practice (GPN EBP) Group

The CCG continues to work collaboratively with Keele University to support the General Practice Nurse (GPN) Evidence Based Practice Group. The Group has been operational since 2015 with aims to review the most up-to-date evidence to deliver high-quality, safe and effective patient care with a focus on minimising unwarranted clinical variation.

The outcome is that evidence-based research translates into evidence-based practice. This is achieved through a partnership with primary care clinicians and clinical academics at Keele University. The group are very successful in supporting a change in practice where the evidence is available to promote more up to date ways of performing patient care and have further supported new studies where the evidence was lacking.

Since the group began, nurse participants have developed their leadership skills including co-authoring publications, presenting at conferences and lecturing on nurse education programmes. Many members of the group were also recognised by the Queen's Nursing Institute and received the Queen's Nurse award; an award that is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice.

The group continues to flourish and highlights the value of the general practice nursing workforce with a focus on leadership, career framework, professional roles, innovation and quality improvement.

Suicide Prevention Strategy Programme

The Staffordshire and Stoke-on-Trent Suicide Prevention Programme has succeeded in bringing multiple organisations around the table to discuss suicide-related matters and works at a strategic and operational level. The partnership, chaired by the CCG, coproduced and maintains a strategy and action plan with a primary aim of reducing the rate of suicide in Staffordshire and Stoke-on-Trent.

The current action plan is subject to refresh through a series of thematic workshops led by Public Health and Prevention at Staffordshire County Council with a focus on areas such as:

- targeting elevated risks or vulnerable groups
- reducing the risk of suicide for people in the criminal justice system
- ensuring a consistent approach to suicide mitigation
- assessment and safety planning across mental health (primary and secondary care)
- services for adults and children
- reducing access to means of poisoning (for example safer prescribing of painkillers and antidepressants)
- reducing the risk of suicide for people who misuse drugs and alcohol and for people who self-harm
- ensuring safe and appropriate access only, to certain physical locations of concern such as bridges and trainlines
- partnership response to emerging clusters of suicides
- ensuring timely updates of local and national data
- timely review of new publications to maintain best practice.

The core membership of the partnership is made up of multiple organisations who play a key role in suicide prevention including Stoke-on-Trent City Council Public Health, Staffordshire County Council Public Health, National Rail, Samaritans, the six Staffordshire and Stoke-on-Trent CCGs, Staffordshire Police, Staffordshire Fire Service, the Coroner's Office, Brighter Futures, North Staffordshire Combined NHS Trust, Midlands Partnership NHS Foundation Trust, Survivors of Bereavement by Suicide (SOBS), local universities, Changes and North Staffs User Group.

Links are being established with Staffordshire and Stoke-on-Trent Integrated Care System to ensure ongoing projects such as investment in bereavement support services, which dovetail with the work of the partnership.

As part of the #TalkSuicide campaign, suicide awareness and prevention training is available to small groups, using Zoom. The half-day online training is free and designed to:

- tackle misconceptions and stigma regarding suicide
- recognise the signs that someone may be at risk
- have open and honest dialogue about suicide
- use a simple four-step suicide intervention
- signpost to local support services.

Training is open to clinical staff across both primary and secondary care and members of the public with around 1,200 people attending training to date.

Quality visits

During the pandemic, in recognition of the pressures faced by providers and respecting COVID-19 safety measures, routine planned quality visits were paused. However, responsive quality visits continued. Further virtual quality visits have been piloted in collaboration with providers during periods of reduced pressure.

As part of our quality assurance and quality improvement process, the Quality team agreed to virtually attend provider internal assurance meetings. This ensured robust scrutiny and assurance that appropriate learning and actions were embedded in order to drive quality improvement and ensure patient safety. These internal meetings have included harm reviews, as well as reviews of pressure ulcers, falls, 12-hour trolley breaches and NHS Constitution breach panels, for issues such as waits over 52 weeks.

Delivery of the Quality and Patient Safety Strategy

Our key role is to commission the best possible services and achieve the best health outcomes for the population that we serve, within available resources. We will always champion quality and patient safety as a central principle, demonstrating that it should, and can, be maintained and improved alongside financial sustainability.

The Quality and Patient Safety Strategy 2019-21 describes a systematic quality assurance structure to ensure that performance concerns and risks around quality are escalated appropriately and openly. The structure incorporates the provider CQRMs and the Quality and Safety Committees ‘in Common’ (QSCC). In accordance with the National Quality Board guidance, a System Quality and Safety Committee was established in July 2021 to run in parallel with the CCG’s existing meetings. Further changes are planned in line with updated guidance published in January 2022.

The CCG is clinically led and committed to engaging with clinicians so that those who deliver care directly to patients can use their clinical knowledge and experience to inform and influence service provision and commissioning decisions.

Patient feedback continues to be received, evaluated and triangulated with other data at the QSCC. This has informed the CCG quality assurance response, which included virtual quality visits and onsite visits to some providers.

The patient journey often involves multiple providers across Staffordshire and Stoke-on-Trent, requiring many patients to travel outside of their immediate area. It is therefore important that all organisations and individuals involved have strong relationships and work together in a systematic way to understand patient needs and ensure that care is safe, effective and provides a positive experience. Furthermore, where the experience is found to be less than positive, mechanisms exist to ensure early warnings, shared learning and continuous improvement.

Patient feedback

The CCG understands how fundamental patient feedback is to the monitoring and influencing of high-quality and safe patient care that the CCG commissions. The patient voice and patient stories have the potential to identify any gaps and best practice in the quality of commissioned services. The patient feedback received by the QSCC is evaluated and triangulated, which informs CCG quality visits to providers or quality improvement work that is subsequently undertaken between the CCG and providers.

The Quality team gathers patient feedback from a variety of sources, including:

- patient group meetings at the QSCC
- Patient Engagement and Experience Reports
- Healthwatch and Soft Intelligence Reports
- CCG quality visits
- joint CCG and provider collaborative working
- GP 60-second reporting
- the Maternity Voices Partnership.

Patient feedback is communicated via the lay member representatives at the QSCC. If any quality or safety issues are identified, they are reviewed at the QSCC, which also hears patient stories and receives patient engagement and experience reports.

Patient Experience Report

The QSCC receives a six-monthly Patient Experience Report which includes an overview of the key themes and trends of patient feedback relating to all providers. The report also includes an overview of actions taken by providers in response to patient and public complaints, Members of Parliament letters, Patient Advice and Liaison Service (PALS) contacts and complaints received directly by the CCG.

Annual complaints analysis

All patients who are unhappy about a service that is funded or provided by the NHS have a right to make a complaint. We actively encourage patients and their families to complain when they are not satisfied with the service, care or treatment they receive.

People within the six Staffordshire and Stoke-on-Trent CCGs use a range of services in local hospitals, health centres or in their own homes and could choose who they make their complaint to. People can decide to complain directly to the provider of their care services or to the commissioner, in this case the CCGs.

From 1 April 2021, the CCGs took on the management of their complaints process from the CSU, with staff being TUPE'd (Transfer of Undertakings – Protection of Employment) across to fulfil this role. The team have immersed themselves well into the CCG. As part of this transfer, a new data system was also put into place – Ulysses – and this is now used to record all contacts with the Patient Services team.

A breakdown of the numbers and type of contacts received during 2021/22 is outlined below. Numbers have been high during this year and have continued to be heavily impacted by the COVID-19 pandemic. A three-month pause on complaints was put in place by NHS England from March to June 2020, and many large providers implemented a further pause when pandemic numbers increased. This continues to have an effect on the response times of our local providers.

Types of feedback received this year across the six Staffordshire and Stoke-on-Trent CCGs

Feedback type	Quarter 1 2021/22	Quarter 2 2021/22	Quarter 3 2021/22	Quarter 4 2021/22	TOTAL 2021/22
PALS	277	436	412	259	1,384
Complaints	44	43	70	49	206
MP letters	39	48	84	50	221
Compliments	3	5	6	4	18
TOTAL	**363**	**532**	**572**	**362**	**1,829**

Themes and trends

The services with the highest amount of feedback during 2021/22 are detailed below:

- **General practice services** – predominantly about the COVID-19 vaccination programme including queries around appointments, availability of appointments, questions about the vaccine, and problems with the vaccination status process. As well as this, issues raised related to accessing appointments, particularly GP appointments, changes to prescribing, and access to services
- **University Hospitals of North Midlands NHS Trust** – about accessing appointments, delays in treatment follow up care, waiting times to be seen, and clinical treatment across all the hospitals' specialities and wards
- **CCG Commissioning Decisions** – about changes to prescribing, fertility services, and treatments not routinely commissioned
- **Midlands Partnership NHS Foundation Trust** – about the commissioned community services.

Complaint outcomes

The table below shows the outcome of complaints closed during 2021/22. This is for cases closed, rather than received for this period. Some of the cases will have been received prior to Quarter 1 of 2021/22 and will remain open at the end of Quarter 4 of 2021/22.

Outcome code	2021/22
Closed by patient	14
Complaint / issue partially upheld	34
Complaint / issue already investigated / being investigated	11
Complaint / issue not upheld	30
Complaint / issue upheld	12
No consent therefore closed	3
No further action required	19
Referred on to Complaints Team	19
Information provided	5
Signposted to NHS England	4
Not recorded	45
TOTAL	**196**

Lessons learned from complaints and PALS

Complaints are viewed positively by the CCG, as they provide us with the opportunity to constantly review our processes to ensure that we continue to meet the needs of our service users. Investigating officers are provided with an investigation report detailing the objectives of their investigation and the issues which require a response. As part of that process, investigating officers tell us about changes or improvements they have made or plan to make and lessons learned where appropriate. We include this detail in our responses providing as much detail as possible.

The PALS team have worked closely with the System Vaccination Operation Centre (SVOC) during this year, dealing with many enquiries relating to the COVID-19 vaccination process.

Parliamentary and Health Service Ombudsman (PHSO)

The PHSO has contacted us in relation to three new cases this reporting period. Numbers per CCG areas are shown below:

- Stoke-on-Trent CCG: 1
- East Staffordshire CCG: 1
- South East Staffordshire and Seisdon Peninsula CCG: 1

Soft intelligence

Monitoring soft intelligence allows patients, the public and healthcare professionals to provide their feedback to the CCG about healthcare services in their local area. Soft intelligence is triangulated with other forms of quality data, to inform the quality team of any areas of quality and safety and good practice which require further attention.

Soft intelligence is reported on our Datix system and reviewed on a weekly basis by clinicians, to identify any themes or trends. Potential Serious Incidents and Never Events are acted upon immediately and processed via the most appropriate governance safety process. Soft intelligence is triaged by the Quality team and shared with Providers, where appropriate. All soft intelligence is presented to the Datix Monitoring Group for the purpose of reviewing themes and trends, and, where appropriate, undertaking a multidisciplinary review to propose further actions.

The group has representation from General Practice, Medicines Optimisation, the Primary Care team, patient representatives, members of the Nursing and Quality Directorate and lay members. The group meets monthly with the aim of improving patient care and safety and ensuring robust governance and assurance. A quarterly soft intelligence report is completed and reviewed by the group's membership prior to wider circulation to stakeholders.

Serious Incidents (SIs)

The Serious Incident function transferred from the Midlands and Lancashire Commissioning Support Unit to the CCGs on 1 June 2021 in readiness for system-wide operating once the ICS is established. The Serious Incident (SI) team have undertaken work to streamline processes across all functions to ensure a focus on lean methodology and to work more collaboratively with providers to ensure robust assurance.

The SI process supports the implementation of learning to prevent recurrence of harm and promote high quality, safe and effective patient care. Investigations are undertaken to identify how and why serious incidents happen, which result in recommendations and action plans to effectively and sustainably address system factors and help deliver safer care for patients.

The SI team continues to work closely with providers and quality leads and support the administration required for the Serious Incident Review Group and Serious Incident subgroup meetings held across the CCG’s footprint. These meetings monitor the completion rate, discuss any concerns detailed in the investigation and address any learning, which requires support or wider dissemination across the system.

Work to transfer the SI function into the CCGs, has enabled the team to be able to provide a more responsive service that better meets the needs of the system.

Learning Disabilities Mortality Review (LeDeR)

The ‘Learning from lives and deaths – People with a learning disability and autistic people’ (LeDeR) programme has remained integral to the work of health and social care partners across Staffordshire and Stoke-on-Trent. With the introduction of autism to the LeDeR programme in January 2022, we plan to continue to uphold the

programme's aims of tackling the causes of early morbidity and preventable deaths in people with a learning disability and autism, through:

- improving the quality of health and social care service delivery for people with learning disabilities and autism
- reducing premature mortality and health inequalities among these groups
- positively influencing practice at individual, operational and strategic levels which affects the lives of our population with a learning disability and autism
- ensuring a positive patient and carer experience.

We are committed to ensuring effective communication and good working relationships with our reviewers and stakeholders. The system had secured a contract with the South Central and West Commissioning Support Unit in February 2021. This was paused in May, as advised by NHSE/I, to allow time for the implementation of a new national LeDeR platform. The contract continued in July 2021 and has supported and enabled a new review allocation, completion and reporting process which has enhanced the overall delivery of the programme. It has also enabled prompt access to records with reviewers critically identifying any local issues and learning that will need to be put into action. This arrangement has enabled a quicker turnaround of reviews, resulting in a greater number of reviews being undertaken by the programme.

The programme worked collaboratively with the North of England Commissioning Support Unit, commissioned by NHSE/I, to complete all "stacked" backlogged reviews which occurred as a result of suspending the programme. This supportive collaboration ensured that all outstanding "stacked reviews" were completed, quality assured and closed before the end of the deadline set by NHSE/I.

The local LeDeR Steering Group meets monthly and includes membership from all our system partners. They have been instrumental in implementing actions from the findings and recommendations that arise from our LeDeR reviews. The group has ensured an active shift in focus from reporting on data, to providers reporting demonstrable actions and impact, captured on a slide deck which can in turn be used by each of our partners within their own organisations.

The national LeDeR Policy, published in March 2021, identified a number of actions to be delivered by 1 April 2022. These included the production of a three-year strategy, setting out the ambitions for our LeDeR programme up to 2024 and the establishment of a Governance Panel to identify and monitor actions that arise from focused reviews. Our three-year strategy was produced in September 2021. Reports are being produced quarterly to demonstrate progress against the Strategy and plans for further implementation going forward. The LeDeR Governance Panel is currently at an advanced stage with the first meeting scheduled for February 2022 ahead of the April 2022 deadline date mandated in the LeDeR Policy.

All systems have received an allocation to support 'Learning into Action'. We are using that funding to develop a Digital Patient Hospital Passport. All system partners are involved with the project at an advanced stage and very near completion. The aim is to produce hard copies as well as digitalising the document via a QR (Quick Response) matrix barcode which can be accessed via a smart device. A training

module will be developed to support the document as well as promotional activities to maximise its effectiveness.

Inclusion, collaboration and co-production remain priorities of the LeDeR programme. The attendance of a lady with lived experience at our Steering Group meetings is invaluable and uplifting. We will continue to champion the inclusion of families, carers and people with lived experiences as well as our Ethnic Diverse Group population within the LeDeR programme, ensuring they are appropriately represented within the programme activities.

Special Educational Needs and Disabilities (SEND)

In 2021/22, the CCG has strengthened its collaborative working relationship with the local authorities and parents and carers to ensure that co-production principles are embedded across the local area and all workstreams. The aim is to deliver a robust response to the requirements of the SEND reforms (2014) and to ensure that the initiative lives up to its intended ambition.

The reforms were ambitious, aiming to place children and young people at the heart of the system with the role of health providers and the meshing of the two systems being pivotal. A Parliamentary Select Committee Report (2019) has confidently stated that the reforms were the right ones, while acknowledging the challenges for partners in delivering them. We are anticipating the publication of the long-awaited SEND Review which will be published in Quarter 1 of 2022 alongside a green paper with proposals and will make recommendation on how the system needs to be overhauled and improved upon. Alongside this a new Inspection framework will also be launched with a focus on strategic leadership and governance, joint commissioning and co-production.

The CCG's Executive Director of Nursing and Quality has overall responsibility for SEND at Board level and has overseen a number of quality initiatives during 2021/22 as follows:

- maintaining CCG representation across the partnerships at both an operational and strategic level
- continued improvements in the EHCP (Education, Health and Care Plan) process including quality markers that support co-production principles
- delivering targeted training to health providers in conjunction with all partners to ensure a continuous cycle of improvement
- preparing and responding to the re-inspection of Staffordshire with regards to the Local Area Review in 2018 and the subsequent Written Statement of Action.

In Staffordshire and Stoke-on-Trent, there are clear governance processes to support the implementation of the SEND agenda, with the SEND inclusion and partnership groups being pivotal in scrutinising delivery of distinct improvement programmes. The CCG jointly chairs key meetings and are represented at all levels of the SEND agenda to support joint working and joint commissioning. SEND governance processes are reviewed regularly, and at least annually, to ensure processes continue to be efficient and equitable.

Infection prevention and control (IPC)

IPC work during 2021/22 has continued to be dominated by the COVID-19 pandemic. Working closely with colleagues across local authorities, UKHSA, NHSE/I and other NHS colleagues, we have supported the wider health and social care systems in maintaining systems to facilitate specialist IPC advice and support, not only in health but across the wider care services across Staffordshire and Stoke-on-Trent. Working together has enabled the maintenance of expected standards and the ongoing provision of safe IPC care across services during a time of frequent guidance changes and concerns.

The response to supporting a system-wide approach commitment to IPC during 2021/22, is seen in the examples set out below:

- Investment into MPFT's IPC service provision allowing the team to provide wider IPC services across Staffordshire and Stoke-on-Trent care services, in particular supporting outbreak management with specialist advice and review of IPC practices. This builds on the achievement to provide IPC training to a consistent standard, to all our care homes during 2020/21, following a national directive
- Continued additional investment from the CCG and both local authorities for the provision of a Strategic Improvement Lead for IPC for a further 24 months, hosted by the CCGs.

IPC leads, and associated roles, from across commissioning and provider organisations, including local authorities, have continued to show a commitment to joint working and shared learning throughout the pandemic. A well-established weekly IPC meeting has enabled a considered approach to new guidance, sharing and concerns of specific issues as well as professional support, in an open and informal forum.

The review of incidence of health care associated infections (HCAIs) continues and enables themes to be identified and learning shared within the wider health and social care systems, resulting in improved practice. This shared learning also supports the national ambition to reduce the incidence of gram-negative blood stream infection and other healthcare associated infection with a commitment for a collaborative approach and focussed workstreams.

Quality Impact Assessments (QIAs)

We remain committed to evaluating the impact on the quality of care for patients for any proposed service changes, either temporary or permanent. A single QIA policy and process for all six Staffordshire and Stoke-on-Trent CCGs has been in place and reviewed annually over a number of years. The process includes a single QIA sub-group, which has a range of members including lay members of the Governing Bodies and members of the Quality team.

The sub-group continues to scrutinise commissioning activities and challenge decision making so that staff who propose the change can ensure that quality is not compromised and, if necessary, mitigate against actions that would impact on the residents that the CCG serves. The subgroup meets at least monthly, and will flex to meet more often, if needed, in response to the fluctuation in QIAs as they arise.

During 2021/22, the CCG further embedded the improvements made in 2020/21 as well as continued to be flexible to the demands within the system. This is supporting plans to develop a system-wide QIA process as we move into 2022/23 and the introduction of an Integrated Care System (ICS).

In recent times, the process was scaled back and QIA sub-groups were cancelled to accommodate the national response to COVID-19. Over this period, the CCGs enacted a 'short form' QIA process that analysed the quality impacts of any changes enforced on the system by COVID-19. Later, the sub-groups resumed and the 'short form' QIA process was incorporated into the sub-group's oversight function. During 2021/22, the full QIA process has resumed with the sub-group members meeting virtually.

QIA development to enable a system-wide QIA process with partners across the local NHS footprint continues, following pauses in response to COVID-19. A working group has now been established with representation from partners across the ICS footprint. Changes include a more robust review of the impact on quality, identified mitigations and aspirations, and oversight using pathway mapping to identify where the change sits within the system. Feedback to the CCG is via the Quality and Safety Committees in Common (QSCC) and the newly formed System Quality and Safety Committee (SQSC). This work will continue into 2022/23, as we design an overarching ICS to ensure quality for patients remains at the heart of the work we do.

Maternity Transformation Programme (MTP)

The CCGs in Staffordshire and Stoke-on-Trent actively support the recommendations within Better Births (2016), Saving Babies Lives Care Bundle Version 1 and 2 (SBLCB v1/v2), the Neonatal Critical Care Review, the NHS Long Term Plan (2019) and Phase 3 COVID-19 priorities through the Staffordshire and Stoke-on-Trent Maternity Transformation Programme (MTP) and Local Maternity and Neonatal System (LMNS). The LMNS membership includes the six CCGs, both Staffordshire and Stoke-on-Trent local authorities, NHS maternity providers, NHS providers, NHSE/I, and women who use maternity services.

NHSE/I provided transformation funding for 2021/22 with revised targets and deliverables which were echoed within the operational and planning guidance of March 2021. These deliverables will be carried over into 2022/23, with realigned trajectories to reflect the ongoing position and are set out below:

Pandemic recovery

Including reopening all services, supporting staff to recover and implementation of four actions to minimise risks for black, Asian and minority ethnic women. An operational policy has been developed and proactive communication via social media routes has promoted early presentation for women when concerned and COVID-19 vaccinations for all pregnant women and maternity staff.

While restrictions have been lifted across the whole maternity pathway in order to support attendance at appointments and visiting arrangements, our maternity services continue to allow the attendance of only one birth partner during labour. The intermittent redeployment of registered staff to support clinical services has also resulted in suspension of some elements of maternity services, for example home births, 'continuity of carer' teams and birth care at the free-standing midwifery led

birthing units during the duration of Q3 and Q4. All our providers remain committed to supporting the reinstating of these services and, with the support of the LMNS and Together We're Better strategy team, will engage with the public to coproduce and strengthen the proposed clinical models.

Ockenden actions

The Chief Operating Officer's letter of 14 December 2020 included the expectation that LMNS would oversee the implementation of immediate and essential actions (IEAs) as set out in the Ockenden report. In addition, the operational planning guidance set out specific changes which were required for LMNS Governance in response to Ockenden, including strengthening ICS oversight and the LMNS role in quality surveillance and learning. The maternity programme governance framework has been reviewed and updated in line with these recommendations and the revised perinatal quality surveillance model implemented.

Maternity transformation

LMNSs were asked to take responsibility – with accountability to ICSs – for ensuring universal implementation of initiatives, in view of the local and national variation in implementation highlighted by the Ockenden report. The CCG remains committed to ensuring women receive 'continuity of carer' as set out in Better Births, the Long Term Plan and the National Guidance on planning implementing and monitoring 'continuity of carer' as published during 2021.

Co-production and transformation of maternity services via the MVP (Maternity Voices Partnership) has continued to progress, with the MVP providing feedback on the Postnatal Improvement Plan, MTP Plan, Neonatal Critical Care Review and leaflets.

Bi-monthly meetings are now taking place, as opposed to quarterly meetings. This provides more focused discussion and engagement from champions and stakeholders. A quarterly service user feedback report, 'You said, we did', has been produced. This allows for champions to feel their opinion is valued and provides feedback to service users and families. Each LMNS workstream now has MVP Champion representation, which has supported even greater co-production of services.

Safeguarding children and vulnerable adults

Safeguarding is a statutory responsibility for the CCG, led by the Executive Director of Nursing and Quality and supported by the Designated Safeguarding Nurses for Children, Looked after Children and Adults. CCG safeguarding responsibilities are covered in key legislation. During this unprecedented period of the COVID-19 pandemic, safeguarding duties and responsibilities remained high priorities for the CCG with the Safeguarding team maintaining a 'business as usual' approach.

The CCG is a statutory partner of both the Adult and Children's Local Safeguarding Boards (or equivalent meeting) with the safeguarding arrangements of our most vulnerable remaining as a key priority. The Designated Nurses for Safeguarding Children, Looked after Children and Adults remain committed to working with multi-agency partners and neighbouring CCGs to ensure that children and adults at risk are protected from harm.

Robust governance and contractual arrangements are in place for reporting and responding to safeguarding issues which fulfil the national and local safeguarding requirements. The CCG's Safeguarding Dashboards, with agreed trajectories for each metric, are now fully embedded within provider organisations and reviewed by the Safeguarding Leads, enabling a full view of performance, quality and trends, and the identification of targeted areas requiring action.

Safeguarding Children priorities

The Designated Nurses, Doctors and Named GPs for Safeguarding Children have prioritised safeguarding workstreams across Staffordshire and Stoke-on-Trent. This has included:

- partnership working with multi-agencies on the Domestic Abuse Strategic Commissioning Board and associated working groups
- partnership working with multi agencies on the Violence Reduction Executive Board and Delivery Groups
- developing and supporting the Domestic Abuse Strategy, the Serious Violence Strategy, Violence Against Women and Girls Strategy and child exploitation task groups, including county lines and modern slavery
- developing the Child Sexual Exploitation Strategy and the Female Genital Mutilation Steering Group agenda
- steering and contributing to the workstreams and contributing towards the Staffordshire and Stoke-on-Trent priority agenda for neglect.

The Designated Nurses have continued to support and guide the CCG regarding their statutory safeguarding duties. Policies for safeguarding children have been developed and updated including the Safeguarding Children Policy, Safeguarding Children Supervision Policy, and the Managing Safeguarding Allegations Against Staff and Domestic Abuse Policy.

The Designated Nurses remain committed to implementing the changes in 'Working Together to Safeguard Children' (2018), stipulated as part of the CCG's responsibilities outlined in the Children and Social Work Act 2017. This work is ongoing and involves development of a revised Safeguarding Executive Partnership in Stoke-on-Trent and an associated Quality and Assurance group, a Safeguarding Children Board in Staffordshire and associated Scrutiny and Assurance group, a Child Death Overview Panel, and two Child Safeguarding Practice Review subgroups.

The newly formed Safeguarding Children Health Forum began in November 2019 with the aim of enabling and coordinating the health economy to improve the wellbeing of children and families. It remains committed to the former joint Safeguarding Children Board's arrangements, ensuring that the relationships and co-production around priorities are owned and valued by all partners across the wider partnership. It specifically seeks to achieve the following goals:

- Provide a communication network for safeguarding children's health professionals, reinforcing relationships and sustaining reciprocal communication and collaboration between the Staffordshire and Stoke-on-

Trent Safeguarding Children Board / Partnership and health provider safeguarding teams

- Facilitate the sharing of best practice and encourage members to promote this within their organisations
- Discuss, share and reflect on current areas of safeguarding work, and identify areas of concern, gaps and themes that require local attention and multi-agency problem solving
- Provide scrutiny and challenge to the Safeguarding Children Scrutiny and Assurance Group, and report to the Staffordshire and Stoke-on-Trent Safeguarding Children Board / Partnership
- Escalate matters that require further scrutiny or investigation to the appropriate forums.

The Designated Professionals chair the Child Safeguarding Practice Review sub-groups of the Staffordshire Safeguarding Children Board and Stoke-on-Trent Executive Children's Partnership, and act as Vice Chair of the CDOP (Child Death Overview Panel) for Staffordshire and Stoke-on-Trent. Both Designated Nurses remain officers of the respective Local Safeguarding Children Boards (or equivalent). Learning from reviews is shared across the wider health system and robustly monitored and tested.

As part of its improvement plan, Stoke-on-Trent City Council has introduced a new model of working, which the Designated Nurses have supported as a health reference group. This group are now members of the Children's Advice and Duty Service (CHADS) working group.

The Safeguarding Partnership has developed a performance framework to enable assurance and monitoring of the newly commissioned Graded Care Profile 2 (GCP2) and Restorative Practice.

The CDOP Nurse Practitioner became an employee of the CCG and a valued member of the Safeguarding Team in 2020. This role provides assurance that providers of health services are compliant with the child death overview processes and deliver valuable training and information pertaining to the prevention of child deaths across Staffordshire and Stoke-on-Trent. The Safeguarding Team enabled a secondment opportunity in 2021 for an experienced Specialist Health Visitor to join the team to deliver the CDOP duties whilst the CDOP Nurse Practitioner commenced her secondment at NHS England. This has proved to be a positive developmental experience, enhancing skills, knowledge and confidence.

The Designated Nurse for Looked after Children has embedded processes across Staffordshire and Stoke-on-Trent, working in partnership with the Local Authority and provider organisations. A robust quality assurance system is in place to monitor the quality of health assessments and this role continues to be an expert source of advice and guidance to medical staff completing the required assessments.

The Designated Nurse and Doctors for Looked after Children are core members of the Corporate Parenting Boards for Staffordshire and Stoke-on-Trent.

Safeguarding adults

The Designated Nurse for Safeguarding Vulnerable Adults for the CCGs in Staffordshire and Stoke-on-Trent, co-ordinates the adult team. They ensure delivery against the statutory duties and responsibilities detailed within the Care Act 2014 and in accordance with the NHS England Safeguarding Accountability Framework, to demonstrate the CCG's compliance with statutory safeguarding functions.

The Designated Nurse is vice chair of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB). Together with the Senior Nurse for Adult Safeguarding, they provide leadership and support to the sub-groups of the Board. The CCG has received the SSASPB Annual Report, which has been discussed in detail at the CCGs' Safeguarding Group, a sub-group of the Quality and Safety Committees in Common (QSCC).

The Safeguarding Group, chaired by the Clinical Chair and Non-executive GP Lead for Adult Safeguarding, agree the workstreams and work plans for the safeguarding team. It discusses safeguarding issues for adults, children and young people in detail, and escalates relevant matters to the QSCC. This has strengthened safeguarding throughout the CCG and ensured robust governance and reporting.

The Designated Nurse, supported by the Senior Adult Safeguarding Nurse and Named GP for Adult Safeguarding, have undertaken Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs), statutory reviews that the Safeguarding Team undertake on behalf of Primary Care General Practice.

The Adult Safeguarding Roles and Competencies for Healthcare Staff intercollegiate document was published in August 2018 and is endorsed by NHSE/I and the Royal Colleges. It was designed to guide professionals and the teams they work with to identify the competencies they need to ensure that people receive personalised and culturally sensitive safeguarding support. The adult safeguarding team has worked with NHS Providers to ensure action plans derived from this document have been delivered and demonstrate compliance.

Across the six CCGs, there have been a high number of Section 21a Deprivation of Liberty Challenges. These have been overseen by the Safeguarding Team in collaboration with external providers and NHS Midlands and Lancashire Commissioning Support Unit (MLCSU).

The Adult Safeguarding Team is working with the Executive Director of Nursing and the Commissioning Team to prepare for the implementation of the MCA (Mental Capacity Act) Amendment Act (2019). This will see a change in the CCG's duties when authorising the arrangements enabling the care or treatment of people who lack capacity to consent to the arrangements, which gives rise to a deprivation of their liberty.

The Designated Adult Nurse also ensures that the Prevent agenda and requirement set out in the Counter Terrorism and Security Act (2015) is achieved by all NHS commissioned services.

The Designated Adult Nurse is a member of the NHSE/I Safeguarding National Network, which is a clinical reference group influencing national policy and developing key partnership working at a national level.

Hospices

End of life (EOL) care remains one of the priority areas for the CCG. A palliative and end of life cell (PEOLC) was developed in 2020/21, linking with the CCG's EOL operational cell. As part of the Palliative Care and EOL Strategy, developed at the end of November 2019, the EOL cell was created to support a system-wide approach to delivering improvements in EOL care during COVID-19. The group is made up of partners from the community services, acute hospitals and the voluntary and community sectors. This cell reports to the COVID-19 response governance structure which then reports into the CCG's Governing Body.

The Quality team representative for the EOL cell is the Designated Nurse for Safeguarding Vulnerable Adults. Due to the escalation of the COVID-19 pandemic, the EOL cell met weekly to focus on operational issues that arose. The Quality team has not conducted quality visits in adult and children's hospices during the pandemic. However, regular communication through the EOL cell and reporting mechanism has ensured ongoing engagement.

Nursing homes

Quality improvement in nursing/care homes remains one of the CCG's priorities. To accomplish this, the local system Nursing Home Quality Assurance and Improvement Group (NHQAIG) meet monthly to ensure the safety and wellbeing of the residents in care homes with nursing provision and other care providers who have residents or service users in receipt of NHS funded care across the local economy. This is achieved through working with key partners, principally the local authorities and regulatory bodies, using new and established governance systems and new innovations to provide strategic oversight of reporting of exceptions, trends and patterns. The main functions of the group are to seek assurance and drive improvement in respect of the safety and quality of nursing care in all areas commissioned through the CCGs and to inform the commissioning process and the market management of care homes with nursing.

The Provider Improvement Response Team (PIRT) has been operational since March 2019, and is an integrated service jointly funded by Staffordshire County Council and the six Staffordshire and Stoke-on-Trent CCGs, with the aim of working with care home services identified as being in urgent need of support. The PIRT works collaboratively with providers across the health and social care system who have triggered PIRT criteria, with a predominant focus on ensuring safe, effective, evidence-based and high-quality care to patients and residents.

The team's aims and intended outcomes are to:

- improve patient safety and quality of life by ensuring care home providers meet individuals' needs
- improve market quality by working with care homes that have an escalated level of risk and those which have continuously struggled to improve the quality of their service
- reduce unnecessary hospital admissions by identifying issues, understanding hospital admission difficulties and working with the care homes to reduce

unnecessary non-elective hospital admissions. The aim is to ensure a timely response to care needs from the right care professional in the right setting

- ensure greater market choice with more services with a CQC 'Good' or 'Outstanding' rating to improve the standards of patient care
- avoid urgent closures by the regulator under Section 30 of the Health and Social Care Act 2008. The aim is to minimise the impact on people and their families and carers in the event of a care home closing (CQC, 2020)
- use quality interventions to reduce the duration of contractual suspensions, increasing the available capacity within the market.

Through their input and collaborative working, the PIRT has been able to demonstrate considerable impact by:

- preventing urgent care home closures
- reducing the need for multi-agency processes including large scale enquiry and quality improvement processes
- enhancing timely response to quality assurance action plans
- supporting referrals to training resources to enhance staff knowledge and adherence to training standards.

To support information sharing, a localised version of MiDoS named 'MiDoS for Care Homes', which is a directory of information and services, has been designed as an online information hub for care homes in Staffordshire and Stoke-on-Trent. It provides access to elements of the NHS Directory of Services (DoS) and a wide range of supportive information, which includes links to various community teams and associated key guidance. The platform itself is a collaboration between the six Staffordshire and Stoke-on-Trent CCGs, West Midlands Ambulance Service and the Staffordshire County Council Quality Assurance team.

There is a wide range of information that can be accessed on the platform, some of which includes:

- contact details for community teams, contract management teams, care review requests and care brokerage services
- contact details for dentists, pharmacies, GPs, opticians and hospitals
- referral links for safeguarding, serious incidents and regulatory notifications
- key information pages for NHS.net
- guidance around safeguarding referrals, mental capacity and other associated guidance
- links to organisations that provide supportive guidance to care homes.

There is a rolling programme of reviews that see the content refreshed and updated, following feedback and the availability of new resources. Promotional work on MiDoS for Care Homes continues to support frontline professionals including, community teams and PCN care coordinators, who work with care homes to have access to the system which enables staff to signpost to appropriate resources.

Care at Home (Domiciliary Care)

The Care at Home (Domiciliary Care) workstream oversees those in receipt of NHS Continuing Healthcare (CHC) and where care is brokered by Midlands and Lancashire Commissioning Support Unit (MLCSU) or MPFT's Palliative Care Centre (PCC).

There are many challenges with this area of work, including a large supplier base, transient workforce and lack of robust intelligence sharing between commissioners of these services. In 2021, it was recognised that the assurance provided to care homes, is not in place for care at home. A Care at Home Monitoring Group, therefore, was establishment in September 2021.

The Care at Home Monitoring Group has representation from the CCG's Nursing and Quality team (Corporate Nursing and Safeguarding), MLCSU, the Primary Care Commissioning Committee and the Care Quality Commission (CQC). All intelligence received by members is shared, discussed and contributes to a discussion about the safety of patients and the continuation, pausing or suspending of services.

A Standard Operating Procedure (SOP) has been developed and includes making recommendations, where appropriate, to the CCG's Executive Director of Nursing and Quality or Deputy Director where it is agreed actions need to be taken to keep people safe. Signed approval is submitted to the monthly CHC Quality Performance and Operations meeting and reported up to the Individual Patient Activity Board (IPA). Any actions are reviewed monthly and aligned to discussions that take place at the system wide monthly Quality and Safeguarding Information Sharing Meeting (QSISM), chaired by Staffordshire County Council.

The group continues to grow in knowledge and breadth, increasing the intelligence received into the CCG, and thereby increasing the level of assurance about care delivery.

Engaging people and communities

The COVID-19 pandemic has altered the way that we engage with people and communities. It forced us to broaden our thinking and accelerate transformation, particularly towards greater digital engagement, but also emphasised the importance of working in collaboration.

Partnership working across the NHS, local authorities, police, fire, and the voluntary and community sector has been key to the success of our local response to COVID-19 and the ongoing work to support the restoration and recovery of health and care services. It is also at the heart of the Staffordshire and Stoke-on-Trent Integrated Care System, which was formally established on 1 April, and continues to be the driving force behind plans for a new way of working.

Responding to the pandemic has underlined how health inequalities can only be addressed by listening to and understanding the people we collectively serve. This year we have built on this learning to develop a more targeted and inclusive approach to communication and engagement and of working directly with communities to understand their needs, reliably identify potential barriers, and co-produce solutions.

The pandemic also demonstrated the value of having common goals that all partners can get behind and the impact of a consistent approach to messaging through shared channels and mutual support. This year we have continued to adopt this approach to deliver a collective response to communication and engagement activities and have worked collaboratively to develop a new approach to future engagement for the system.

Due to the ongoing impact of COVID-19, we have continued to use new approaches to maintain and widen engagement, without losing sight of those who are unable to engage though digital channels. We have used online platforms, such as Microsoft Teams, WhatsApp and social media, to engage with the population as well as creative materials such as videos and animations to reach a wider audience including translated versions and through the use of BSL interpreters.

In addition, we have continued our engagement with community and voluntary sector networks to reach seldom-heard groups, such as ethnic minorities as well as those with disabilities, homeless people and travelling communities. We have also worked with community champions and local networks to help reach and understand the needs of our diverse population and adapted both our communication activities and operational delivery of services accordingly.

Throughout the pandemic, we have proactively sought feedback from stakeholders and the public through a variety of channels including:

- working with Healthwatch to capture people's experiences during the pandemic
- regular surveys through the Together We're Better People's Panel, which aims to be broadly representative of our general population – including by age, geography, and protected groups
- working with existing patient groups through digital channels
- temperature check surveys – shared through partner channels and online including social media, websites and staff
- social media conversations and webinars/online focus groups encouraging people to share their views on specific areas of interest
- phone calls with community groups that represent seldom-heard groups, for example with ASIST to understand the needs of people with learning disabilities/hearing impairments as we move towards more virtual working.

Engagement to support the COVID-19 vaccination programme

Vaccine hesitancy provided us with new challenges around engagement and behaviour change and forced us to think more creatively on how to communicate with the diverse populations across Staffordshire and Stoke-on-Trent.

We worked with partners, including third sector, voluntary and community organisations, to reach out to communities to capture thoughts and feedback about the vaccine and to have discussions with groups where we knew uptake of the vaccine was low, such as with Black, Asian and minority ethnic groups.

Working with faith leaders, we learned more about the issues for some of the faith groups and through conversations with community champions we adapted our approach for different audiences to maximise our impact. Some of the tailored approaches we used to encourage uptake of the vaccine include:

- information in appropriate languages to improve vaccine uptake in Bangladeshi, Pakistani and Black communities
- information in The Muslim Council of Britain 'Safer Ramadan' guide that was later used nationally
- pop-up vaccine clinics in mosques and community centres which improved uptake by 23%
- GP-led virtual sessions with communities in different languages
- interviews on a variety of radio stations with GPs about hesitation, concerns, and Ramadan
- ad-vans at local football grounds with football-themed messages
- a 'Safe spaces' campaign – including Q&A webinars for parents of 12 to 15-year-olds, and young adults in care
- mobile vaccination units working with system partners to reach wider communities, for example pop-up vaccination clinics in local fire stations, seasonal fruit farms, churches, and large industrial distribution centres
- dedicated sessions for people with sensory or learning disability needs – including translated materials such as videos in British Sign Language (BSL)
- mobile vaccination bus – providing outreach vaccination clinics in rural areas or areas where there may be challenges. One of the first locations was to provide vaccines to refugees from Afghanistan
- digital engagement – reaching out to young adults during Valentine's Day, running a Q&A campaign for parents of 12 to 15-year-olds to provide assurance
- celebration engagement – Chinese New Year digital campaign, Holi festival campaign
- clinically extremely vulnerable and learning disability groups – targeted communications from GPs to ensure clarity of messaging from trusted sources
- a resource centre so partners can find relevant toolkits, and for toolkits to be easily accessible, with identified languages included and version controlled
- daily updates to partners listing the COVID-19 vaccination walk-in clinics available across the patch pulled from the National Booking System. This helps stakeholders and partners have the information readily available for them to promote.

In addition to the engagement, regular information has been shared across a range of channels to ensure people have been kept up to date with the programme as well as providing reassurance and clarity on areas of concern. A dedicated COVID-19

vaccine bulletin has been sent to stakeholders fortnightly sharing the latest news, resources, FAQs and media coverage, as well as weekly updates on the vaccination figures.

Meetings have also taken place with MPs and council leaders to keep them informed about the latest news and updates, led by the programme team and supported by communications. Following each meeting, stakeholders were sent an information pack, which included the key messages, so they were able to respond to queries from their constituents or other stakeholders.

Social media continues to be an important and effective channel for the system in the delivery of the COVID-19 vaccination programme. The vaccine materials and content shared on social media relating to the vaccination programme have achieved high levels of engagement and organic reach. A blend of paid and organic content has been pushed out on social media, targeting specific audiences based on their demographics, geographic location and interests. The vaccine content has also achieved much higher levels of engagement and reach through community pages.

A range of graphics and videos from local clinicians (using different languages) were produced to increase reach with our followers. These resources were routinely shared with partners, including GP practices, to support consistent messaging, and there has been a responsive approach to feedback received across all social media channels.

Monitoring soft intelligence

Regular monitoring of soft intelligence and proactive engagement with a range of community groups has helped to shape the communications response to the vaccination programme. Comments and questions raised via social media or directly through discussions, highlighted areas of focus for communications, which were then addressed through a variety of activities, including social media messaging, videos and stakeholder bulletins.

A COVID-19 vaccine intention survey was shared among stakeholders to help evaluate how many communities were intending to get the vaccine and the reasons why. Most respondents welcomed the vaccine, however the survey helped to identify a key theme of hesitancy related to the safety of the vaccine and fears that it was developed too quickly.

A COVID-19 patient refusal survey was also produced for GPs to send via email or text message to patients who had refused the vaccine. The survey provided soft intelligence on the reasons for hesitancy and refusal, which were then fed back into the seldom-heard workstream and used to shape and form communication strategies.

Working with groups such as Asist and DeafLinks enabled communications to be tailored to meet the needs of the people with sensory impairments and supported the vaccination programme operationally. Feedback from Communities2gether and meetings with faith leaders helped to identify concerns that people had in relation to the vaccine, which could be addressed through communication resources. This also led to a number of pop-up clinics in the relevant areas.

Engaging with seldom-heard groups

To support our ongoing response to COVID-19, we have continued to work in partnership with the Communities2gether forum and our Local Equalities Advisory Forum (LEAF) to help shape our approach to engagement with seldom heard groups. This has supported a more targeted approach to communication and engagement and ensured information was both inclusive and accessible.

The Communities2gether forum includes representatives from the wider equality and health inclusion groups, such as faith leaders, support groups and members of the community and voluntary sector. It supports and informs the development of local resources as well as helping to disseminate key messages to its own groups, organisations, and wider networks. The forum has also helped to collate feedback from the community highlighting examples of good practice as well as areas that needed further focus or development.

LEAF is a group of people who represent communities with protected characteristics and vulnerabilities and acts as a critical friend to all six CCGs in Staffordshire and Stoke-on-Trent. They help to inform our decision making by advising on policies, public campaign material and service change proposals. The group also includes representatives from vulnerable communities (such as homeless people, asylum seekers and refugees) and people who can help more broad consideration of how health inequalities can be reduced.

As the members of LEAF are asked to join from local organisations that support people from seldom-heard groups, this provides access to their wider networks and they kindly give support by promoting information or circulating consultations. This enables views and feedback to be gathered from a wide range of people.

Commissioners attend the meetings when they are considering changing the way health services are delivered, to be able to understand whether there would be any unintended consequences from the changes or any mitigations needing to be put in place to minimise adverse impacts on groups. The forum is chaired by a CCG lay person with responsibility for patient and public involvement. There is a doctor at each meeting to answer any medical questions.

Some of the areas of work that LEAF has influenced this year include:

- Learning from COVID-19 vaccinations
- The role of the CRUK Facilitator within primary care
- GP primary care
- Together We're Better Transformation Programme updates:
    - Maternity
    - Urgent and emergency care
    - George Bryan Centre
    - Community Diagnostic Hubs
    - General practice access
- Equality statement for job applicants

- Communications and engagement.

Developing the future approach to working with people and communities

Community engagement and involvement has always been recognised as a key enabler in supporting effective health and social care service planning and delivery across Staffordshire and Stoke-on-Trent. However, there is also a recognition that it could be done better.

There is now an opportunity as a new Integrated Care System (ICS) to strive further and harder than ever before to ensure people and communities are at the heart of everything done. That includes developing our new approach to community engagement.

The core requirements of the ICS guidance around working with people and communities is for the Integrated Care Board (ICB) to develop a system-wide strategy. The strategy will describe the ICB's principles and arrangements for working with people and communities. It will also set out its approach to working with partners to ensure that Integrated Care Partnerships (ICPs) and Place-Based Partnerships have representation from local people and communities in priority-setting and decision-making forums.

To develop a system-wide strategy for the ICB in Staffordshire and Stoke-on-Trent that is transparent, effective, and meaningful, there has be collaborative working with partners, the public, Healthwatch and the voluntary, community and social enterprise sector (VCSE).

There was recognition and desire to build on established relationships and the work already being done by partners across the system to involve and engage with people and communities. There was also a need to align the approach to existing organisational principles and continue to work with system communications and engagement leads to develop these further as the strategy evolves.

In the summer of 2021, work was undertaken with partners and the public to review how to involve people in the work, including with seldom heard groups or groups representing communities with protected characteristics and vulnerabilities. Collectively a core set of principles were developed that reflect how the public would like to be engaged and would empower people to become active participants in their own health and wellbeing.

During autumn 2021, partners were engaged, including lay members, Healthwatch, community groups and system leads to sense-check the approach and the principles in draft before recommending them to the ICS Board. Further engagement included an online survey to the Together We're Better People's Panel, focus groups with existing forums, and targeted engagement with seldom-heard groups and place-based leads to understand if they had any specific requirements, or if there were any potential barriers that needed to be addressed.

In December 2021, the local principles, which are set out below and echo the principles that have been set out within the ICS guidance, were agreed by the ICS Partnership Board, along with the recommendation to use these principles to shape the ICB strategy for engaging with people and communities.

The local principles for working with people and communities are:

- Health and wellbeing are everyone's business – engagement needs to be inclusive and accessible to all
- Put the public voice at the heart of decision making
- Don't make assumptions – ask how best to engage
- Recognise the different needs of the population, especially those who could be excluded
- Do it once and do it well – shared intelligence between partners
- Allow enough time to engage properly, adapting the approach where necessary
- Be honest, open and transparent – authentic involvement
- Clear communication that can be understood by all – be clear on what you are asking and consider your audience
- Commit to feedback – explain what impact engagement has made in simple terms
- Build on what is already there – utilise existing knowledge, relationships, experience and local assets, including the community and voluntary sector.

Board members also agreed to support the development of the strategy through their own organisations, including helping to map existing channels and to ensure the strategy was aligned with their individual organisation's strategies for patient and/or public involvement.

Conversations have already started with leads who can help to champion and embed this work across the system and build on local strengths and assets to improve the way that community involvement takes place, and to establish a co-ordinated approach between partners that puts the person at the centre of everything we do. There will also be further engagement with the public and community groups to develop a strategy that will be effective, inclusive and support continuous engagement with the populations across Staffordshire and Stoke-on-Trent.

Transformation

One of the key areas of engagement for the ICS this year has been the clinically-led transformation programme that started in 2019 with a listening exercise but was paused in 2020 in response to the COVID-19 pandemic.

Involvement work was restarted this year with a refresh of previous activity to understand if anything had changed, if there was anything new, and what impact the pandemic had had on experiences of health services.

The pandemic created a number of challenges and opportunities for the system, particularly in relation to engaging with the public, with a requirement to shift to a 'Digital First' approach instead of face-to-face discussions and involvement opportunities (retaining the use of traditional methods where possible). Recognising the barriers this approach might have created for some people, we developed a series of robust approaches, including:

- Accessibility Approach – a process to manage and monitor how to support people for who English is not their first or preferred language, or who live with barriers to online routes to involvement because of infrastructure and geographic connectivity, access to devices or skills
- Voluntary Sector Partnerships – a new approach to build on existing relationships with partners to either:
- Reach their networks with communications and updates, including invitations to participate in involvement activity
- Support their events by attending to provide an update, hear views and answer questions
- Host voluntary sector partners to translate online meetings and events, either in live scenarios or with translated recordings of presentations and updates being shared during discussions
- Access the extensive network of translation partners to provide materials in a range of alternative formats spanning languages, large-print, Braille, BSL and others as requested
- Learning from COVID-19 – using the approaches developed during the system's approach to the pandemic to reach diverse communities via the established network of 'Trusted Voices and Trusted Faces' - people who are already living and working in the county, and in many cases in contact with communities that have historically struggled to be reached. This approach has helped understand communities better, appreciate their different cultural priorities and concerns, and benefit from an increased use of networks and community relationships.

As this work continues during 2022/23, alternatives continue to be reviewed to provide virtual events to allow groups of people in face-to-face environments to participate. And the best methods to deploy continue to be reviewed, based on current guidance and the audience involved.

Online

Digital communications

Digital communications have continued to be developed and strengthened over the last 12 months, partly due to ongoing restrictions due to COVID-19, but also because of positive feedback from stakeholders. During joint engagement with Staffordshire County Council to develop a strategy for children with Special Educational Needs and Disabilities, for example, parents and carers fed back that they welcomed the online approach as for many it was a more accessible way to engage.

This activity also supports the Digital Communication Strategy, which involves using a variety of digital assets and innovative methods to share our messages and engage with the local population as well as internal colleagues and GP practices.

Social media

Social media has been a key channel of communication for both the CCGs and the wider partnership, supporting the use of more innovative and accessible methods of sharing information. Videos and infographics have enabled more effective

explanation of complex information and to target key messages more effectively, particularly using paid-for advertisements on channels such as Facebook.

As social media channels have developed, and the digital audience expanded additional channels such as Spotify, pay-per-click adverts (PPC) and Snapchat have been used. A tester budget was used to reach younger demographics on Snapchat. This achieved 439,913 impressions and 1,009 link clicks over a four-week period. The vaccination campaign was targeted at 18 to 29-year-olds and surpassed other platforms used for this campaign that are favoured by older age groups, such as Facebook.

By using platforms such as Spotify, it has been possible to target audience through other senses bedsides visual, in this case audio, allowing key local NHS messages to be pushed through various sensory routes in addition to widening accessibility opportunities. Assets have also been tailored to meet the needs of different communities using interpreters to translate information into different languages or using British Sign Language (BSL) interpreters.

Storytelling has been used through Facebook carousels to push several key health messages at once, allowing the audience to understand important, key messages and action all at once. Training was also provided to the team around organic targeting, which has allowed specific audience demographics to be targeted, preventing over-saturating of channels by using a more targeted approach.

Innovation will continue on social media and digital strategies and implementations through learnings from the past year.

Live meetings/webinars

The use of virtual meetings and webinars has continued to support communication and engagement with stakeholders of all levels across the system. This has included virtual focus groups to support engagement on several projects including the SEND joint strategy, the clinical transformation programme and the mental health transformation for community services.

The joint Annual General Meeting (AGM) was held as a live webinar again this year where attendees could hear about achievements and focus for the next year. Feedback from the previous year's event was used to improve the format and approach to this year's meeting and received positive feedback from those who attended.

Governing Body meetings and the Primary Care Commissioning Committee meetings have also continued as virtual meetings in public with videos of these events and meetings made available for people to watch after the event on the website.

GP-led sessions have been supported as have presentations by GPs about the vaccine to community groups members, and other vaccine-related sessions with faith leaders and councillors. The communications and engagement team have provided further technical support and training for other departments to hold their own virtual meetings, such as unconscious bias training and protected learning time (PLT) sessions with GP practices.

Internally, live meetings and webinars have supported the ongoing Back to the Future programme of work for staff. Weekly live conversations, known as the Team

Brief, have taken place between senior leaders and staff about the organisational development work programme, as well as interactive development sessions with all staff throughout the year.

E-newsletters

E-newsletters have been used to support communication around key activities across the integrated care system, including a dedicated newsletter for the COVID-19 vaccination programme. Regular bulletins have continued to be delivered to stakeholders that provide updates on the work of the partnership, including the development of plans to support the transition from CCGs to an Integrated Care Board and Integrated Care Partnership.

Internally there continues to be delivered twice-weekly bulletins to staff within the CCGs. This is supported by a weekly webinar hosted by the accountable officer and other members of the executive team to provide updates from different departments within the organisation. There is also a continuous feed of information through other mediums such as social media, websites, Microsoft Teams chats and intranets.

Websites and intranets

The website is central to providing meaningful public information and feedback in accessible formats. The website is AA standard compliant. The site map and functionality were co-designed with patients, who said what they needed to know and how they wished to access the information they seek.

Feedback was provided on what has been done with the information that people give to let them know how services have changed as a result – this is covered in the engagement and consultation section of the site. It details all current and previous activity covering the background, the activity, what people said and a 'you said, we did' approach so people can clearly see how their impact has made a difference.

Information and resources around COVID-19 and the vaccination programme are hosted on the Together We're Better website for a system-wide approach. Various materials and resources in different languages and formats are hosted on the website, while toolkits and social media posts all feed to this page to help measure its usage.

The staff intranet continues to be the one-stop host of resources for CCG colleagues including news, training opportunities and resources. This year the intranet was moved to a SharePoint platform to aid easier access for staff, and the use of features to connect with the Microsoft package. The GP intranet, developed in response to COVID-19, has also now been moved to a SharePoint platform and has been developed to incorporate primary care news, forms, operational procedures and other resources.

Face-to-face

Engagement with our various patient groups has continued using online mechanisms put in place due to social distancing restrictions. Feedback has also been responded to from some of the groups to introduce Zoom meetings where required to support engagement with those who were struggling to use Microsoft Teams.

Patient Congress/Board/Council

An active Patient Congress continues to bring together a group of informed participants to contribute to the strategic planning, development and delivery of local health services. Patient Congress meets in common with North Staffordshire CCG Patient Congress.

The Lay Member for Patient and Public Involvement for each CCG co-chair the meetings, which this year have continued online using Microsoft Teams. There is an embedded process for gathering soft intelligence through the collection of patient stories which are reported to the CCGs' Quality and Safety Committees in Common and then disseminated to patient participation groups (PPGs) and locality groups by the Congress members.

Lay Member for Patient and Public Involvement (PPI)

Lay members are integral to the assurance and governance processes of the CCGs. The Lay Member for PPI ensures that patients' voices are brought to the table and able to influence decisions taken at a strategic level.

All decision-making committees of the CCG include lay member representatives to ensure patient and public views are heard in all aspects of the CCG's business including the Governing Body and the Primary Care Commissioning Committee. The front cover of all Governing Body papers requires officers to provide assurance about patient and public involvement activity undertaken to support the proposals being made.

Through the Communication, Engagement, Equality and Employment Committee, equality and inclusion are woven into day-to-day practice. The Lay Member for PPI has a key role to play in assuring the CCG in relation to public involvement and holds the CCG to account for its involvement activity.

For every engagement process undertaken, every endeavour is made to gather on an optional basis, equality and diversity monitoring data. This is so assurance can be given that information is gathered from a representative sample group and reaching out for feedback to all sections of local communities.

Some examples of patient representatives' involvement in CCG activities this year includes:

- The Communications, Engagement, Equalities and Employment (CEEE) Committee monitors and shapes patient and public involvement activity regularly. The CEEE Committee has a strategic responsibility and reports to the Governing Body
- The Primary Care Commissioning Committee monitors public involvement through the contracts with primary care services. The meetings are chaired by CCG lay members and part of their role is to ensure that GP practices have undertaken the correct level of involvement in relation to potential changes to services, such as branch closures and mergers
- Together We're Better undertook listening events during the pandemic to capture people's experiences and to understand how COVID-19 had affected their access to services. The feedback was fed into the restoration and

recovery work and will continue to be used to shape planning of future services.

Clinical and Professional Leadership

NHS England and NHS Improvement released guidance in September 2021 around implementing effective clinical and professional leadership within integrated care systems (ICSs). ICS and designate Integrated Care Board (ICB) leaders have been asked to agree on a local framework and associated development plan, as well as to ensure that leaders from all clinical and care professions are involved and invested in the vision, purpose, and work of their ICS as it matures.

Clinical and care professionals will be involved in decision-making at every level of the system and the ICS has been engaging with multiple partners to inform the emerging framework and model. This includes the development of communication materials to explain the vision and five core principles for clinical and professional leadership at a local level.

During 2021/22, the first multi-organisation and multi-professional networking event for clinical and care professionals across Staffordshire and Stoke-on-Trent was held. The event enabled clinical and care professionals to understand what the framework is and how they can connect and contribute towards the panel as well as highlighting opportunities or challenges. The event also allowed attendees to shape and inform the evolution of the local clinical and professional leadership approach.

A survey was run alongside the event and feedback from both is currently being collated and analysed to inform the approach going forwards. Due to the success of this event, another event is being planned for the summer of 2022.

Overview and Scrutiny Committee

The Health and Care Overview and Scrutiny Committee is responsible for scrutiny of matters relating to the planning, provision and operation of health services in the local authority's area. This includes public health, in accordance with regulations made under the Health and Social Care Act 2001 and subsequent guidance.

The Committee has the power to make reports and recommendations to NHS bodies conferred by the Health and Social Care Act 2001 and may respond independently to health-related consultations from government and external agencies.

The Committee takes the lead in scrutinising the work of the CCG, which has been actively engaged with the Committee throughout the year in formal meetings and informal briefings. This is to make sure that Committee members can scrutinise our plans and proposals in a public forum.

Items that have been presented to the Committee for consideration during 2021/22 include:

- The journey towards an Integrated Care System / Integrated Care System Delivery Plan
- The George Bryan Centre
- Maternity services
- Difficult Decisions engagement work

- Phase 3 COVID-19 vaccination
- Transforming urgent and emergency care engagement
- The Transformation programme
- Performance overview and dashboard
- Quality assurance of independent hospitals providing care for patients with mental health and/or learning disabilities
- General practice access
- System pressure and emergency care.

Health and Wellbeing Strategy

The Staffordshire/Stoke-on-Trent Health and Wellbeing Board, which is co-chaired by North Staffordshire CCG's Clinical Chair, brings together key health and care organisations to improve the health of local people and ensure fair access to services.

The Health and Wellbeing Board meets to understand local needs, agree priorities, and ensure NHS organisations and the council work more closely, including commissioning services together where possible. The Health and Wellbeing Board is key to delivering integrated health and social care through strong local leadership across health, local authority, and voluntary sector partners.

The Board's key functions are:

- to undertake a Joint Strategic Needs Assessment (JSNA)
- to develop a joint Health and Wellbeing Strategy
- to ensure that the commissioning plans and activities of CCGs and the council are consistent with the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy
- to support the development of joint commissioning, integrated delivery and pooled budgets
- to assess the need for pharmaceutical services in its area, and publish a statement of its first assessment and of any revised assessment
- to encourage integrated working under the Health and Social Care Act 2012.

Examples of the contribution to the Health and Wellbeing Board include the following:

- The board is co-chaired by a senior elected member of Staffordshire County Council and North Staffordshire CCG's Clinical Chair. This has been the case since the board was established
- While there are five CCGs within the Staffordshire County Council footprint, they act as one body and contribution to the board reflects this arrangement
- Regular updates have been provided to the Health and Wellbeing Board on the system's response to the COVID-19 pandemic.

- During 2021/22, the NHS, working closely with the local authorities, has continued to manage the largest vaccination programme in the history of the NHS. Regular updates have been provided to the board and any feedback has been shared with the programme to inform the approach to the programme
- During the second half of the year, the Health and Wellbeing Board have been actively engaged in the development of plans for the Integrated Care System.

This information has been developed in conjunction with the Health and Wellbeing Board and was agreed to be included in this year's Annual Report.

Key achievements

Supporting the workforce

Staff Survey

The NHS National Staff Survey has been participated in again, with a high rate of 85% of staff responding. This feedback was and continues to be an essential source of information in which the CCG(s) can develop programmes and tools to support the workforce.

Acknowledging equality, diversity and support

We continue to support the wellbeing of the workforce, and in the past 12 months have appointed a number of volunteer Diversity Champions, Menopause Ambassadors, Change Ambassadors, Domestic Abuse Ambassadors, and a further 10 trained Mental Health First Aiders. These Champions and Ambassadors work alongside the staff network groups through Executive sponsorship, which include the Ethnic Diverse Group, Disability and Neuro-diverse Group, Carers Group and LGBTQ+ Group.

Health and Wellbeing conversations for all staff are held annually, in addition to monthly development sessions.

Our job adverts include an Equality Statement, and the requirement for all new starters to attend unconscious bias and invisible disabilities training and a specific Equality Induction session.

Additional roles into primary care

A core component of the PCN Direct Enhanced Service (DES) is the provision of funding for the Additional Roles Reimbursement Scheme (ARRS). These are additional roles recruited to support general practice to help address the workforce gaps by introducing alternative roles to improve timely access for patients.

Roles include physiotherapists, dietitians, advanced paramedics, nursing associates, podiatrists, occupational therapists, mental health workers, care coordinators, social prescribers, clinical pharmacists and physician associates. As of January 2022, Staffordshire and Stoke-on-Trent had recruited 375 whole-time equivalent (WTE) staff, and this number continues to grow.

The introduction of these new roles has been linked to the local communications campaign to increase the public awareness about what these roles can do, and why reception staff may ask questions when patients are booking appointments.

Flexible Staff Pools

To recruit and provide locum GPs for practices across Staffordshire and Stoke-on-Trent, an online pool called ‘Find me a Locum’ is in place. There are currently around 50 locum GPs available on this platform, and work continues to increase the number of locums available. Through close working with Staffordshire Training Hub, a GP Locum Peer Support Network has been developed to support locums working in the local area.

In addition, Clinical Champions for workforce have also been recruited which will support workforce planning, recruitment and retention into 2022/23, who again are working very closely with the Staffordshire Training Hub.

Supporting patients and communities

Access to general practice

During the COVID-19 pandemic, access to general practice has been challenging with key drivers to this including pent-up demand, donning and doffing of personal protective equipment (PPE) and social distancing challenges within the general practice buildings and also the longer waits on the telephones due to vaccination and outpatient referral queries.

Since early into the pandemic, the Primary Care team have continued to develop and implement a seven-point access action plan which includes communications, the rollout of an access improvement programme with NHS England's Time to Care team, digital solutions, record keeping, quality/variation/resilience, training and development and workload initiatives.

Some key achievements have included:

- the widespread ability for general practice to work remotely by providing the relevant digital infrastructure
- ongoing communications with the public on how general practice is operating
- the continuing implementation of the Community Pharmacy Consultation Service to facilitate patients having a same-day appointment with their community pharmacist for minor illnesses or an urgent supply of a regular medicine
- improving access to services
- providing more convenient treatment closer to patients' homes.

Long-term conditions

The care of patients with long-term conditions is one of the greatest challenges for the health and care system. There is significant variation in the prevalence of long-term conditions in Staffordshire and Stoke-on-Trent, which has implications for how health and care services are provided.

The Long-Term Conditions Programme is looking at the way work is undertaken and is making improvements top quality, stops waste, and delivers care where it is needed. The aims are to improve care delivered without increasing costs.

There is commitment to joint working in the key areas of prevention and reducing health inequalities. This will involve actively working in partnership with public, private, and third sector organisations, as well as local communities and citizens, towards a shared vision of improving health and wellbeing across neighbourhoods and communities.

By reviewing respiratory, diabetes and cardiovascular pathways using the National Institute for Health and Care Excellence (NICE) Baseline Toolkit, best practice is

used to ensure the necessary skills and capacity are in place and agreeing a plan to close the gaps in core provision and levelling up.

A methodology has been agreed for using Population Health Management for the approach to transformation. Rich sources of data have been identified, and data packs are currently being developed for each Place-Based Partnership.

Clinical Improvement Groups have been established in all Place-Based Partnerships, and a Long-Term Condition Forum for sharing ideas and challenges. Commissioners across the three PBPs are working closely together to understanding the impact of COVID-19 on the Quality Outcome Framework and on people with long-term conditions.

Respiratory

- Following the successful pilot across four of the six CCGs, Pulmonary Rehabilitation Virtual Reality across all six CCGs for clinically appropriate patients is being rolled out
- A training programme is in development for respiratory nurses
- The Spirometry service will commence very soon
- British Lung Foundation Asthma Bundles are being scoped.

Cardiovascular disease

The national Blood Pressure@Home programme is being rolled out locally. A total of 3,403 blood pressure monitors were distributed across the six CCGs during 2021/22. Pharmacists are also undertaking blood pressure checks.

A smartphone app called FibriCheck monitors heart rhythm to detect irregularities and prevent strokes. A training plan and communications plan are in development to support local implementation, and a hub model will allow full roll-out to Primary Care Networks.

Diabetes

- Following the ongoing commission of flash glucose monitoring, evidence of significant reductions in high blood sugar levels has been seen, and improved glycaemic control within patients with type 1 diabetes
- The return to face-to-face sessions of the National Diabetes Prevention Programme (NHS DPP) are currently being mobilised. System-wide data shows an average weight change of -5.5 kg for the participants at milestone four completers in November 2021
- The Healthier You (NHS DPP) programme supports patients identified as being at a high risk of developing type 2 diabetes through evidence-based interventions. Over a course of nine or 10 months, group sessions or digital engagements help patients achieve a healthy weight, improve nutrition, and increase their levels of physical activity
- Formal reporting on the eight care process in the National Diabetes Audit is being restored
- There is a focus on socio-economically deprived populations and certain ethnic minority groups

- One of three North PBP diabetes workshops have been held to date.

Pulse Oximetry@Home

Pulse oximeters are small devices attached to the finger to measure the oxygen level (oxygen saturation) of the blood. During 2021/22, a total of 4,654 pulse oximeters were distributed across the six Staffordshire and Stoke-on-Trent CCGs, another 500 were allocated to care homes across the county, and 1,600 were allocated by the Community Rapid Intervention Service (CRIS) team.

Community ears, nose and throat (ENT) services

The community ENT provides a one-stop diagnostic and treatment service for a range of non-urgent adult and paediatric ENT conditions. The existing provider served three months' notice in September 2021, and alternative provision was sought for 12 months. Step-in providers were successfully established and mobilised, with services commencing on 16 December 2021. The same locations, pathway, and service specification remain in place. There was no break in service, and existing patients transitioned smoothly into the new service.

Long COVID clinic

We continue to support the delivery of the Staffordshire long COVID clinic open to all residents registered with a Staffordshire GP regardless of any pre-existing diagnosis. This has grown in strength and will continue to deliver into 2022/23. The service offers a holistic physical assessment and treatment including mental health support, Cognitive management, specialist mental health support, and psychological support via our IAPT services with adjustments made for neurodevelopmental conditions.

Mental Health Support Teams (MHSTs) for children and young people

We successfully bid and have set up an additional MHST for the Stafford borough schools commencing delivery in January 2022. This new service is designed to help meet the mental health needs of children and young people in education settings. It provides individual, group or parenting interventions for children, young people and families experiencing anxiety, low mood, friendship or behavioural difficulties. Cognitive behavioural therapy is also offered for young people for conditions such as anxiety, and parenting classes include issues around conduct disorder and communication difficulties.

Discharge to Assess (D2A)

Over recent years, care home Discharge to Assess (D2A) beds have been commissioned by the CCGs. However, during autumn 2021, the transfer of these beds went to MPFT so they could be operationally managed and commissioned by the same organisation, leading to an improved service for patients over the coming years. A procurement process secured care homes that were deemed 'good quality' by the CCG, and many of them had previous experience of caring for patients on the D2A pathway.

Staying Well Service

The Staying Well Service supports people with mild to moderate frailty by providing a holistic approach to the management of their mental and physical wellbeing. Originally piloted in Stafford in 2018, the service is now delivered across the whole South-West footprint. The service now has a full establishment including community nurses, occupational therapists, a nurse practitioner for memory and mental health, and assistant practitioners. In addition, there are community connectors specialising in supporting patients with mild to moderate frailty to access voluntary and community sector and other support options.

2021/22 has been the first full year of roll out across the whole South-West footprint, with 942 patients from Stafford, Cannock and Seisdon have been referred into the service. These patients will have access to a comprehensive assessment of their needs, onward referral where required and a care plan to achieve and support identified outcomes. The service continues to develop pathways including the development of community-based 'hubs' and working more collaboratively with practice managers, social prescribers, care co-ordinators, PCN pharmacists and third sector organisations to grow the reach of the service.

Southwest Place Based Partnership (SWS PbP)

SWS PbP membership includes the Clinical Directors of the local primary care networks (PCNs), along with representation from the CCG, local authority, local acute and community providers, and the voluntary, community and social enterprise (VCSE) sector through Support Staffordshire.

The partnership aims to develop a clear strategic focus on embedding place-based approaches to tackle personal and structural inequalities and inclusion, to increase resilience to stresses and shocks, and to maximise community involvement in decision making. This is supported by insight from the Southwest Care and Clinical and Care Assembly developed during 2022.

A place-based, community asset-led partnership for tackling health inequalities in Southwest Staffordshire was endorsed by the partnership during 2022. This project is aimed at capacity building and connecting support and resources within the area and encouraging collaboration with colleagues across organisations, service users and communities. It will be led by the local VCSE sector. An early identified opportunity is 'Compassionate Communities' to mobilise community assets, harness and connect inherent skills and resources that already exist at a neighbourhood level, to improve experiences for people experiencing life-limiting illness, loss, or grief.

Population Health Management

SW PbP has been selected to be the 'Place' level area of the national Population Health Management (PHM) programme for delivery in Staffordshire and Stoke-on-Trent Integrated Care System from March 2022. PHM is based on a whole-person view that takes wider health determinants into account, and it aims to be transformative and build on existing strengths of communities and partners.

It should support the addressing of health inequalities and engage place-wide providers to develop an integrated and proactive model of care.

Health Navigator (HN)

HN is a digital health company that uses artificial intelligence (AI) powered predictive analytics to identify high-intensity users of urgent and emergency care (UEC) services. The intervention is delivered by HN clinical staff, and has been scientifically documented to significantly reduce hospital UEC consumption whilst improving patient-reported quality of life and activation.

Following a successful operation in the South West since 2020 to respond to COVID-19, this was expanded to the South East to support 692 patients across the four south Staffordshire CCGs. Monthly performance meetings have monitored key outcomes which are to reduce non-elective activity and in some cases a reduction of primary care events. Once the service has been concluded, an independent evaluation will be undertaken to affirm full benefits realisation.

Accountability Report

Corporate Governance Report

The Corporate Governance Report seeks to explain the composition and organisation of the CCG's governance structures and how they support achievements.

Member profiles

Dr Gary Free is Chair of Cannock Chase CCG.

Marcus Warnes is the single Accountable Officer for Cannock Chase CCG, East Staffordshire CCG, North Staffordshire CCG, South East Staffordshire and Seisdon Peninsula CCG, Stafford and Surrounds CCG and Stoke-on-Trent CCG.

Cannock Chase CCG member practices

Practice Name	Address	Post Code
Aelfgar Surgery	Church Street, Rugeley	WS15 2AB
Alderwood Medical Practice	Longford Road, Cannock	WS11 1QN
Brereton Surgery	Main Road, Brereton, Rugeley	WS15 1DU
Chadsmoor Medical Practice	45 Princess Street, Chadsmoor, Cannock	WS11 5JT
The Colliery Practice	60 Hednesford Street, Cannock	WS11 1DJ
Essington Medical Centre	Hobnock Road, Essington, Wolverhampton	WV11 2RF
Heath Hayes Health Centre	Gorsemoor Road, Heath Hayes, Cannock Branch Surgery: Chase Practice, 65 Church Street, Cannock	WS12 3TG WS11 1DS
Dr S Geeranavar, Hednesford Medical Practice	Hednesford Valley Health Centre, Station Road, Hednesford	WS12 4DJ
Dr Manickam, Hednesford Valley Health Centre	Hednesford Valley Health Centre, Station Road, Hednesford	WS12 4DJ
High Street Surgery	High Street, Cheslyn Hay, Walsall Branch Surgery:	WS6 7AB

	Great Wyrley Health Centre, Wardles Lane, Great Wyrley, Walsall	WS6 6EW
Horsefair Practice	Springfields Health and Wellbeing Centre, Lovett Court, Rugeley	WS15 2FH
	Branch Surgeries:	
	Sandy Lane Health Centre, Sandy Lane, Rugeley	WS15 2LB
	The Armitage Surgery, Shropshire Brook Road, Armitage, Rugeley	WS15 4UZ
Moss Street Surgery	Moss Street, Chadsmoor, Cannock	WS11 6DE
The Nile Practice	High Street, Cheslyn Hay, Walsall	WS6 7AE
	Branch Surgeries:	
	The Nile Practice, Old Penkridge Road, Cannock	WS11 1AB
	Hednesford Valley Health Centre, Station Road, Hednesford	WS12 4DJ
Dr B K Singh, Norton Canes Practice	Norton Canes Health Centre, Brownhills Road, Norton Canes, Cannock	WS11 9SE
Dr P K Jalota, Norton Canes Surgery	Norton Canes Health Centre, Brownhills Road, Norton Canes, Cannock	WS11 9SE
Dr W Nilar, Norton Canes Health Centre	Brownhills Road, Norton Canes, Cannock	WS11 9SE
(The) Quinton Practice	Great Wyrley Health Centre, Wardles Lane, Great Wyrley, Walsall	WS6 6EW
Dr I Rasib GP Suite	Cannock Chase Hospital, Brunswick Road, Cannock	WS11 5XY
Rawnsley Road Surgery	Rawnsley Road, Rawnsley, Cannock	WS12 1JF
The Red Lion Surgery	Cannock Chase Hospital, Brunswick Road, Cannock	WS11 5XY
Sandy Lane Surgery	Sandy Lane Health Centre, Sandy Lane, Rugeley	WS15 2LB
Southfield Way Surgery	2a Southfield Way, Great Wyrley, Walsall	WS6 6JZ

Composition of the Governing Body

Voting	Number
Board Nurse/Secondary Care Consultant	2
GPs	7
Officers	2
Lay members – statutory	3

Governing Body members

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Dr	Gary	Free	Clinical Chair		
Mr	Marcus	Warnes	Accountable Officer		
Mr	Paul	Brown	Chief Finance Officer		
Mrs	Heather	Johnstone	Director of Nursing and Quality		
Dr	Doug	Robertson	Secondary Care Consultant		
Dr	Anna	Onabolu	Clinical Leader		
Dr	Mukesh	Singh	Clinical Leader		
Dr	Hirendra	Choudhary	Clinical Leader		
Dr	Murray	Campbell	Clinical Leader		
Dr	Sandeep	Geeranavar	Clinical Leader		
Mr	Neil	Chambers	Lay Member for Governance		30/09/2021
Mr	John	Howard	Lay Member for Governance	01/10/2021	
Mr	Paul	Gallagher	Lay Member for PPI		
Mrs	Janet	Toplis	Lay Member		

**Dates will only be included if there has been a change in-year*

Governing body profiles can be viewed on our website.

Committee(s) including Audit Committee

Audit Committee

This is a committee held in common with East Staffordshire CCG, North Staffordshire CCG, South East Staffordshire and Seisdon Peninsula CCG, Stafford and Surrounds CCG and Stoke-on-Trent CCG. Only Cannock Chase CCG members vote on Cannock Chase issues.

Cannock Chase CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	Neil	Chambers	Lay Member for Governance		30/09/2021
Mr	John	Howard	Lay Member for Governance	01/10/2021	
Mr	Paul	Gallagher	Lay Member for Patient and Public Involvement (PPI)		
Dr	Doug	Robertson	Secondary Care Consultant		

East Staffordshire CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	David	Harding	Lay Member for Governance		
Ms	Anne	Heckels	Lay Member for PPI and Quality		
Dr	Doug	Robertson	Secondary Care Consultant		

North Staffordshire CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	John	Howard	Lay Member for Governance		
Dr	Doug	Robertson	Secondary Care Consultant		
Mr	Tim	Bevington	Lay Member		

South East Staffordshire and Seisdon Peninsula CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Ms	Anne	Heckels	Lay Member for PPI		
Mr	Neil	Chambers	Lay Member for Governance		30/09/2021
Mr	John	Howard	Lay Member for Governance	01/10/2021	
Mr	Paul	Gallagher	Lay Member for Quality		
Dr	Doug	Robertson	Secondary Care Consultant		

Stafford and Surrounds CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	Neil	Chambers	Lay Member for Governance		30/09/2021
Mr	John	Howard	Lay Member for Governance	01/10/2021	
Mrs	Diana	Smith	Lay Member		
Mr	Paul	Gallagher	Lay Member		
Dr	Doug	Robertson	Secondary Care Consultant		

Stoke-on-Trent CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	John	Howard	Lay Member for Governance		
Mr	Tim	Bevington	Lay Member		
Dr	Doug	Robertson	Secondary Care Consultant		

**Dates will only be included if there has been a change in-year.*

Remuneration Committee

The Remuneration Committee has met in common once with East Staffordshire CCG, North Staffordshire CCG, South East Staffordshire and Seisdon Peninsula CCG, Stafford and Surrounds CCG and Stoke-on-Trent CCG during 2021/2022.

Details of membership can be found in the Remuneration and Staff Report.

Further details of the sub-committees of the Governing Body can be found in the Annual Governance Statement.

Register of Interests

Details of company directorships and other significant interests held by members of the Governing Body which may conflict with their management responsibilities, as well as details of how these conflicts are managed, can be viewed on the website: Governing Body Membership Conflicts of Interest Quarter 4.

Please see the Governance Statement for more information.

Personal data-related incidents

Please see the Governance Statement for more information.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act 2015

The Modern Slavery Act 2015 establishes a duty for commercial organisations with an annual turnover in excess of £36 million to prepare an annual 'Slavery and Human Trafficking Statement'. This is a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business. Income earned by NHS bodies from government sources, including CCGs and local authorities, is considered to be publicly funded and is therefore outside the scope of these reporting requirements.

After discussion with our Auditors, the CCG does not consider that it has any activities that requires it to be treated as a commercial organisation for the purpose of the Modern Slavery Act 2015. We do not engage in profit-making activities, and so do not trigger the mandatory reporting requirements.

However, we fully support the government's objectives to eradicate modern slavery and human trafficking. Even though we do not meet the requirements for producing

an annual statement, as best practice, the six Staffordshire and Stoke-on-Trent CCGs have provided a combined Modern Slavery Act statement.

Statement of Accountable Officer's responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Mr Marcus Warnes to be the Accountable Officer of Cannock Chase CCG.

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

- the propriety and regularity of the public finances for which the Accountable Officer is answerable
- keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- the relevant responsibilities of accounting officers under Managing Public Money
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- prepare the accounts on a going concern basis.

The CCG has complied with its financial duties under Section 223H to 223J of the National Health Service Act 2006 (as amended) and has made a surplus. In all other respects 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 Clinical Commissioning Group 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. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

Marcus Warnes

Accountable Officer

NHS Cannock Chase CCG

22 June 2022

Governance Statement

Cannock Chase CCG is a corporate body 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 2022, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

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

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this Governance Statement.

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the group 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.

This has been achieved by the following.

Key features of the CCG's constitution for governance

The CCG will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

The principles of good governance are established in our Constitution.

The CCG will at all times observe these generally accepted principles in the way it conducts its business.

These include:

- the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business
- the Good Governance Standard for Public Services
- the standards of behaviour published by the Committee on Standards in Public Life (1995), known as the 'Nolan Principles'
- the seven key principles of the NHS Constitution
- the Equality Act 2010.

Information about the Governing Body, the Membership Board and the committees

The Governing Body has an ongoing role in reviewing the CCG's governance arrangements, to ensure that they continue to reflect the principles of good governance. The CCG has a programme of organisational development sessions for the Governing Body held bi-monthly to strengthen commissioning arrangements and provide mandatory training. As CCGs are permitted to delegate to the Governing Body and its committees that meet at the same time and in the same location as other committees (from other CCGs) it is referred to as "committees in common".

Our Membership Board has a clinician from each of the 22 practices in Cannock Chase. The Membership Board provides the professional clinical expertise and scrutiny to ensure the CCG's decisions are clinically led.

Committees of the Governing Body (all held in common)

- Audit Committee
- Remuneration and Terms of Service Committee
- Quality and Safety Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee
- Communication, Engagement, Equality and Employment Committee.

Cannock Chase CCG, Stafford and Surrounds CCG and South Staffordshire and Seisdon Peninsula CCG have met as a Joint Committee at the Locality Commissioning Board, for 11 meetings between April 2021 and February 2022.

These have been set up in the South West (Cannock Chase CCG, the Seisdon locality of South East Staffordshire and Seisdon Peninsula CCG and Stafford and Surrounds CCG); in the South East (South East Staffordshire and Seisdon Peninsula CCG, minus Seisdon locality and East Staffordshire CCG) and the North (North Staffordshire and Stoke-on-Trent CCGs).

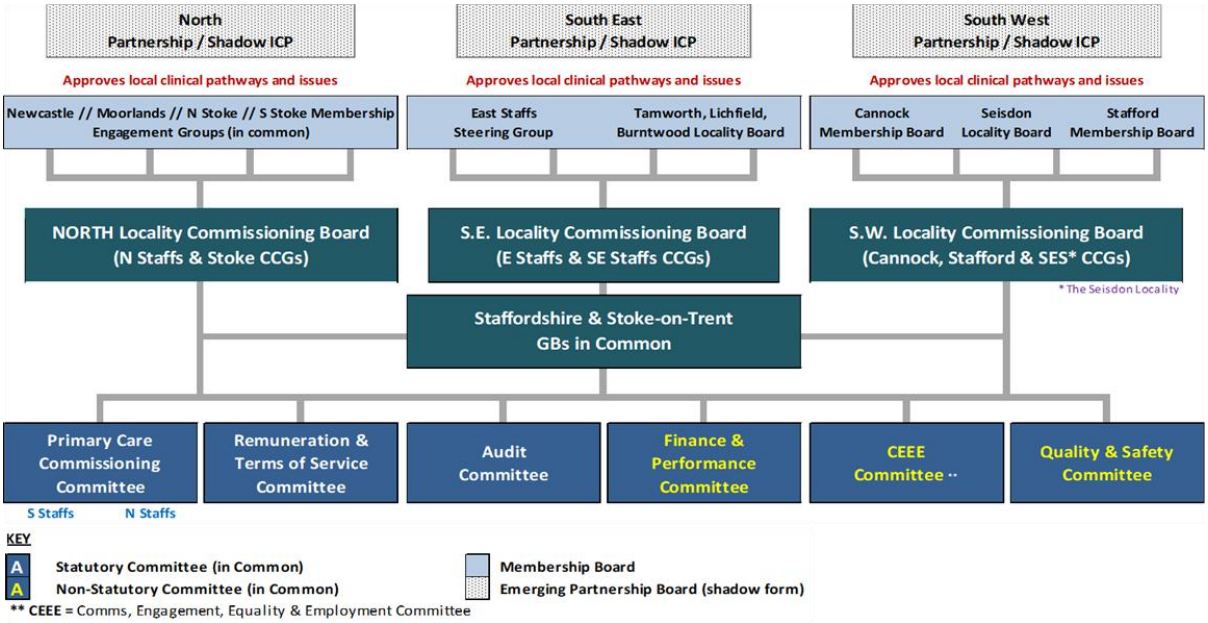
Joint arrangements with other CCGs

A White Paper was released in February 2021 setting out plans for wide-ranging reforms to how health and social care services are to be commissioned in England,

with CCG functions being taken over by integrated care systems (ICSs). These plans will be implemented in 2022.

The CCG has been working towards the establishment of the ICB, which was intended to be formed on 1 April 2022, but following directives from NHSE/I this has now been put back to 1 July 2022.

The CCGs continue their close working and maintain arrangements for holding meetings in common.



Meetings of the Governing Body

As a CCG we have a duty to demonstrate accountability to our key stakeholders. Our staff continue to work from home due to the COVID-19 pandemic. We continue to hold our meetings remotely including holding our statutory meetings via Microsoft Teams. We held six Governing Body meetings in public that were all quorate, 12 in private that were all quorate and an Annual General Meeting on Teams to which the public could listen in and were able to submit questions.

Information about the committees

The Finance and Performance and the Quality and Safety Committees have at least one clinician, executive and lay member as part of their membership. The membership of the Audit Committee, the Remuneration and Terms of Service Committee, the Communication, Engagement, Equality and Employment Committee and the Primary Care Commissioning Committee consists of the CCG's lay members.

The terms of reference for each of the CCG's committees provide further details of their membership, roles and responsibilities, and can be found in our Constitution.

Performance of the Membership Board and Governing Body, including their own assessment of their effectiveness

During 2021/22 we have continued to hold our Membership and Governing Body meetings virtually as part of our response to COVID-19.

The switch to virtual meetings continues to be of benefit making the majority of meetings quorate, as people have not had to travel across the county.

Virtual meetings have also created efficiency savings thanks to reduced travel cost claims and savings in other corporate overheads, such as printing (see the Sustainability section of this report).

In addition, public meetings have had a better attendance than those held face-to-face and for these reasons we will continue to meet virtually.

Each committee meeting has a standing agenda item to review its effectiveness (against terms of reference, objectives for the meeting, and so on). All members who are present complete a series of self-assessment questions, which are noted in the minutes – with any issues escalated by the Chair through routine highlight reports that go to subsequent Governing Body meetings for information.

The questions are as follows.

- Did we achieve what we set out to do; linking back to the Agenda?
- Were the Nolan Principles adhered to during the meeting?
- Was the meeting conducted effectively, in line with the Meetings Charter?
- Do we need to escalate any issues or inform anyone of our decisions?

The CCG has now had nine years' experience of delivering its functions as a statutory organisation, and we have used a review of performance against key standards and domains designed by NHS England to evaluate the effectiveness and impact of the CCG.

As part of ensuring that the required professional standards are achieved, the CCG's Governing Body and committees adhere to the following principles, drawn from our Constitution and their terms of reference.

The Governing Body audits its own and its committees' performance and effectiveness in a number of ways:

- it does so according to provisions within our Constitution
- Governing Body and committee members abide by the 'Nolan Principles'
- quoracy and conflicts of interest are recorded at the start of each meeting and throughout, and include details of how conflicts are managed
- draft minutes of each preceding meeting are approved at each subsequent meeting
- approved minutes of committees are submitted to each Governing Body meeting

- the Governing Body delegates powers to the committees to manage certain items: for example, policy approvals (the Governing Body still formally ratifies these)
- Board observations are carried out by our internal auditors
- escalation and highlight reports are submitted for each subsequent Governing Body meeting, and the Chair raises any issues by exceptions.

Our internal auditors – RSM – undertook an observation of the Governing Body's approach to managing risk. The risk observation formed part of the reports on the CCG's overall risk management arrangements and the recommendations are being overseen by the Audit Committee.

There is also provision in our Constitution for our member practices to call a meeting of the Governing Body (where due process has been followed and using the Teams approach as noted previously). Member practices have not called for a meeting of the Governing Body in 2021/22.

The names of all members present at Governing Body, the Membership Board and formally constituted committee meetings in 2021/22. have been routinely recorded in the minutes of these meetings. Attendance has been more than satisfactory throughout 2021/22. with the use of Microsoft Teams, as we have achieved more than minimum quoracy requirements for all CCG in common meetings.

All papers for the meetings held in public can be found on our website.

In the very few areas where quoracy has not been maintained for meetings, the arrangements to mitigate this have been set out in the minutes.

All Governing Body meetings were quorate throughout 2021/22, as these were held virtually through Microsoft Teams.

The CCG Governing Body can confirm that it has received verbal reports from the CCG committees, along with approved minutes, and it is satisfied with the composition, attendance and efficacy of these committees.

Highlights of the work of all the above committees, sub-committees and joint committees

Membership Board

Our CCG Membership Board has met 12 times during 2021/22 and the meetings were quorate.

The Membership Board focused on:

- COVID-19 update
- Restoration and recovery update
- Area prescribing
- Workforce
- Performance
- Staffordshire and Stoke-on-Trent Clinical Leadership Framework and Model

- Children and Young People's mental health
- Proposal for Use of Faecal Immunochemistry Test (FIT) in primary care for patients with lower GI symptoms who meet the two week wait referral criteria
- Quality Improvement Framework 2021/22
- Future of clinical decision making/membership board.

South West Locality Board

Our CCG have two Locality Boards – one in Cannock Chase and one in Stafford and Surrounds. They have met 12 times throughout 2021/22. The meetings were not quorate with the exception of meetings held in December 2021 and January 2022. The meetings focused on:

- budget setting
- Integrated Care Partnership
- restoration and recovery of elective services
- finance update
- attention deficit hyperactivity disorder (ADHD) update
- wheelchair procurement
- post-COVID syndrome assessment clinics
- Primary Care Access Plan.

Audit Committee

The Audit Committee meetings in common with the other five Staffordshire and Stoke-on-Trent CCGs were held in April, May, September and November 2021, and February and March 2022. The meetings were held via Microsoft Teams and all were quorate.

The committee's role is to provide assurance to the Governing Body on systems of internal control through the independent, objective review of financial and corporate governance / risk management arrangements. These include internal and external audit matters, compliance with the law, guidance and regulations pertinent to the NHS.

The Audit Committee focused on:

- The Internal Audit Plan
- The receipt and scrutiny of reports from both external and internal auditors and the scrutiny of action plans to address these reports
- Annual Report for 2021/22
- The ongoing review of fraud prevention including the summary reports from any investigations
- Scrutiny of Board Assurance Framework and risk register

- Scrutiny of CCG registers for conflicts of interest, and gifts and hospitality, freedom of information and active monitoring of an agreed conflicts of interest action plan
- Scrutiny of single tender waivers.

Extra Ordinary Audit Committees in Common – Due Diligence

The Audit Committees in Common also held six Extra Ordinary Due Diligence meetings in the period October 2021 to March 2022.

The purposes of these meetings were in line with the national guidance released by NHS England in September 2021, to comply with due diligence requirements as the sending organisation to incorporate the functions of the CCG into the Integrated Care Board (ICB).

The Audit Committees agreed to hold these meetings to complete a deep dive into each area and highlight any areas of concern or highlight any areas that may be missing to ensure a smooth transition into the ICB.

Extra Ordinary meetings held have covered the following areas:

- Finance
- HR
- Quality
- Information Governance (IG) and Information Technology (IT)
- Strategy Planning and Performance and Business Interruption (BI)
- Commissioning
- Primary care.

In May 2022, we will do a further review to ensure the CCGs have completed a thorough check of the requirements of the due diligence before they hand over to the ICB.

Membership of the CCG's Audit Committee is cited as part of the Members' Report within this Annual Report.

Remuneration Committee

Remuneration Committee meeting in common met once with the other five Staffordshire and Stoke-on-Trent CCGs in July 2021.

The committee's role is to make recommendation to Governing Bodies on determinations about remuneration, conditions of service, benefits and allowances for Very Senior Managers and any alternative to the NHS scheme for employees and members of the Governing Bodies.

The meeting was quorate.

Quality and Safety Committee

Committee meetings were held in common with the other five Staffordshire and Stoke-on-Trent CCGs. The Quality and Safety Committee met 10 times in 2021/22, and all meetings were quorate. The committee's role is to provide assurance to

individual Governing Bodies on the quality and safety of all services commissioned for local patients, including those led by other CCGs where the CCGs from Staffordshire and Stoke-on-Trent are an 'Associate Commissioner'.

It also leads on other joint commissioning duties relating to pan-CCG quality strategy elements such as the assurance of non-clinical services (including Commissioning Support Unit Quality KPIs, approval of Quality Impact Assessments (QIAs) for QIPP schemes, research governance matters, the agreement of policies, and receipt / management of clinical risk registers).

All of the meetings were quorate with the exception of the meeting held in December 2021.

The committee focused on:

- A COVID-19 Quality and Safety report, which included:
    - provider assurance – where the CCGs are the lead/host commissioner
    - incidents management
    - independent sector assurance
    - QIAs
    - quality and safeguarding
    - soft intelligence
    - risk register and issues log
    - COVID-19 testing
- waiting list backlog
- patient engagement
- safeguarding
- D2A (Discharge to Assess).

The committee also received reports on:

- the LeDeR programme
- Special Educational Needs and Disabilities (SEND)
- autism services – Independent Review Report
- patient safety
- Primary care quality
- Nursing Home Quality and Assurance Group
- the PIRT (Patient Improvement Response Team)
- CHC (continuing healthcare) and Care at Home (domiciliary care)
- infection, prevention and control
- patient engagement
- complaints and soft intelligence

- medicines optimisation
- serious incidents
- QIA sub-group
- maternity and neonatal services.

Finance and Performance Committee

Committee meetings were held in common with the other five Staffordshire and Stoke-on-Trent CCGs. The Finance and Performance Committee has met 12 times. All meetings were quorate, with the exception of the meetings held in October 2021 and March 2022. The committee's role was to assure the Governing Bodies on issues related to finance, performance and contracting, including financial and commissioning plans and performance management of contracts.

The discussion of meetings focused on:

- Performance report
- Month 9 Performance Report: Staffordshire and Stoke-on-Trent System Summary
- COVID-19 finance update and returns
- Contracting report
- Risk register
- System Financial Strategy and Transformational Savings
- Prescribing Local Improvement Scheme 2020/2021 Results Summary
- 2022/23 financial plan
- contractual arrangements with independent sector providers.

As noted in the Performance Report sub-sections on NHS Oversight Framework (NHS OF) and NHS Constitutional Standards, a number of system provider and commissioner failures occurred this year in the delivery of key performance indicators (KPIs) or outcome measures.

Performance improvement is being targeted to align with national priorities linked to restoring access and services post COVID-19, with system organisations continuing to operate in partnership to deliver improved performance for 2021/22. Performance improvement within individual areas is led by cross-system boards focussed respectively on urgent and elective care.

The Finance and Performance Committee will continue to monitor system wide improvement plans throughout 2021/22. It will look for evidence in further performance reports that the necessary improvements in performance are being made in each individual performance area.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee met in common with East Staffordshire CCG, South East Staffordshire and Seisdon Peninsula CCG and Stafford and Surrounds CCG 10 times in public. All public meetings were quorate.

The committee is responsible for corporate decision making in the management of the delegated functions / exercise of delegated powers in relation to primary medical services review, planning and procurement.

The meetings have focused on:

- National GP Retention Scheme – future process
- GP Improvement Grants
- COVID-19 vaccination programme update
- Translation and interpretation services
- Roadmap to Recovery – General Practice
- Workforce update
- Primary care quality update
- Staffordshire and Stoke-on-Trent GP retention plan proposal for 2021/22 enhanced services
- Special Allocation Scheme extension and General Practice Security Services extension
- GP Access update
- Estates
- Digital
- Risk register and Board Assurance Framework (BAF).

The Primary Care Commissioning Committee has also held 11 confidential meetings. The meetings focused on local primary care issues relating to specific practices.

Communications, Engagement, Equality and Employment Committee

The Communications, Engagement, Equality and Employment Committee (CEEE) has met in common with the five other Staffordshire and Stoke-on-Trent CCGs 11 times. All meetings were quorate with the exception of the meeting held in June 2021.

The committee's role is to support strategic commissioning by feeding in local views. It also provides a vehicle for Patient and Public Involvement lay members from the six CCGs to agree common approaches. It covers all CCGs' statutory duties, pertinent to title, including the Equality Act 2010.

It provides meaningful and timely communication to stakeholders, and engagement with communities, clinicians and staff (including consultation arrangements for changes to healthcare services in line with legislation). It oversees the joint Organisational Development Plan to develop and empower Governing Bodies, the senior leadership team and staff to deliver strategic objectives. It provides oversight of aspects of employment (including labour law compliance, employment standards and employee relations).

The committee focused on:

- COVID-19 position update including the impact on the CCGs and the vaccination programme
- Annual Report and AGM
- Gender Pay Gap Report
- 2020/21 Public Sector Equality Duty (PSED) Equality and Inclusion annual report
- Statutory and mandatory training
- Staff engagement
- Membership engagement
- Agile Framework
- Board Assurance Framework (BAF)
- Creating a single commissioning organisation (CCG) application update
- ICS People transition
- Coaching and mentoring framework
- Staff development events
- Human Resources and Organisational Development (HR OD) Plan
- Staff support groups.

Equality Impact and Risk Assessments (EIRAs) are a tried and tested way to evidence ‘due regard’ to the Equality Act and Public Sector Equality Duty. Update documents are produced on a quarterly basis and assurance is given to the CEEE Committee.

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 Good Governance Institute best practice.

Discharge of statutory functions

The CCG has put in place arrangements, developed with expert external legal advice, to ensure our compliance with all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decisions and the scheme of delegation.

In light of the recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk management arrangements and effectiveness

As part of the Staffordshire and Stoke-on-Trent CCGs' Internal Audit Plan for 2020/21, a BAF and risk management review was undertaken to provide assurance on the frameworks in place and any changes made to them during COVID-19. During 2021/22 the CCG has continually reviewed the BAF and made changes to enhance the reporting and provide robust assurance to the CCG's board and committees.

In 2021/22 a decision was made to suspend the risk register and introduce a COVID-19 register, which continued to be reviewed during 2021/22 until the suspended risk register was re-introduced in August 2021.

The CCG now uses a system called Ulysses, which captures all the risks the CCG consider would harm the business of the organisation. Risk owners provide their updates onto Ulysses in a timely manner enabling the Governance team to provide reports to the various Boards and committees.

The Ulysses system also captures the Board Assurance Framework risks.

The Governance team have provided training to all CCG staff and provided a working guide to assist them completing updates on the system.

There is also oversight through the CCG's Committees and Governing Body in Common which now receive monthly full versions respectively of the BAF and risk registers.

The administration of both the BAF and risk registers is undertaken by the governance team who have provided support on the completion of the new system.

There is also oversight through the CCG's Committees and Governing Body in Common which now receive monthly full versions respectively of the BAF and risk registers.

The administration of both the BAF and risk registers is undertaken by the governance team who have provided support on the completion of thew new system.

We have auditor-assured and adequate risk management control frameworks, with clear reporting lines and regular review of the CCG's identified risks.

In this way we have continued to actively support our 'risk culture', despite the impact of COVID-19 on normal risk management business processes. We have ensured that risk management has remained fully embedded in the CCG's core business activity (including interlinked areas such as undertaking Equality Impact Assessments with in-built risk assessment checks, or to support all incident reporting to be carried out openly).

The BAF and the risk register work together to identify and monitor threats to the CCG's strategic goals. A 2021/22 BAF was agreed by the Governing Bodies and internal auditors in June 2021 to ensure the Governing Bodies are alerted to risks that could impact delivery of the strategic objectives throughout the year.

The Governing Body receives the risk register and BAF early on the agenda to ensure discussions are informed by risk. All Board reports identify links between their content and items on the risk register. At the end of each meeting, the committee considers whether any new risks have been identified and are recommended for addition to the risk register. This practice remains embedded in the work of all the Governing Body sub-committees.

An audit was carried out by RSM on our BAF this year and noted that the BAF aligned to the CCG's seven strategic aims. It contains risks, controls and assurances. Gaps in control and assurances are identified and appropriate actions are allocated to individuals to address the gaps.

Risks are scored at three stages: initial risk score, residual risk score and target risk score.

Testing confirmed that regular review, monitoring and scrutiny of the BAF and risk registers are undertaken by the CCG Governing Body in Common and its sub-committees.

These meetings are attended by lay members – both statutory and non-statutory. Risk is discussed at the CCG's Annual General Meeting, where the Governance Statement and Annual Reports and Accounts are presented.

The RSM audit reviews of the corporate governance and risk management processes, and a more focused piece on risk management, have resulted in the following findings.

Three 'medium' category management actions relating to the following:

The CCGs will review the Board Assurance Framework and ensure the following:

- The control description is clearly recorded and assessed as genuine, relevant and timely
- Any actions are removed from the control description and transferred to the gaps in control column, with an appropriate action identified to address the gap.

The CCGs will review the Board Assurance Framework and ensure the following:

- Assurances are specific enough to allow readers to identify what information they are expecting and how this provides assurance against an individual objective and risk
- Assurances are actual assurances and not controls or actions
- Where possible, explicitly reference the source of assurance (for example document/report name – January 2020). Where negative assurances are highlighted, additional actions will be raised to address the issue(s)
- Assurances are received from a range of sources (for example Internal Audit, Clinical Audit or CQC relating to providers, etc) and their independence, objectivity and relevance considered.

The coversheets will be further enhanced to ensure that it clearly draws out key information such as:

- Whether all risks have been reviewed each time

- Where slippage is identified including the likelihood of achievement and the implementation of actions
- Significant changes to risk (this should also be highlighted on the BAF, so it is clear for the reader)
- For the Audit Committee and Governing Body, the coversheet should highlight key areas discussed at sub committees which should be brought to their attention in respect of the BAF.

RSM also noted that the majority of assurances identified within their sample were from an internal source/process. A range of assurance sources should be considered to diversify and strengthen the assurances received (internal audit, external audit, KPIs, independent reports, and so on).

Capacity to handle risk

The CCG Governing Body is responsible for the organisation's systems for internal control, including risk management. The Accountable Officer is designated with overall responsibility for ensuring the implementation of external assurances covering risk management and reporting to the Governing Body. The Accountable Officer delegates some of these responsibilities to senior officers of the CCGs.

Single leadership team

The role of the single leadership team covering all six CCGs in Staffordshire and Stoke-on-Trent is to have oversight of the BAF and the encompassing risk register for all risks. Executive directors through their 'Start the Week' weekly meeting were responsible for validating and managing risks within their designated remit of work, including COVID-19 response.

Audit Committee (held in common)

The Audit Committee ensures that effective systems of integrated governance, risk management and internal control are maintained.

The Audit Committee reviews the risk register and BAF.

The sub-committees of the Governing Bodies are responsible for overseeing the risks relating to their workstreams. The Audit Committee has oversight of all risks.

Accountable Officer

The Accountable Officer has overall responsibility to ensure appropriate systems of internal control are in place for all aspects of governance, including financial and risk management as well as plans for dealing with emergencies that may impact on the CCGs.

Day-to-day management of risk management processes is delegated to the Executive Director of Corporate Services, Governance and Communications.

Executive directors

The relevant executive director ensures that all risks are identified, managed and mitigated for their workstreams and that the risk owner carries out their duties effectively. The attribution of risks is aligned with the programme portfolios (including the COVID-19 response). Executive directors led the interim risk review process throughout the COVID-19 response.

Risk owners

The risk owners will ensure that their risks are continuously managed. They will check that the risk register is updated on at least a monthly basis or as deemed appropriate by their executive director.

The directors are:

Executive leads	Area of work (including COVID-19 ICC Cell)
Chief Finance Officer	Finance, Governance and Senior Information Risk Owner
Executive Director of Quality and Safety – Chief Nurse	Quality, Safety, Safeguarding, Caldicott Guardian
Executive Director of Corporate Services, Governance and Communications	Corporate Governance, Human Resources, Organisational Development, Equalities and Communications and Engagement
Executive Director of Primary Care	Primary Care and Medicines Optimisation
Executive Director of Strategy, Planning and Performance	Performance, Information, Planning and Strategy, as well as formal processes for ICC incident response
Executive Director of Strategic Commissioning and Operations	Commissioning and Operations, including the operational cells' work in COVID-related areas

Risk assessment

As noted above, the COVID-19 pandemic required the CCGs to deploy staff to work in other areas while still maintaining their statutory duties in relation to risk management. In doing so, the executive management team made a decision to "mothball" the corporate risk register and develop the dedicated COVID-19 risk register. However, a decision was made to "stand up" and reinstate the "mothballed" risk register. The register was re-introduced in August 2021 once the work on Ulysses had been completed.

To ensure further scrutiny, the formal committees of the Governing Bodies received copies of the COVID-19 risk register at their regular meetings for risks scoring 15 and above.

The CCG can declare that it is currently managing 15 risks on the register scoring 15 and above, which will be carried forward into 2022/23. This includes:

- Four risks scoring 20 (extreme)
- Eight risks scoring 16 (extreme)
- Three risks scoring 15 (extreme).

The Audit Committee and the Governing Body have oversight of these risks and details of the top extreme scoring risks are as follows.

Top extreme scoring risks

Risk description	Actions to mitigate
1. Underlying deficit: Without the delivery of robust system saving schemes, the system and consequently the CCGs will be unable to deliver a financially stable position, in line with the regional control total (yet to be confirmed).	System Directors of Finance meeting weekly until March 2022. System reporting of savings to resume. System and organisational plans being reviewed at system director of finance and deputy's meetings for submission March and finalisation April 2022. Longer-term financial plan expected to prepare for Quarter 2 of 2022/23.
2. NHS Oversight Framework (NHS OF): Deterioration of performance, deterioration across the NHS of indicators and may impact on overall CCG annual rating.	Meeting held with MDs on 17 January 2022. Further work being undertaken to support MDs with indicators and metrics.
3. Ambulance handover delays at Queen's Hospital Burton and Royal Stoke University Hospital: Impact upon flow for the ambulance service and quality of patient experience.	Frequency and duration of ambulance delays have increased within Staffordshire. Both QHB and UHNM have confirmed that they will facilitate rapid transfers if required to allow WMAS to respond to CAT 1 / 2 calls within the community. All patients pending transfer into ED receive clinical review on arrival and throughout the duration of their wait. CRIS transfers continue to positively impact upon the level of conveyances undertaken by WMAS.
4. Cancer activity UHDB and UHB: There is an overall increase in the number of two week wait referrals due to the pandemic, with increases in referrals for dermatology, breast cancer which is potentially delaying diagnosis and treatment.	Task and finish group in place. UHB changed two week wait forms focusing on additional capacity and pathway management reviews, health checks on patients likely to breach. UHDB standard 28-day letters being sent out for tumour sites, pathway redesign is being implemented. "Deep dives" taking place. Additional clinics and straight to test pathways in place.
5. New ICS White paper: A risk that staff will leave rather than put themselves through the organisational changes likely to be ahead, includes disengagement of staff, loss of or significantly reduced discretionary effort.	Risk re-opened at the request of the lay members at the last CEEE meeting due to the concern in relation to the post of CEO not being filled and uncertainty generally.

6. Maternity transformation programme: The system is unlikely to deliver the requirements of the MTP due to delays resulting from COVID-19.	Recruitment process completed and new team members expected in post by mid-March 2022. Exception reports still requested, QSOF forum reduced but not cancelled. Regular short update catch-ups continue with DOM and Neonatal service. Oversight maintained by appropriate meetings.
7. The long-term consequences to patients and staff of Staffordshire and Stoke-on-Trent following the demands placed on the system in response to COVID-19 are not yet known. There is a potential unintended consequence which will have significant impact on physical / emotional patient wellbeing and optimal treatment outcomes across all commissioned services.	There is significant increased demand for services within acute, community and mental health providers and workforce challenges, exacerbated by COVID-19 outbreaks and staff isolations across all partners, both of which impact on increasing already high waiting lists across the system. System partners continue to work collaboratively to identify early warning of emerging issues or impact.
8. Risks to finance team/function: If the transition on 1 July 2022 leads to a national system that has capacity issues and delays to running reports, raising orders and making payments.	Meetings continuing, although will be less frequent in February and March 2022. Project continues with clear tasks and timelines.
9. There is a risk that payment will not be made properly to suppliers for purchase orders that have been receipted.	Monitored weekly at senior finance team meeting and improvement continues. Meeting with SBS Director of Finance due mid-February 2022 to gain assurance on delivery of their action plan.
10. There is a risk that the gaps in Maternity and Neonatal workforce due to vacancies and retention will impact on the implementation of safety initiatives and the transformation agenda.	Workforce papers go to provider boards six monthly. LMNS workforce group will be held quarterly and oversee progress.
11. To ensure that the trajectory is met and patients are discharged in line with their individual care plans.	Trajectory still on target to deliver.
12. Transformation Care Programme: TCP Care management and project team capacity is being utilised to maintain business as usual rather than the development of new processes and protocols that will improve longer term flow of this patient cohort.	This programme forms part of the integration transformation work.

13. Urgent Care flow: Staffordshire urgent care system has been subject to extensive intervention in order to support the achievement of sustained flow and improved process which results in a zero tolerance to 12-hour trolley breaches and achievement of 95% four-hour wait target. Risk community service.	Ambulance and discharge delays continue to impact upon patient flow within ED, acute bed base and community services. Mitigating actions have been identified and rolled out to reduce impact. Actions are monitored through the System Assurance meeting, Ops Cell and UEC board.
14. Maternity services: Unable to deliver continuity of carer trajectories for the NHS Long Term Plan of continuity of carer for the default model of care for the majority of women by March 2023. May not be achieved due to insufficient staffing levels within provider trust.	Some UHDB teams continue to provide antenatal, post-natal and some intro-partum care. Progress reported via CNST and internal quality meetings. National policy remains in place. Both maternity services have action plans.
15. Delegated commissioning: A new model is coming into place in April 2020 which removes the local team. There is a risk that there is not the capacity to deliver the delegated commissioning functions.	A primary care working group for the West Midlands is in place to review the GMAST support function as well as the functions relating to pharmacy, dentistry and optometry PODs. Currently working through a function mapping exercise with a workshop being planned for early 2022.

The risks detailed above are considered to be important to the CCG as they directly impact on patient care and the services provided, it is therefore important that these are monitored regularly and mitigations put in place to reduce them. The extreme risks listed above, and the high-scoring risks can be found in the Governing Body papers on our website.

However, during January and February 2022 the risk management was reported by exception due to staff being re-deployed in the wake of the Omicron outbreak. Normal reporting functions will resume in March 2022.

Other sources of assurance

Internal control framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it 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 BAF and review of the risk register are included within the Governing Body and Audit Committee Cycle of Business, as appropriate. The BAF will be refreshed to

develop the objectives in 2022/23. Work is underway to develop an ICS BAF that includes taking forward elements from the CCG BAF that remain outstanding.

Assessment of CCG effectiveness

The CCGs in Staffordshire and Stoke-on-Trent are and have been working towards the cessation of the CCGs and development of the new Integrated Care Boards (ICBs). CCGs will cease to be statutory organisations on 30 June 2022 with the ICBs being formalised on 1 July 2022.

The Remuneration and Terms of Service Committee oversees the performance appraisal cycle for senior staff. 'Senior staff' are defined as those staff who are directly accountable to the Accountable Officer, and the Accountable Officer post which is appraised by the Clinical Chair.

As part of ensuring that the required professional standards of performance and effectiveness are achieved, the Governing Body and its committees adhere to the following principles, drawn from our Constitution and terms of reference.

- All Governing Body and committee members abide by the Nolan Principles
- Quoracy and conflicts of interest are recorded at / throughout each meeting
- Draft minutes of preceding meetings are approved at each subsequent meeting
- Committee Chair reports are presented to the Governing Body on the business conducted by the committee, if not covered by another paper, for example the finance report. Approved business cycles govern the items of business to be transacted at each meeting to ensure that the right report is sent to the right meeting at the right time
- All committees are encouraged to undertake a self-assessment as part of their annual business cycle.

Annual audit of conflicts of interest management

The statutory guidance on managing conflicts of interest for CCGs (June 2017) 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.

Headlines/summary of findings

The six CCGs in Staffordshire and Stoke-on-Trent have an aligned Conflicts of Interest Policy. They have also reviewed and aligned the templates used to collate the declarations from their staff and membership. CCGs were not required to submit quarterly returns to NHSE during the last year. We publish our register of interest on our website and we request conflict of interest returns on an annual basis as per the statutory guidance.

Our internal auditors, RSM, carried out their annual internal audit of conflicts of interest on behalf of the CCG in September 2021 and presented their finding in Quarter 3 of 2021/22. RSM's review focused on:

- Policies and procedures established by the CCG, including process for recording and monitoring gifts and hospitality and capturing conflicts of interest
- Roles and responsibilities related to the conflicts of interest
- Roles and responsibility of Conflicts of interest guardian
- Conflicts of interest registers and requirements for boards and committees
- Communication, training and engagement of staff to ensure their awareness
- CCG commissioners involved with PCNs
- Conflicts of interest in relation to the maintenance and requirement of procurement decisions.

The review identified a well-designed control framework, however two medium priority management actions were identified which relate to the completion and retention of Conflicts of Interest forms during the procurement process; and ensuring in date Declaration of Interest forms are in place for all members of staff attending Governing Body in Common and sub-committee meetings.

Taking account of the issues identified, the Governing Body in Common can take reasonable assurance that the controls upon which the organisation relies to manage this area are consistently applied and effective.

Whilst opportunities for some enhancements to the control environment were identified, Internal Audit have based their opinion assessment on the following work undertaken in 2021/22:

- COVID-19 Emergency Preparedness and Business Continuity Plans (Reasonable Assurance)
- Quality Innovation, Productivity, and Prevention (QIPP) Programme Framework (Reasonable Assurance)
- Safeguarding Adults (Reasonable Assurance)
- Governance Arrangements – Phase One (Substantial Assurance)
- Board Assurance Framework and Risk Management – Phase One (Reasonable Assurance)
- Financial Model Health Check (Advisory)
- Management and Resilience of IT and Home Working Arrangements (Substantial Assurance)
- Financial Feeder Systems (Reasonable Assurance)
- Provider Contract Management and Performance – During the COVID-19 pandemic (Substantial Assurance)
- Financial Management Review (Advisory)
- Board Assurance Framework – Phase Two (Reasonable Assurance)

- We have also undertaken an advisory piece of work around Personal Health Budgets (PHBs) which has been completed outside of the 2020/21 Internal Audit Plan. This has not formed part of our opinion.

Internal Audit has not issued any 'No Assurance' or 'Partial Assurance' opinion reports in 2020/21 to date. In the audits shown as providing 'Reasonable Assurance', we have identified some areas where enhancements are required and in each of these cases management actions have been agreed – the implementation of which will improve the control environment. Topics judged relevant for consideration as part of the Annual Governance Statement.

The ongoing action tracking has identified progress against actions taking place although there are some which have been impacted due to the COVID-19 pandemic. The Audit Committees in Common has been kept appraised of progress through the year via our progress reports.

NHS England conflicts of interest training

We have proactively encouraged staff to complete mandatory training on time, with regular monitoring and reporting throughout the year. We send notices to staff regularly reminding them of the importance of completing their training, and a training report is received monthly.

Further action is put in place in cases where training has not been completed by the required date. This includes potential restrictions on attending meetings until either training or declarations gaps are remedied, in line with the agreed conflicts of interest action plan monitored by the Audit Committees.

Data quality

The Governing Body agrees that the data, information and intelligence brought to its attention and the attention of the Membership Board and its committees are fully acceptable and fit for purpose.

Information governance (IG)

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 framework is supported by a Data Security and Protection Toolkit (DSPT) 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.

We place high importance on ensuring there are robust information governance systems and processes in place to protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the NHS DSPT. All staff undertake annual information governance training, and we regularly update the staff IG handbook to ensure staff understand their information governance roles and responsibilities.

There are processes in place for reporting and investigating serious incidents. We have information risk assessments and management procedures, and we will establish a programme to embed an information risk culture against identified risks throughout the organisation.

The Data Protection Act 2018 and General Data Protection Regulation (GDPR) introduced more rights for individuals and the accountability principle for organisations to provide greater assurances relating to data-sharing practices and protocols.

We adhere to the legislation and have implemented data protection by design.

- We appointed the Deputy Director of Corporate Governance, Compliance and Data Protection and Data Protection Officer as the Data Protection Officer
- A Data Privacy Impact Assessment is completed for all projects, processes and services carried out by or on behalf of the CCG in which personal data is or may be processed or accessed
- We publish privacy notices on our website explaining what data is collected and how the data is collected, shared and processed – with appropriate legal basis to support processing evidence
- We maintain an Information Asset Register to show all information assets held and that associated data flows are mapped.

The DSPT is an online self-assessment tool that enables organisations to demonstrate and publish their compliance against the 10 data security and protection assertions. We will be completing our DSPT declaration as required, for the financial year 2021/22. This is planned to take place by 30 June 2022.

To support staff, a suite of documents was produced, incorporating the IG handbook, Staff Code of Conduct and Information Governance and Data Security and Protection Policies. Staff are required to read and acknowledge their understanding of these documents to ensure accountability of processes. All staff employed by or on behalf of CCGs must undertake and pass annual IG training.

Personal data-related incidents

There have not been any personal data breaches during the period 1 April 2021 to 31 March 2022.

Freedom of Information (FOI) requests

The Freedom of Information service was previously provided to the CCG by the NHS Midlands and Lancashire Commissioning Support Unit. At 1 April 2021, the CCG in-housed the service and had its own dedicated team to oversee the requests.

During 2021/22, the six Staffordshire and Stoke-on-Trent CCGs received 196 FOI requests, and an additional 22 requests were solely for Cannock Chase CCG. This year's FOIs had a focus on:

- Integrated care systems
- Continuing healthcare
- Contract procurement
- Weight management services
- Primary care rebate schemes
- Primary Care Networks

- Blood glucose formulary
- IT support services
- Mental health and learning disabilities
- NHS 111 / out of hours services.

All FOIs were responded to within the statutory 20 working days.

All of the FOIs specifically relating to Cannock Chase CCG and 187 of the joint FOIs have been closed and the final response sent. Of the remaining requests sent to the six CCGs, one was withdrawn, two were closed due to no further action, two were closed due to no further contact, and four are awaiting information from an internal contact.

Business critical models

In line with the best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, we confirm that an appropriate framework and environment are in place to provide quality assurance of business critical analytics and modelling.

Third party assurances

The CCG commissions its back-office support from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). Monthly performance reviews are scheduled with MLCSU.

MLCSU's Internal Audit support is provided by Deloitte. The CCG is awaiting the outcome of the MLCSU's Service Auditor Reports, and will include any identified weaknesses in controls within the final submission.

Control issues

No material issues requiring reporting beyond the underlying financial position were identified via the Month 9 Governance Statement return to NHSE. However, we face an ongoing control issue relating to the COVID-19 pandemic.

The financial framework for 2022/23 is returning to a population-based funding method. The system operating plan is still under development with a publication date of 28 April 2022. This plan will describe the system response to all operational requirements. The accompanying financial plan is based on the latest system allocations and is currently showing that the system will have a financial deficit in 2022/23. This financial forecast is under discussion with NHSE/I and an agreed plan will be published as soon as agreements have been reached.

While it was determined that this issue did not prejudice the achievement of the other organisational priorities or undermine the integrity or reputation of the CCG and/or wider NHS, advice and opinions were sought by both internal and external audit and provided to the Audit Committee, including briefings on the financial position by the Chief Finance Officer throughout the year.

At the time of writing the external audit, opinion on the financial statements is expected to be unqualified; therefore, delivery of the standards expected of the Accountable Officer are not deemed to be at risk. Furthermore, the issue has not

made it harder for us to resist fraud or other misuse of resources, and has not diverted resources from another significant aspect of the business.

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

Financial planning and in-year performance monitoring (such as details about the CCG's recovery planning process) are covered within the Performance Report section.

Central management costs are provided in the Financial Performance Targets note in the Accounts section.

Our Governing Body in Common and the Finance and Performance Committee and Audit Committees meeting in Common have been kept fully abreast of the CCG's financial position, and have provided both support and challenge as would be expected.

The CCG's QIPP delivery and monitoring function has been paused and revised during this financial year due to COVID-19 national requirements. In addition, business processes have been restructured to enable the Finance and Performance Committee to scrutinise and lead the COVID-19 financial agenda within standard business processes.

Delegation of functions

The key financial systems (general ledger, accounts payable, accounts receivable and payroll) are operated by Shared Business Support under contract to MLCSU. These systems undergo a separate regime of Internal Audit assessment which is provided by Deloitte. Their Service Auditor Reports are published twice a year, presented to the Audit Committee and reviewed by our external auditors in terms of informing the overall audit opinion.

For details on internal delegations, please refer to our Constitution.

Counter-fraud arrangements

The CCG has an accredited Local Counter Fraud Specialist (LCFS) in place to undertake counter fraud work proportionate to identified risks. This service is provided by RSM. The CCG seeks to ensure that a comprehensive counter fraud and anti-bribery culture exists throughout the CCG as detailed in the Counter Fraud and Bribery Policy and through the work undertaken by the LCFS. All such policy and procedure is subject to review by the LCFS to ensure all documentation is maintained in accordance with Service Condition 24 (SC24) of the NHS Standard Contract 2021/22 and the NHS Requirements to meet Government Functional Standard 013: Counter Fraud.

The Chief Finance Officer and Counter Fraud Champions work with the LCFS to support a proactive work plan to address identified risks. We have undertaken the annual Counter Fraud Functional Standard Return (CFFSR) we met the majority of areas and were rated as compliant in May 2022. Any areas subject to 'Amber' or 'Red' assessment will have detailed actions set – which will form part of the Integrated Improvement Plan and routinely be monitored through the Audit Committee.

Fraud information is available on the CCG intranet and is effectively signposted on the CCG website. Regular articles appear in staff newsletters highlighting this important issue. The LCFS actively promotes such policies at all awareness events.

We have not had any areas identified or actions recommended to be taken as a result of the NHS Counter-Fraud Authority (NHSCFA) quality assurance. The Chief Finance Officer is proactively and demonstrably responsible for tackling fraud, bribery and corruption.

Head of Internal Audit Opinion

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

In accordance with Public Sector Internal Audit Standards, the head of internal audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's Annual Governance Statement.

This section provides RSM's annual internal audit opinion for 2021/22 as at 4 March 2022.

For the 12 months ended 31 March 2022, as at 4 March 2022, our head of internal audit opinion for the six Staffordshire and Stoke-on-Trent CCGs is as follows:

The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Marcus Warnes

Accountable Officer

NHS Cannock Chase CCG

22 June 2022

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The CCG has a Remuneration and Terms of Service Committee in Common, which is a sub-committee of the Governing Bodies in Common. The Chair of the Remuneration Committee is the Lay Member for Governance and its members are the Clinical Chairs of each CCG, lay members and secondary care consultants.

The purpose of the committee is to advise the Governing Bodies about appropriate remuneration and terms of service for the Accountable Officer, Director of Finance and other senior employees, on Very Senior Manager contracts, including:

- all aspects of salary
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms
- discipline and dismissal of officer members of the Governing Body.

The Director of Corporate Services, Governance and Communications and the HR lead from the Midlands and Lancashire Commissioning Support Unit, support the meeting with the Chair, the Accountable Officer and the Director of Finance being asked to attend as appropriate.

Remuneration Committee members

First name	Surname	Position	Date of joining the committee	Date of leaving the committee
Neil	Chambers	Lay Member for Governance (Chair)	07/12/2017	
Paul	Gallagher	Lay Member for Patient and Public Involvement	07/12/2017	
Gary	Free	Clinical Chair	12/06/2019	
Doug	Robertson	Secondary Care Member	07/12/2017	

Details of the Remuneration and Terms of Service Committees meeting in Common can be found in the committee section of the Annual Governance Statement.

Policy on the remuneration of senior managers

Senior Managers are paid under one of three national frameworks.

- The Accountable Officer and the Director of Finance were paid under remuneration guidance for Chief Officers (where the Senior Manager also undertakes the Accountable Officer role) and Chief Finance Officers, published in 2012.
- The following posts were paid on the Very Senior Manager pay scale:
    - Director of Strategy, Planning and Performance
    - Director of Commissioning and Operations
    - Director of Nursing and Quality, and Chief Nurse
    - Director of Corporate Services, Governance and Communications
    - Director of Primary Care and Medicines Optimisation
    - Managing Director – North Staffordshire
    - Managing Director – East Staffordshire
    - Managing Director – South Staffordshire.
- Agenda for Change – see next paragraph.

Agenda for Change

All other staff except medical and dental staff are paid through the Agenda for Change pay structure.

Lay member remuneration was based on the rate for PCT non-executive directors set by the former Appointments Commission in accordance with national policy.

No senior managers have been paid/will be paid through a performance-related pay mechanism in 2021/22.

Everything relating to the remuneration and terms and conditions of the Accountable Officer, Director of Finance and Very Senior Managers is subject to approval by the Remuneration Committee.

Remuneration of Very Senior Managers

In accordance with the Department of Health and Social Care group accounting manual paragraph 3.90, we can confirm Marcus Warnes, Accountable Officer is paid more than £150,000 per annum.

A letter from Amanda Pritchard, Chief Operating Officer NHS England and Chief Executive NHS Improvement was received by the Remuneration Committee in July 2021 outlining a recommendation for a 3% pay rise for Very Senior Managers. This recommendation was adopted/approved by the CCGs Remuneration Committee meeting of 07 July 2021.

The outcome of adopting this recommended pay rise was to increase the overall remuneration of the Accountable Officer above £150,000 per annum.

Senior manager remuneration 2021/22 (including salary and pension entitlements) (subject to audit)

Name and title	a) Salary (bands of £5,000) £000	b) Expense payments (taxable to nearest £100) £	c) Performance pay and bonuses (bands of £5,000) £000	d) Long-term performance pay and bonuses (bands of £5,000) £000	e) All pension-related benefits (bands of £2,500) £000	f) Total a-e (bands of £5,000) £000
Marcus Warnes - Accountable Officer *	15 - 20	800	0 - 0	0 - 0	2.5 - 5	20 - 25
Paul Brown - Chief Finance Officer *	15 - 20	400	0 - 0	0 - 0	2.5 - 5	20 - 25
Jane Moore - Director of Strategy, Planning and Performance *	10 - 15	0	0 - 0	0 - 0	2.5 - 5	15 - 20
Heather Johnstone - Director of Nursing and Quality *	10 - 15	0	0 - 0	0 - 0	2.5 - 5	15 - 20
Lynn Millar - Director of Primary Care *	10 - 15	500	0 - 0	0 - 0	2.5 - 5	15 - 20
Sally Young - Director of Corporate Services, Governance and Communications *	10 - 15	0	0 - 0	0 - 0	2.5 - 5	15 - 20
Cheryl Hardisty - Director of Strategic Commissioning and Operations *	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15
Craig Porter - Locality Director South *	10 - 15	0	0 - 0	0 - 0	2.5 - 5	15 - 20
Mark Seaton - Locality Director North *	10 - 15	0	0 - 0	0 - 0	5 - 7.5	15 - 20
Nicola Harkness - Locality Director East *	10 - 15	800	0 - 0	0 - 0	0 - 2.5	10 - 15
Gary Free - Clinical Chair **	50 - 55	0	0 - 0	0 - 0	0 - 0	50 - 55
Anna Onabolu - Clinical Leader **	25 - 30	0	0 - 0	0 - 0	0 - 0	25 - 30
Mukesh Singh - Clinical Leader **	25 - 30	0	0 - 0	0 - 0	5 - 7.5	30 - 35
Paul Gallagher - Lay Member for PPI ****	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5
Neil Chambers - Lay Member for Governance ****	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5
Janet Toplis - Lay Member **	20 - 25	0	0 - 0	0 - 0	0 - 0	20 - 25
Douglas Robertson - Secondary Care Specialist *	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5

Hirendra Choudhary - Clinical Lead **	10 - 15	0	0 - 0	0 - 0	42.5 - 45	55 - 60
John Howard - Lay Member for Governance *	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5
Murray Campbell - Clinical Lead **	20 - 25	0	0 - 0	0 - 0	0 - 0	20 - 25

Note: Taxable expenses are expressed to the nearest £100

Neil Chambers Lay Member for Governance left the organisation on 30/09/21 and was replaced on 01/10/21 by John Howard.

All other post holders were employed for the full duration of the financial year (01/04/21 – 31/03/22).

Murray Campbell had an additional clinical role in 2020/21 which was not continued this year therefore not included above.

The three locality directors have been included within the tables above as they have significant influence over the decisions of the entity, however they are not governing body members.

All expense payments in the tables above and below relate to benefits in kind in relation to lease cars.

NHS Cannock Chase CCG shares a single leadership team with five other Staffordshire and Stoke-on-Trent CCGs. The remuneration of those senior officers is apportioned on a capitated basis unless stated otherwise.

The table above shows the costs apportioned to NHS Cannock Chase CCG associated with the remuneration of the senior management team.

*Note: NHS Cannock Chase CCG pays 11.80% capitated basis of the highlighted individuals' costs.

**Note: NHS Cannock Chase CCG pays 100% capitated basis of the highlighted individuals' costs.

***Note: NHS Cannock Chase CCG pays 50% capitated basis of the highlighted individuals' costs.

****Note: NHS Cannock Chase CCG pays 26.60% capitated basis of the highlighted individuals' costs.

The table below shows the costs of the individuals 100% attributable to the six Staffordshire and Stoke-on-Trent Clinical Commissioning Groups.

Name and title	a) Salary (bands of £5,000) £000	b) Expense payments (taxable to nearest £100) £	c) Performance pay and bonuses (bands of £5,000) £000	d) Long-term performance pay and bonuses (bands of £5,000) £000	e) All pension-related benefits (bands of £2,500) £000	f) Total a-e (bands of £5,000) £000
Marcus Warnes - Accountable Officer	145 - 150	6900	0 - 0	0 - 0	40 - 42.5	195 - 200
Paul Brown - Chief Finance Officer	135 - 140	3400	0 - 0	0 - 0	30 - 32.5	170 - 175
Jane Moore - Director of Strategy, Planning and Performance	115 - 120	0	0 - 0	0 - 0	35 - 37.5	150 - 155
Heather Johnstone - Director of Nursing and Quality	115 - 120	0	0 - 0	0 - 0	32.5 - 35	150 - 155
Lynn Millar - Director of Primary Care	110 - 115	4300	0 - 0	0 - 0	25 - 27.5	145 - 150
Sally Young - Director of Corporate Services, Governance and Communications	120 - 125	0	0 - 0	0 - 0	30 - 32.5	150 - 155
Cheryl Hardisty - Director of Strategic Commissioning and Operations	115 - 120	0	0 - 0	0 - 0	0 - 0	115 - 120
Craig Porter - Locality Director South	105 - 110	0	0 - 0	0 - 0	27.5 - 30	135 - 140
Mark Seaton - Locality Director North	105 - 110	0	0 - 0	0 - 0	45 - 47.5	150 - 155
Nicola Harkness - Locality Director East	100 - 105	6500	0 - 0	0 - 0	7.5 - 10	115 - 120
Gary Free - Clinical Chair	50 - 55	0	0 - 0	0 - 0	0 - 0	50 - 55
Anna Onabolu - Clinical Leader	25 - 30	0	0 - 0	0 - 0	0 - 0	25 - 30
Mukesh Singh - Clinical Leader	25 - 30	0	0 - 0	0 - 0	5 - 7.5	30 - 35
Paul Gallagher - Lay Member for PPI	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Neil Chambers - Lay Member for Governance	5 - 10	0	0 - 0	0 - 0	0 - 0	5 - 10
Janet Toplis - Lay Member	20 - 25	0	0 - 0	0 - 0	0 - 0	20 - 25
Douglas Robertson - Secondary Care Specialist	5 - 10	0	0 - 0	0 - 0	0 - 0	5 - 10

Hirendra Choudhary - Clinical Lead	10 - 15	0	0 - 0	0 - 0	42.5 - 45	55 - 60
John Howard - Lay Member for Governance	20 - 25	0	0 - 0	0 - 0	0 - 0	20 - 25
Murray Campbell - Clinical Lead	20 - 25	0	0 - 0	0 - 0	0 - 0	20 - 25

Note: Taxable expenses are expressed to the nearest £100.

Neil Chambers Lay Member for Governance left the organisation on 30/09/21 and was replaced on 01/10/21 by John Howard.

All other post holders were employed for the full duration of the financial year (01/04/21 – 31/03/22).

Murray Campbell had an additional clinical role last year which was not continued this year therefore not included above.

The three locality directors have been included within the tables above as they have significant influence over the decisions of the entity, however they are not governing body members.

All expense payments in the tables above and below relate to benefits in kind in relation to lease cars.

Senior manager remuneration 2020/21 (including salary and pension entitlements)

The 2020/21 values in the table below have been represented to ensure consistency with the 2021/22 format.

The prior year tables below have been re-stated following review. Sandeep Geeranavaar has been removed from these tables as he is not a Governing Body member, nor is he deemed to have a role of senior authority in the CCG.

Name and title	a) Salary (bands of £5,000) £000	b) Expense payments (taxable to nearest £100)** £	c) Performance pay and bonuses (bands of £5,000) £000	d) Long-term performance pay and bonuses (bands of £5,000) £000	e) All pension-related benefits (bands of £2,500) £000	f) Total a-e (bands of £5,000) £000
Marcus Warnes - Accountable Officer *	15 - 20	800	0 - 0	0 - 0	22.5 - 25	40 - 45
Paul Brown - Chief Finance Officer *	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15
Neil Cook - Interim Chief Finance Officer *	5 - 10	0	0 - 0	0 - 0	2.5 - 5	5 - 10
Jane Moore - Director of Strategy, Planning and Performance *	10 - 15	0	0 - 0	0 - 0	17.5 - 20	30 - 35
Heather Johnstone - Director of Nursing and Quality *	10 - 15	0	0 - 0	0 - 0	0 - 2.5	15 - 20
Lynn Millar - Director of Primary Care *	10 - 15	400	0 - 0	0 - 0	0 - 2.5	10 - 15
Sally Young - Director of Corporate Services, Governance and Communications *	10 - 15	0	0 - 0	0 - 0	0 - 2.5	10 - 15
Cheryl Hardisty - Director of Strategic Commissioning and Operations *	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15

Craig Porter - Locality Director South *	10 - 15	0	0 - 0	0 - 0	2.5 - 5	15 - 20
Mark Seaton - Locality Director North *	10 - 15	0	0 - 0	0 - 0	0 - 2.5	10 - 15
Nicola Harkness - Locality Director East *	10 - 15	300	0 - 0	0 - 0	0 - 2.5	10 - 15
Gary Free - Clinical Leader **	50 - 55	0	0 - 0	0 - 0	0 - 0	50 - 55
Anna Onabolu - Clinical Leader **	25 - 30	0	0 - 0	0 - 0	0 - 0	25 - 30
Mukesh Singh - Clinical Leader **	25 - 30	0	0 - 0	0 - 0	0 - 2.5	25 - 30
Paul Gallagher - Lay Member for PPI ***	5 - 10	0	0 - 0	0 - 0	0 - 0	5 - 10
Neil Chambers - Lay Member for Governance ****	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5
Janet Toplis - Lay Member **	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15
Douglas Robertson - Secondary Care Specialist *	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5
Hirendra Choudhary - Clinical Lead **	10 - 15	0	0 - 0	0 - 0	172.5 - 175	185 - 190
Murray Campbell - Clinical Lead	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Murray Campbell - Clinical Director	20 - 25	0	0 - 0	0 - 0	0 - 0	20 - 25

The table above shows the costs apportioned to NHS Cannock Chase CCG associated with the remuneration of the senior management team.

The table below shows the costs of the individuals 100% attributable to the six Staffordshire and Stoke-on-Trent Clinical Commissioning Groups.

Name and title	a) Salary (bands of £5,000) £000	b) Expense payments (taxable to nearest £100) £	c) Performance pay and bonuses (bands of £5,000) £000	d) Long-term performance pay and bonuses (bands of £5,000) £000	e) All pension-related benefits (bands of £2,500) £000	f) Total a-e (bands of £5,000) £000
Marcus Warnes - Accountable Officer	140 - 145	6400	0 - 0	0 - 0	202.5 - 205	350 - 355
Paul Brown - Chief Finance Officer	105 - 110	0	0 - 0	0 - 0	0 - 0	105 - 110
Neil Cook - Interim Chief Finance Officer	50 - 55	0	0 - 0	0 - 0	30 - 32.5	80 - 85
Jane Moore - Director of Strategy, Planning and Performance	115 - 120	0	0 - 0	0 - 0	147.5 - 150	260 - 265
Heather Johnstone - Director of Nursing and Quality	115 - 120	0	0 - 0	0 - 0	10 - 12.5	125 - 130
Lynn Millar - Director of Primary Care	110 - 115	3200	0 - 0	0 - 0	2.5 - 5	115 - 120
Sally Young - Director of Corporate Services, Governance and Communications	110 - 115	0	0 - 0	0 - 0	2.5 - 5	115 - 120
Cheryl Hardisty - Director of Strategic Commissioning and Operations	115 - 120	0	0 - 0	0 - 0	0 - 0	115 - 120
Craig Porter - Locality Director South	105 - 110	0	0 - 0	0 - 0	25 - 27.5	130 - 135
Mark Seaton - Locality Director North	105 - 110	0	0 - 0	0 - 0	5 - 7.5	110 - 115

Nicola Harkness - Locality Director East	100 - 105	2700	0 - 0	0 - 0	5 - 7.5	110 - 115
Gary Free - Clinical Leader	50 - 55	0	0 - 0	0 - 0	0 - 0	50 - 55
Anna Onabolu - Clinical Leader	25 - 30	0	0 - 0	0 - 0	0 - 0	25 - 30
Mukesh Singh - Clinical Leader	25 - 30	0	0 - 0	0 - 0	0 - 2.5	25 - 30
Paul Gallagher - Lay Member for PPI	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Neil Chambers - Lay Member for Governance	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Janet Toplis - Lay Member	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15
Douglas Robertson - Secondary Care Specialist	5 - 10	0	0 - 0	0 - 0	0 - 0	5 - 10
Hirendra Choudhary - Clinical Lead	10 - 15	0	0 - 0	0 - 0	172.5 - 175	185 - 190
Murray Campbell - Clinical Lead	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15
Murray Campbell - Clinical Director	20 - 25	0	0 - 0	0 - 0	0 - 0	20 - 25

Pension benefits as at 31 March 2022 (subject to audit)

The Cash Equivalent Transfer Values contained in the table below relate to the total value accrued by the individual across all six Staffordshire and Stoke-on-Trent CCGs. The total amount is shown due to not being able to reliably estimate the split of the CETVs by individual CCG.

Name and title	a) Real increase in pension at pension age (bands of £2,500) £'000	b) Real increase in pension lump sum at pension age (bands of £2,500) £'000	c) Total accrued pension at pension age at 31.03.22 (bands of £5,000) £'000	d) Lump sum at pension age related to accrued pension at 31.03.22 (bands of £5,000) £'000	e) Cash Equivalent Transfer Value at 31.03.21 £'000	f) Real increase in Cash Equivalent Transfer Value £'000	g) Cash Equivalent Transfer Value at 31.03.22 £'000	h) Employer's contribution to stakeholder pension £'000
Marcus Warnes - Accountable Officer	2.5 - 5	0 - 2.5	55 - 60	110 - 115	1046.41	48.55	1121.39	0
Paul Brown - Chief Financial Officer	2.5 - 5	0 - 2.5	35 - 40	80 - 85	733.01	39.05	795.48	0
Jane Moore - Director of Strategy, Planning and Performance	2.5 - 5	0 - 0	65 - 70	0 - 0	1046.61	45.88	1114.91	0
Heather Johnstone - Director of Nursing and Quality	2.5 - 5	0 - 2.5	40 - 45	75 - 80	714.37	33.73	768.86	0
Lynn Millar - Director of Primary Care	0 - 2.5	0 - 0	30 - 35	60 - 65	478.88	18.87	516.72	0
Sally Young - Director of Corporate Services, Governance and Communications	0 - 2.5	2.5 - 5	35 - 40	105 - 110	835.09	49.81	906.97	0

Craig Porter - Locality Director South	0 - 2.5	0 - 0	10 - 15	0 - 0	114.82	14.39	144.53	0
Mark Seaton - Locality Director North	2.5 - 5	2.5 - 5	25 - 30	75 - 80	597.39	51.53	666.66	0
Nicola Harkness - Locality Director East	0 - 2.5	0 - 0	35 - 40	70 - 75	637.40	10.26	664.72	0
Hirendra Choudhary - Clinical Lead	0 - 2.5	0 - 0	10 - 15	20 - 25	169.38	34.72	206.75	0
Mukesh Singh - Clinical Leader	0 - 2.5	0 - 0	10 - 15	30 - 35	284.06	9.51	298.61	0

**Column E disclosed the growth of all pension-related benefits during the year. It reflects pension-related benefits and is sourced from the Greenbury information.

Paul Gallagher, Neil Chambers, Janet Toplis, John Howard and Murray Campbell are all lay members who are not eligible to opt into the pension scheme.

Cheryl Hardisty, Gary Free, Anna Onabolu, and Douglas Robertson chose not to be covered by the pension arrangements during the reporting year.

NHS Pensions are using pension data from their systems without adjustment for potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design.)

Given the considerable uncertainty, this means that the benefits and related CETVs presented do not allow for a potential future adjustment arising from the McCloud judgement.

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement of for loss of office

No payments have been made in respect of compensation on early retirement. Payments paid or payable in respect of loss of office are summarised within the notes relating to Exit Packages.

Payments to past members

No payments have been made in relation to Exit Packages.

Pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

For the majority of staff, costs are shared across the six Staffordshire and Stoke-on-Trent CCGs in proportion to their Running Cost Allocation. To report the salary band of the highest paid director/member for each individual entity based upon the share of basic salary costs paid by each CCG would result in an abnormally low figure. Therefore, to maximise transparency and to show a true and fair view of the pay multiple across the six Staffordshire and Stoke-on-Trent CCGs, the banded

remuneration of the aggregate total salary cost of the highest paid director/member for the six Staffordshire and Stoke-on-Trent CCGs is shown and used as the basis for the pay multiple calculation.

The banded remuneration of the highest paid director / member in the organisation in the financial year 2021/22 was £150,000 - £155,000 (2020/21, £145,000 - £150,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2021/22	25th Percentile	Median Salary Ratio	75th Percentile
Total remuneration (£)	32,306.00	47,126.00	65,664.00
Salary component of total remuneration (£)	32,306.00	47,126.00	65,664.00
Pay ratio information	4.72	3.24	2.32

2020/21	25th Percentile	Median Salary Ratio	75th Percentile
Total remuneration (£)	33,326.75	45,753.00	63,751.00
Salary component of total remuneration (£)	33,326.75	45,753.00	63,751.00
Pay ratio information	4.43	3.22	2.31

Note: Salary movement for all pay scales reflects annual pay award and incremental movement only.

There has been a 1% increase in the salary of the highest paid director and a 3% increase to average the employee's salary when compared to 2020-21. Salary movement for all pay scales reflects annual pay award and incremental movement only.

In 2021/22, 0 (2020/21, 0) employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £3,707 to £136,391

(Restated 2020/21 £3,574 - £135,000. This restatement now excludes the highest-paid director in line with the requirements of the 2021/22 Group Accounting Manual).

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

Staff Report

The six CCGs in Staffordshire and Stoke-on-Trent agreed to transfer their staff onto a single payroll administered through Stafford and Surrounds CCG in 2019. This was to ensure that efficiencies were achieved by going from six separate payrolls to one. This section reflects staffing information pertaining to all six organisations, unless otherwise stated.

Number of senior managers

A senior manager is defined by NHS Business Services Authority as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS organisation.

For the purposes of this report, we believe those persons in Band 8a and above are senior managers.

Senior Staff Analysis by Band (based on staffing at 31.03.2022 – Extracted from ESR 19.04.2022)

Pay band	Headcount
Apprentice	1
Band 1	0
Band 2	4
Band 3	2
Band 4	28
Band 5	24
Band 6	35
Band 7	35
Band 8 - Range A	59
Band 8 - Range B	32
Band 8 - Range C	20
Band 8 - Range D	9
Band 9	7
Medical	23
Very Senior Managers	31
Governing Body (off payroll)	0
TOTAL	**310**

Staff numbers and costs (subject to audit)

The table below shows average number of people employed in 2021/22 for NHS Cannock Chase CCG:

Average number of people Cannock Chase CCG employed in 2021/22

	Permanently employed	Other	TOTAL
Administration and estates	22.54	0.71	**23.25**
Medical and dental	1.09	0	**1.09**
Nursing, midwifery and health visiting staff	2.24	0	**2.24**
Other	0.36	0	**0.36**
Scientific, therapeutic and technical staff	2.42	0	**2.42**
TOTAL	**28.65**	**0.71**	**29.36**

The table below shows the associated staff costs for NHS Cannock Chase CCG:

Associated staff costs for Cannock Chase CCG for 2021/22

	Permanently employed (£000)	Other (£000)	Total (£000)
Salaries and wages	£1,402	£64	**£1,466**
Social security costs	£150	£0	**£150**
Employer contributions to NHS Pension Scheme	£267	£0	**£267**
Apprenticeship levy	£6	£0	**£6**
Total	**£1,825**	**£64**	**£1,889**

Staff composition

Staff Analysis by Gender (based on staffing at 31.03.2022 – Extracted from ESR 19.04.2022)

Staff grouping	Female	Male	Totals
Governing Body	6 (42.9%)	8 (57.1%)	**14**
Other senior management (Band 8C+)	45 (59.2%)	31 (40.8%)	**76**
All other employees	182 (82.7%)	38 (17.3%)	**220**
TOTAL	**233 (75.16%)**	**77 (24.84%)**	**310**

Sickness absence data

The sickness absence data for the six Staffordshire and Stoke-on-Trent CCGs in 2021/22 was whole time equivalent (WTE) days available of 56,999.53 and WTE days lost to sickness absence of 1,429.8 and average working days lost per employee was 5.64 which was managed through the absence management policy.

Staff sickness absence across the six Staffordshire and Stoke-on-Trent CCGs

	2021 number
Total days lost	1,429.80
Total staff years	253.33
Average working days lost	5.64

Staff turnover data

The Staff Turnover Rate for the six Staffordshire and Stoke-on-Trent CCGs in 2021/22 has been calculated by dividing the total full-time equivalent (FTE) leavers in-year by the average FTE staff in post during the year. The total FTE leavers in-year was 39.94. The average FTE staff in post during the year was 254.08. The staff turnover rate for the year was 15.72%.

Staff turnover rate across the six Staffordshire and Stoke-on-Trent CCGs

	2021/22 number
Average FTE employed 2021/22	254.08
Total FTE leavers 2021/22	39.94
Turnover rate	15.72%

Staff policies

The CCG has continued to work with the Staff Engagement Group (SEG), Staff Network/support Groups, Staff Side Representatives and the Communications, Engagement, Equalities and Employment (CEEE) committee to align all HR policies across the six CCGs in Staffordshire and Stoke-on-Trent. As part of the due diligence process for the transition of staff to the ICB on 01 July 2022, a review of all policies is ongoing to ensure they are fully aligned at the point of TUPE transfer (Transfer of Undertakings – Protection of Employment). However, the policies in common across all six CCGs are used by managers and staff for consistency. All reviewed policies have an accompanying Equality Impact Assessment (EIA).

Our rolling programme of training for current staff and new starters on mandatory equality and diversity includes awareness of a range of issues impacting on people with disabilities. The CCGs introduced independent mandatory training for all staff on invisible disabilities and unconscious bias. We also ensure that any employee who needs training (either because they work with people with disabilities, or because they have acquired an impairment or medical condition) receives the necessary support through workplace risk assessments and health and wellbeing conversations.

Through unconscious bias training, all interview panel members must have attended the training, and each panel has a band-related equality question to ask all candidates.

Staff can easily access HR policies and documents by using the staff intranet, ‘Information and News’, known by staff as IAN.

Trade union facility time reporting requirements

We have one local representative across the six CCGs in Staffordshire and Stoke-on-Trent. However, as we continue to work across the Staffordshire and Stoke-on-Trent system, we have utilised a system of local representative as well as continuing to engage and consult with regional representatives from various trade unions. The percentage of facility time internally is not monitored.

Health and safety

Midlands and Lancashire Commissioning Support Unit (MLCSU) provides advice and support on all health and safety-related matters. However, from October 2021, the majority of CCG staff had a change of base to home and relevant display screen equipment (DSE) assessments are reviewed annually. Those staff who are still office-based continue to be supported by the Buildings Management team, where they are based. The staff that continued to work in the office had additional safety precautions in place along with the appropriate personal protective equipment (PPE) and distancing guidance.

All staff are asked annually to undertake a DSE assessment for their home office set up, and this was sent to the HR team for inclusion in their personnel records. Staff were required to complete a risk assessment prior to visiting any of the offices for particular reasons, and for this to be signed off by their line manager within the national or local COVID-19 restrictions at the time.

MLCSU's Health and Safety team have also kept the CCGs updated on any changes in government guidance and health and safety legislation during this time – and continue to do so.

There were no health and safety-related incidents reported to the MLCSU Health and Safety Officer and no RIDDOR incidents.

Other employee matters

Shift to remote working during COVID-19

In line with national government guidance in March 2020, the majority of the CCGs' workforce have been working from home and agilely since March 2020.

This has resulted in continuing ways of working, embracing IT and other technology to continue to provide services without impact to patients and citizens. All meetings continue to be held virtually, and all staff have been trained to use Microsoft Teams. Technology has supported almost all staff to be able to work from home successfully and further planned digital transformation continues to be reviewed into future models of working.

In October 2021, following a staff consultation, the majority of staff had a formal change of base to home. The benefits have been tangible from both an organisational and staff wellbeing perspective:

- Virtual meetings have proven more productive and seen higher attendance rates
- Staff sickness has been reduced since people have begun working from home

- Some directorates were previously spread across the three offices, but have found it easier to bring people together virtually in order to collaborate on larger strategic projects
- Internal 'workforce' communications improved, with a single team brief being held digitally and recorded for those members of staff who were unable to attend and many other initiatives
- Clinical engagement increased as the barrier of travel was removed, and clinicians could more easily attend meetings and workshops from their consulting rooms
- A large majority of staff reported their work-life balance had improved
- People have reported that they are more productive when working from home
- The CCGs' carbon footprint has reduced, along with a significant fall in travel expenses.

The health and wellbeing of the workforce has been a key concern as staff have been working from home. Throughout the year, monthly virtual development sessions have been held to continue with open engagement on health and wellbeing. In November 2021, the CCGs took part in the national NHS Staff Survey for the first time for a number of years, resulting in 85% response rate and with a resulting action plan to be published and engagement with the Staff Engagement Group (SEG)

The CCGs' HR lead has continued to ensure health and wellbeing is a priority for the culture of our workforce, ensuring that all staff are signposted to services, apps and the system Psychological and Wellbeing Hub.

Agile working

Agile working is about what you do, and not where you do it. We have developed our agile working principles and framework to provide an opportunity to modernise our working practices – moving away from assumptions of traditional office working about where, when and how work should be done, to a culture of working wherever, whenever and however is most appropriate to get the work done.

It is not just about working hours, locations and workstyles – it is about being responsive and adaptive to service needs and advancements in technology. Agile working aims to provide greater flexibility, particularly in relation to the time and location our staff can work, subject to the requirements of the service and individual job.

The 'Back to the Future Programme' brought together and co-ordinated the broad range of changes around digital transformation, estates, corporate governance, human resources, wellbeing and organisational development we require to implement the new Agile Framework from April 2021 which has been introduced successfully as part of the change of base consultation.

The Agile Framework provides the CCGs with information of how agile working will commence from April 2022, utilising two existing office hubs and a new hub in Stafford. It will help the CCGs to develop a new work culture and create new approaches to future agile and hybrid working.

Temporary redeployments

As part of a Memorandum of Understanding (MOU), a number of CCG staff were temporarily deployed across the system into frontline and back-office posts external to the CCGs in January 2022. This was as a result of a critical incident response to the number of workforce absences due to COVID-19 and self-isolation as part of the system requirement to support the pandemic mutual aid workforce response. The MOU was signed by all system partners, and ensured a quick mechanism to deploy staff, without any financial impact of recharging, and was reviewed again in 2021.

Staff development days

Development days have occurred virtually throughout the year, embracing new technology and new ways of getting staff together to hear key messages and provide feedback from previous events. Some of the events were recorded through Microsoft Teams, so staff who may have missed the event could watch back. Several equality, diversity and inclusion related topics and themes have been presented and discussed during these sessions – some of which have influenced the wider equality agenda across the six CCGs.

- 27 April 2021
- 26 May 2021
- 29 June 2021
- 10 August 2021
- 23 September 2021
- 17 November 2021
- 15 December 2021
- Due to the critical incident, the session for January 2022 was stood down
- 15 February 2022
- 15 March 2022.

Staff training

The commitment to organisational development by the Governing Bodies remains strong and work will progress for 2021/22, with the release of the Training and Development catalogue. Over 218 courses have been approved during 2021/22, with 152 members of staff taking up the opportunity to develop their skills and knowledge. A broad range of training has been delivered, from nationally-recognised accreditation such as Prince 2 and Managing Successful Programmes, to ILM5 coaching and mentoring.

Health and wellbeing support to staff

The CCGs took part in the national NHS Staff Survey in 2021 with a response rate of 85% resulting in feedback via free text which will form the Action Plan working group with staff members, to transfer to the ICB.

The CCGs' HR lead has continued to ensure health and wellbeing is a priority for the culture of our workforce, ensuring that all staff are signposted to local and national services and support, apps and the system Psychological and Wellbeing Hub. The introduction of the Coaching Culture app with various support modules has also been launched.

Our job adverts state that all staff will receive a health and wellbeing conversation with their line manager, and staff are signposted to support via two Wellbeing Guardians.

A significant number of staff are also trained Mental Health First Aiders, and we have recently appointed volunteer staff, Change Ambassadors, Menopause Ambassadors and Domestic Abuse Ambassadors.

Whistleblowing

For our corporate whistleblowing obligations, we have a dedicated policy in place. We have appointed Freedom to Speak Up Guardians, and all our staff are assured that they can speak up freely to raise any concerns they may have.

Governing Body Organisational Development session

Governing Body meetings are held in common for all six CCGs, with six Governing Body meetings in common held in public and a confidential meeting. These alternate with an OD session for six Governing Bodies and a confidential Governing Body meeting in common. A longer confidential meeting was held in February rather than the final OD session of 2021/22.

The OD sessions focus on planned development sessions aligned to the OD work and statutory training, to support the implementation of new ways of working. The following sessions were held during 2021/22:

- 29 April 2021 – Board Assurance Framework and key elements captured against risks within a Board Assurance
- 24 June 2021 – invisible disabilities training
- 28 August 2021 – ICS development update
- 28 October 2021 – information governance training and ICS development update.

Staff Engagement Group

The six CCGs have successfully maintained a formal Staff Engagement Group (SEG) while working virtually, which includes core members and various volunteers from all directorates and reports directly to the Communications, Engagement, Equality and Employment Committees in Common (CEEE). During 2021/22, the group have continued to support staff events, supported charity and health awareness days, initiated investment in Mental Health First Aiders refresher training and provide monthly feedback on key issues.

The group have supported the business cycle review of a significant number of aligned HR Policies and a Standing Items have been introduced on the Equality, Diversity and Inclusion (EDI) and People Plan.

Staff Survey

The Staff Survey ran between October and November 2021. Overall there was a response rate of 85%. The average response rate for similar organisations is 79%.

A Staff Survey Task and Finish Group has been established to review the feedback from the NHS Staff Survey to form an action plan to recognise the achievements, investigate areas of concern and seek new opportunities of support for staff.

We will ensure that the action plan tracks progress towards the seven elements of the People Promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team.

All members will be sent a copy of the free text submitted anonymously, which will be aligned to the People Promise, Bench Mark report of the CCGs to comparable organisations and responses broken down by directorates where the numbers in the teams are greater than 11.

The action plan will be shared with the ICB Chief People Officer to deliver during 2022/23 from 01 July 2022.

Staff diversity and inclusion (best practice disclosures)

These best practice disclosures are as follows.

Changes to staff composition of under-represented groups at the entity over time, both for the workforce as a whole and for management and/or senior management positions, are provided in separate, nationally-published 2021 Workforce Race Equality Standard (WRES) reports and Combined CCG Staff Workforce Diversity Profile Review. In July 2021, the CCGs published a Gender Pay Gap Report.

The Equality and Inclusion Action Plan features a comparison of staff composition of under-represented groups against any diversity and inclusion targets that the CCG has. Alongside this are explanations of what the CCG has done to meet those to improve the diversity and inclusiveness of its workforce, including outputs and publications in respect of responsibilities under other legislation to report on the diversity and inclusiveness of the workforce and to promote equality of opportunity.

Further data is published in our WRES reports, Combined CCG Staff Workforce Diversity Profile Review 2021 and 2021 Public Sector Equality Duty (PSED) Annual Report (available on the CCG website). The CCGs' 2021/22 PSED Annual Report will be published in June 2022.

The CCGs are working with NHS provider partners around a system-wide staff ethnic minority, disability and neurodiversity, and LGBTQ+ groups; and in developing the Midlands EDI Strategy and Six High Impact Actions on race inclusion.

The six CCGs have mandated unconscious bias and invisible disability training for all its staff and an 'Introduction to EDI' session is incorporated within the new staff induction programme.

Expenditure on consultancy

The table below details expenditure on consultancy for the financial year 2021/22.

Consultancy Expenditure 2021/22

Consultancy provision	£000
Deloitte LLP	17
G Smith	1
Hill Dickinson LLP	1
HMFA	4
Liaison VAT Consultancy Ltd	1
PJB Associate (UK) Ltd	9
Skills for Health	10
Stand Transformation	1
The Knowledge Academy	5
Thinknow Consultancy Ltd	1
West Midlands Employers	8
TOTAL	**58**

Off-payroll engagements

The six Staffordshire and Stoke-on-Trent CCGs operate under a single management structure, meaning that most employees are contracted to work across more than one CCG and their costs have been attributed accordingly.

In relation to the off-payroll workers, the figures represent the number of engagements rather than the Full-Time Equivalent (FTE) of each contractor. For example, if an individual is contracted by all six CCGs irrespective of the hours worked, they will be represented within each CCG's Tables as a whole single engagement.

A £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2022, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2022	4
Of which, the number that have existed:	
for less than one year at the time of reporting	1

for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	2
for 4 or more years at the time of reporting	0

The CCG can confirm that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	2
Of which:	
Number not subject to off-payroll legislation	2
Number subject to off-payroll legislation and determined as in-scope of IR35	0
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll board members/senior official engagements

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number 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 includes both on payroll and off-payroll engagements	20

Exit packages, including special (non-contractual) payments

Exit package cost band (Inc. any special payment element	Number of compulsory redundancies (whole numbers only)	Cost of compulsory redundancies (£s)	Total number of exit packages (whole numbers only)	Total cost of exit packages (£s)
Less than £10,000	0	0	0	0
£10,000 - £25,000	0	0	0	0
£25,001 - £50,000	0	0	0	0
£50,001 - £100,000	0	0	0	0
£100,001 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,000	0	0	0	0
Totals	**0**	**0**	**0**	**0**

HM Treasury requires the disclosure of exit package information in the Annual Report and Accounts. In 2021/22, the CCG did not incur any expenditure arising from exit packages (compulsory or voluntary redundancies or other agreed staff departures).

When incurred, redundancy and other departure costs are paid in accordance with the provisions of the NHS Agenda for Change agreement. Where the CCG agrees early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme. When incurred, ill-health retirement costs are met by the NHS Pension Scheme.

Analysis of other departures

	Agreements (number)	Total value of agreements (£000s)
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0

Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	**0**	**0**

As a single exit package can be made up of several components each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in Table 1 which will be the number of individuals.

**any non-contractual payments in lieu of notice are disclosed under 'non-contracted payments requiring HMT approval' below.*

***includes any non-contractual severance payment made following judicial mediation, and nil relating to non-contractual payments in lieu of notice.*

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that report.

Parliamentary Accountability and Audit Report

Cannock Chase 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 report at pages 5 to 24 of the annual accounts. An audit certificate and report is also included in this Annual Report at page 154.

Marcus Warnes

Accountable Officer

NHS Cannock Chase CCG

22 June 2022

List of Acronyms

Acronym	Definition
A&E	Accident and Emergency
BAF	Board Assurance Framework
BSL	British Sign Language
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CEEE	Communication, Engagement, Equality and Employment Committee
CETV	Cash equivalent transfer value
CFFSR	Counter Fraud Functional Standard Return
CHADS	Children's Advice and Duty Service
CHC	Continuing healthcare
CQC	Care Quality Commission
CQRM	Clinical Quality Review Meetings
CRIS	Community Rapid Intervention Service
CSU	Commissioning Support Unit
CYP	Children and young people
D2A	Discharge to Assess
DGFT	Dudley Group NHS Foundation Trust
DHRs	Domestic Homicide Reviews
DOS	Directory of Services
DSE	Display Screen Equipment
DSPT	Data Security and Protection Toolkit
EBP	Evidence-Based Practice Group
ED	Emergency department
EHCP	Education, Health and Care Plan
EIA	Equality Impact Assessment
EOL	End of life
FOI	Freedom of Information
GB	Governing Body
GDPR	General Data Protection Regulation
GMS	General Medical Services contract
GP	General Practitioner
GPC2	Graded Care Profile 2
GPN	General Practice Nurse
HCAI	Healthcare Associated Infections
HPMA	Healthcare People Management Association
HR	Human Resources

HSJ	Health Service Journal
IAPT	Increased Access to Psychological Therapies
ICB	Integrated Care Board
ICC	Incident Co-ordination Centre
ICP	Integrated Care Partnership
ICS	Integrated Care System
IEA	Immediate and essential action
IG	Information Governance
IPA Board	Individual Patient Activity Board
IPC	Infection prevention and control
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LD	Learning disability
LEAF	Local Equality Advisory Forum
LeDeR	Learning Disabilities Mortality Review
LGBTQ+	Lesbian, gay, bisexual, transgender, queer and others
LMNS	Local Maternity and Neonatal System
MCA	Mental Capacity Act
MHST	Mental health support team
MLCSU	Midlands and Lancashire Commissioning Support Unit
MOU	Memorandum of Understanding
MPFT	Midlands Partnership NHS Foundation Trust
MTP	Maternity Transformation Programme
MVP	Maternity Voices Partnership
NHQAIG	Nursing Home Quality Assurance and Improvement Group
NHSCFA	NHS Counter-Fraud Authority
NHSE	NHS England
NHSE/I	NHS England and Improvement
NHS OF	NHS Oversight Framework
NSCHT	North Staffordshire Combined Healthcare NHS Trust
OD	Organisational Development
PALS	Patient Advice and Liaison Service
PBP	Place-Based Partnership
PCC	Palliative care centre
PCCC	Primary Care Commissioning Committee
PCN	Primary Care Network
PEOLC	Palliative and end of life cell
PHB	Personal Health Budget
PHM	Population health management

PHSO	Parliamentary and Health Service Ombudsman
PIRT	Provider Improvement Response Team
PLACE	Patient-Led Assessments of Care Environment
PLT	Protected learning time
PMS	Personal Medical Services contract
PPC	Pay-per-click
PPE	Personal protective equipment
PPGs	Patient Participation Groups
PPI	Patient and Public Involvement
PSED	Public Sector Equality Duty
QIA	Quality Impact Assessment
QIPP	Quality Innovation Productivity and Prevention
QR code	Quick Response code
QSAV	Quality Standards Assurance visit
QSCC	Quality and Safety Committees in Common
QSISM	Quality and Safeguarding Information Sharing Meeting
RTT	Referral to Treatment
RWT	The Royal Wolverhampton NHS Trust
SARs	Safeguarding Adult Reviews
SBLCB	Saving Babies Lives Care Bundle
SEG	Staff Engagement Group
SEND	Special Educational Needs and Disabilities
SES&SP	South East Staffordshire and Seisdon Peninsula
SI	Serious Incident
SMI	Severe mental illness
SOBS	Survivors of Bereavement by Suicide
SOP	Standard Operating Procedure
SQSC	System Quality and Safety Committee
SSASPB	Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board
SVOC	System Vaccination Operation Centre
TCP	Transforming Care Partnership
TUPE	Transfer of Undertakings – Protection of Employment
UCC	Urgent care centre
UHB	University Hospitals of Birmingham NHS Foundation Trust
UHDB	University Hospitals of Derby and Burton NHS Foundation Trust
UHNM	University Hospitals of North Midlands NHS Trust
VCSE	Voluntary, community and social enterprise
WHT	Walsall Healthcare NHS Trust
WMAS	West Midlands Ambulance Service University NHS Foundation Trust

WTE	Whole Time Equivalent

Independent auditor's report to the members of the Governing Body of NHS Cannock Chase CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Cannock Chase CCG (the 'CCG') for the year ended 31 March 2022, 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 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 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 2021 to 2022; 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 16 to the financial statements, which indicates that, under the Health and Care Act 2022 the commissioning functions, assets and liabilities of NHS Cannock Chase CCG are due to transfer to NHS Stafordshire and Stoke on Trent Integrated Care Board on 1 July 2022.

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. However, future events or conditions may cause the CCG to cease to continue as a going concern.

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 2021 to 2022 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 this other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office 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 2021 to 2022; 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.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, 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.

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.

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 95 to 96, 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 2021 to 2022).
- 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, internal audit 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, 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:
  - Material manual year end journals and unusual manual journals
  - Reasonableness of year end accruals
- 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 material year end journals andunusual manual journals
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of year end 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. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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, and the significant accounting estimates related to year end accruals
- Our 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 2022.

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 significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. 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 2022.

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 December 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 Cannock Chase CCG for the year ended 31 March 2022 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 the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Avtar Sohal

Avtar Sohal, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

Date: 22 June 2022

NHS Cannock Chase Clinical Commissioning Group - Annual Accounts 2021-22

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(499)	(355)
Total operating income		**(499)**	**(355)**
Staff costs	4	1,889	1,799
Purchase of goods and services	5	232,018	219,502
Provision expense	5	291	(20)
Other Operating Expenditure	5	92	94
Total operating expenditure		**234,289**	**221,376**
Net Operating Expenditure		**233,790**	**221,021**
Total Net Expenditure for the Financial Year		**233,790**	**221,021**
Comprehensive Expenditure for the year		**233,790**	**221,021**

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Current assets:			
Trade and other receivables	8	2,747	4,246
Cash and cash equivalents	9	114	52
Total current assets		**2,861**	4,298
Total assets		**2,861**	4,298
Current liabilities			
Trade and other payables	10	(12,965)	(14,455)
Provisions	11	(291)	0
Total Current liabilities		**(13,256)**	(14,455)
Assets less Liabilities		**(10,394)**	(10,157)
Financed by Taxpayers' Equity			
General fund		(10,394)	(10,157)
Total taxpayers' equity:		**(10,394)**	(10,157)

The notes on pages 5 to 24 form part of this statement

The financial statements on pages 1 to 4 were approved on behalf of the Audit Committee in common on 16th June 2022, and signed on its behalf by:

Marcus Warnes
Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(10,157)	**(10,157)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating expenditure for the financial year	(233,790)	**(233,790)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(233,790)**	**(233,790)**
Net funding	233,553	**233,553**
Balance at 31 March 2022	**(10,394)**	**(10,394)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	(6,753)	**(6,753)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating costs for the financial year	(221,021)	**(221,021)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(221,021)**	**(221,021)**
Net funding	217,617	**217,617**
Balance at 31 March 2021	**(10,157)**	**(10,157)**

The notes on pages 5 to 24 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	**2021-22 £'000**	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(233,790)	(221,021)
(Increase)/decrease in trade & other receivables	8	1,499	(661)
Increase/(decrease) in trade & other payables	10	(1,491)	4,177
Provisions utilised	11	0	(53)
Increase/(decrease) in provisions	11	291	(20)
Net Cash Inflow (Outflow) from Operating Activities		**(233,491)**	(217,578)
Net Cash Inflow (Outflow) before Financing		**(233,491)**	(217,578)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		233,553	217,617
Net Cash Inflow (Outflow) from Financing Activities		**233,553**	217,617
Net Increase (Decrease) in Cash & Cash Equivalents	9	**62**	38
Cash & Cash Equivalents at the Beginning of the Financial Year		**52**	14
Cash & Cash Equivalents at the End of the Financial Year		**114**	52

The notes on pages 5 to 24 form part of this statement

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 2021-22 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 Health and Care Bill was introduced into the House of Commons on 6 July 2021. The Bill will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs. Should the Bill be passed the CCG functions, assets and liabilities will therefore transfer to an ICB.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

The CCG has referred to the Department of Health Manual of Accounts 2021-22 (pages 99-100), which outlines the following in respect of the going concern assumption:

IAS 1 presentation of financial statements: preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.
- For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

The following is clear evidence that the CCG meets the requirement highlighted above and as set out in section 4.18 - 4.28 of the Department of Health Manual of Accounts:

- NHS Cannock Chase CCG (the CCG) was established on 1 April 2013 as a separate statutory body;
- the CCG has an agreed Constitution which it is operating to for the governance of its activities;
- the CCG and, pending legislation, its successor organisation the Staffordshire and Stoke-on-Trent ICB have been allocated funds from NHS England for 2022/23; and submitted a financial plan to NHS England for 2022/23.
- the CCG is allocated a cash drawdown which is based on the cash requirements of the CCG

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 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the NHS Act 2006, 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.

Following the Care Act 2014 that amended the NHS Act 2006 to provide the legislative basis for the delivery of the Better Care Fund (BCF), the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups entered, from 2019/20, into a Section 75 and Section 256 Pooled Budget agreement with Staffordshire County Council (SCC).

The BCF is a key catalyst for Health and Social Care working with other partners, to establish a complementary approach to whole systems working that builds upon approaches and infrastructures that are already part of the Staffordshire and Stoke-on-Trent landscape. BCF affords the opportunity to develop shared positions, to adopt agreed objectives and to drive changes that are systems wide.

The accounting treatment for the pooled budget agreement varies from scheme to scheme. For some schemes SCC acts as the principal and, in these cases, the CCG reports transactions and balances with SCC and SCC accounts for expenditure and balances with the end providers. For some schemes the CCG has not transferred any resources to SCC as these relate to current CCG contractual commitments. Until the current CCG contractual commitments are decommissioned and then re-commissioned jointly through the BCF these transactions are excluded from pooled budget arrangements and, as before, accounted for in the CCGs accounts. The CCG has transferred some of its resources to SCC for it to be used to protect social care services and to implement the Care Act. These transfers are recorded as expenditure in the CCG accounts. There are also some schemes for which SCC controls and expends all resources. None of the expenditure on such schemes is recorded in the CCG accounts. Finally there are some schemes for which resources are transferred to other CCGs and the CCG reports transactions and balances with those CCGs and the other CCGs account for expenditure and balances with the end providers. To ensure comprehensive disclosure in respect of BCF, 'Note 17' discloses the accounting treatment of all the schemes included in the Section 75 agreement between Staffordshire and Stoke-on-Trent CCGs and SCC.

1.4 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

1.5 **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 (The Government Financial Reporting Manual) 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 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.

1.6 **Employee Benefits**

1.6.1 **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.

1.6.2 **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.
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.

1.7 **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.

1.8 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.9.1 **The Clinical Commissioning Group as Lessee**

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10 **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.

Notes to the financial statements

1.11 **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 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2020-21: 0.18%) 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 0.95% (2020-21 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 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.12 **Clinical Negligence Costs**

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

1.13 **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 the 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.

1.14 **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. The CCGs financial assets are all measured at amortised cost.

1.14.1 **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.

1.15 **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.

Notes to the financial statements

1.16 **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 **Value Added Tax**

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

1.18 **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).

1.19 **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 about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.19.1 **Critical accounting judgements in applying accounting policies**

Management has made no critical accounting judgements, apart from those involving estimations, in the process of applying the clinical commissioning group's accounting policies.

1.19.2 **Sources of estimation uncertainty**

There are considered to be no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the clinical commissioning groups financial statements. Estimations have been made in respect of a number of accruals; these accruals have been calculated based on the best available information when preparing the financial statements, and on historic experience, principally in respect of certain elements of GP prescribing and the Continuing Healthcare service

1.20 **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.

1.21 **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 2021-22. 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 – IFRS 16 Leases has been deferred until 1 April 2022.

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

Management has reviewed the financial impact of adopting this accounting standard from April 2022 and concluded that this would be immaterial due to the small number of leases held by the CCG.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	20	22
Other Contract income	479	333
Total Income from sale of goods and services	**499**	**355**
Total Operating Income	**499**	**355**

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

	2021-2022 Non-patient care services to other bodies £'000	2021-2022 Other Contract income £'000
Source of Revenue		
NHS	20	298
Non NHS	0	181
Total	**20**	**479**

	2021-2022 Non-patient care services to other bodies £'000	2021-2022 Other Contract income £'000
Timing of Revenue		
Point in time	20	479
Total	**20**	**479**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total 2021-22		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	1,402	64	1,466
Social security costs	150	0	150
Employer Contributions to NHS Pension scheme	267	0	267
Apprenticeship Levy	6	0	6
Gross employee benefits expenditure	1,825	64	1,889

	Total 2020-21		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	1,357	37	1,395
Social security costs	147	0	147
Employer Contributions to NHS Pension scheme	252	0	252
Apprenticeship Levy	6	0	6
Gross employee benefits expenditure	1,762	37	1,799

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**
Total	28.65	0.71	**29.36**	28.47	0.41	28.88

4.3 Exit packages agreed in the financial year

	2021-22 Compulsory redundancies		**2021-22 Total**	
	Number	**£**	**Number**	**£**
£150,001 to £200,000	0	0	0	0
Total	**0**	**0**	**0**	**0**

	2020-21 Compulsory redundancies		2020-21 Total	
	Number	£	Number	£
£150,001 to £200,000	1	160,000	1	160,000
Total	**1**	**160,000**	**1**	**160,000**

The tables in this note show the aggregate total of Exit Packages agreed in year for three of Staffordshire CCGs which were NHS Cannock Chase CCG, NHS Stafford and Surrounds CCG and NHS South East Staffordshire and Seisdon Peninsula CCG. There were no exit packages in 2021-22, the CCG's share of costs relating to Exit Packages agreed in 2020-21 was £53,333. The CCGs share of the cost was split equally alongside the other two CCGs.

Redundancy costs have been paid in accordance with the provisions of the Agenda for Change Scheme or in line with contractual terms and conditions.

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

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website. 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:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially 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.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website.

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,618	1,775
Services from foundation trusts	44,753	44,625
Services from other NHS trusts	90,386	85,116
Services from Other WGA bodies	0	0
Purchase of healthcare from non-NHS bodies	35,028	34,333
Purchase of social care	7,637	4,775
Prescribing costs	26,038	25,456
General Ophthalmic services	250	129
GPMS/APMS and PCTMS	21,977	20,951
Supplies and services – clinical	51	53
Supplies and services – general	929	131
Consultancy services	58	227
Establishment	604	830
Transport	795	746
Premises	1,658	132
Audit fees *	52	49
Other non statutory audit expenditure		
· Internal audit services	19	27
· Other services **	7	45
Other professional fees	79	6
Legal fees	22	34
Education, training and conferences	55	64
Total Purchase of goods and services	**232,018**	**219,502**
Provision expense		
Provisions	291	(20)
Total Provision expense	**291**	**(20)**
Other Operating Expenditure		
Chair and Non Executive Members	92	85
Expected credit loss on receivables	0	9
Total Other Operating Expenditure	**92**	**94**
Total operating expenditure	**232,400**	**219,577**

* *Audit fees are inclusive of VAT*

** *Includes fees for Mental Health Investment Standard*

The auditor's liability for external audit work carried out throughout the year is limited to £2m

6. Better Payment Practice Code

Measure of compliance	**2021-22 Number**	**2021-22 £'000**	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	5,471	43,980	4,598	36,251
Total Non-NHS Trade Invoices paid within target	5,383	43,392	4,480	35,450
Percentage of Non-NHS Trade invoices paid within target	**98.39%**	**98.66%**	**97.43%**	**97.79%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	444	163,546	689	157,551
Total NHS Trade Invoices Paid within target	433	163,165	682	157,502
Percentage of NHS Trade Invoices paid within target	**97.52%**	**99.77%**	**98.98%**	**99.97%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target for the CCG to be compliant is to pay 95% of invoices, in terms of value and volume.

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2021-22		2020-21	
	Buildings	**Total**	Buildings	Total
	£'000	**£'000**	£'000	£'000
Payments recognised as an expense				
Minimum lease payments	258	**258**	87	**87**
Total	**258**	**258**	**87**	**87**

7.1.2 Future minimum lease payments

		2021-22		2020-21
	Buildings	**Total**	Buildings	Total
	£'000	**£'000**	£'000	£'000
Payable:				
No later than one year	43	**43**	40	**40**
Between one and five years	112	**112**	136	**136**
After five years	0	**0**	14	**14**
Total	**154**	**154**	**190**	**190**

The six Staffordshire and Stoke-on-Trent CCGs operate under a single leadership arrangement and, where appropriate, share their corporate costs on a capitated basis. As a result, the Operating Lease costs of buildings across the six Staffordshire and Stoke-on-Trent CCGs are shared on that basis.

8. Receivables

8.1 Trade and other receivables

	Current 2021-22 £'000	Current 2020-21 £'000
NHS receivables: Revenue	8	255
NHS prepayments	194	0
NHS accrued income	1,975	3,419
Non-NHS and Other WGA receivables: Revenue	11	486
Non-NHS and Other WGA prepayments	265	58
Non-NHS and Other WGA accrued income	274	23
VAT	19	4
Total Trade & other receivables	**2,747**	**4,246**

8.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	**2021-22 Non DHSC Group Bodies £'000**	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	8	6	210	479
Total	**8**	**6**	**210**	**479**

9. Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	52	14
Net change in year	62	38
Balance at 31 March 2022	**114**	**52**
Made up of:		
Cash with the Government Banking Service	114	52
Cash and cash equivalents as in statement of financial position	**114**	**52**
Balance at 31 March 2022	**114**	**52**

10. Trade and other payables	**Current 2021-22 £'000**	Current 2020-21 £'000
NHS payables: Revenue	2	637
NHS accruals	1,403	1,853
Non-NHS and Other WGA payables: Revenue	356	1,337
Non-NHS and Other WGA accruals	8,096	9,128
Payments received on account	0	8
Other payables and accruals	3,108	1,492
Total Trade & Other Payables	**12,965**	**14,455**

Included in Other payables are outstanding pension contributions of £99,539 (£90,486 2020-21)

11. Provisions

	Current 2021-22 £'000	Current 2020-21 £'000
Redundancy	89	0
Legal claims	42	0
Continuing care	83	0
Other	77	0
Total	**291**	**0**
Total current and non-current	**291**	**0**

	Redundancy £'000	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2021	**0**	**0**	**0**	**0**	**0**
Arising during the year	89	42	83	77	**291**
Balance at 31 March 2022	**89**	**42**	**83**	**77**	**291**
Expected timing of cash flows:					
Within one year	89	42	83	77	**291**
Balance at 31 March 2022	**89**	**42**	**83**	**77**	**291**

'Other' provision relates to GP Premises Rent Reviews covering any premises that have not been reviewed to ascertain their current market rental value within the last three years.

12. Financial instruments

12.1 Financial risk management

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

Because the NHS Clinical Commissioning Group (CCG) 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 CCG has limited powers to borrow or invest surplus funds, financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

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

12.1.1 Currency risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operation and therefore has low exposure to currency rate fluctuation.

12.1.2 Interest rate risk

The CCG 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, interest is charged at the National Loans Fund rate and fixed for the life of the loan. The CCG therefore has low exposure to interest rate fluctuations.

12.1.3 Credit risk

Because the majority of the CCGs revenue comes from parliamentary funding, the CCG has low exposure to credit risk. The maximum exposure at the end of the financial year is receivables from customers, as disclosed in the trade and other receivables note.

12.1.4 Liquidity risk

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

12.1.5 Financial Instruments

As the cash requirements of the CCG 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 the CCG's expected purchase and usage requirements and is therefore exposed to little credit, liquidity or market risk.

12. Financial instruments cont'd

12.2 Financial assets

	Total Financial Assets measured at amortised cost 2021-22 £'000	Total Financial Assets measured at amortised cost 2020-21 £'000
Trade and other receivables with NHSE bodies	1,858	3,610
Trade and other receivables with other DHSC group bodies	398	87
Trade and other receivables with external bodies	13	486
Other financial assets	0	0
Cash and cash equivalents	114	52
Total at 31 March 2022	**2,383**	**4,236**

12.3 Financial liabilities

	Total Financial Liabilities measured at amortised cost 2021-22 £'000	Total Financial Liabilities measured at amortised cost 2020-21 £'000
Trade and other payables with NHSE bodies	1,218	2,008
Trade and other payables with other DHSC group bodies	186	4,414
Trade and other payables with external bodies	11,560	8,025
Total at 31 March 2022	**12,965**	**14,448**

13. Operating segments

IFRS 8 defines an operating segment as follows. An operating segment is a component of an entity:
- That engages in business activities from which it may earn revenues and incur expenses (including revenues and expenses relating to transactions with other components of the same entity)
- Whose operating results are reviewed regularly by the entity's chief operating decision maker to make decisions about resources to be allocated to the segment and assess its performance and
- For which discrete financial information is available.

The term 'Chief Operating Decision Maker', per IFRS8, identifies a function, not necessarily a manager with a specific title. That function is to allocate resources to and assess the performance of the operating segments of an entity. The CCG's chief operating decision maker is its group of executive and non-executive officers (the Governing Body). The CCG considers it has only one operating segment: commissioning of healthcare services. Finance and performance information is reported to the Governing Body as one segment and these financial statements have been prepared in accordance with this reporting.

14. Joint arrangements - interests in joint operations

14.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	2021-22 Expenditure	2020-21 Expenditure
			£'000	£'000
Section 256 Fund Transfer	Staffordshire County Council	Protection of Adult Social Care	6,574	3,753
Section 256 Fund Transfer	Staffordshire County Council	Implementation of the Care Act	353	336
Carers	Staffordshire County Council	Carers Breaks	122	116
Support to live at home	Staffordshire County Council	Community Equipment (ICES)	753	668
Frail Elderly	Midlands Partnership NHSFT	Dementia / Frailty / Complex Needs (MPFT Contract)	3,358	3,213
End of Life	Various Voluntary Sector Organisations	Hospices	1,227	1,082
Support to live at home	Various Private Sector	Healthcare Tasks	200	100
Frail Elderly	Accredited Continuing Healthcare Providers	Intermediate Care / Step Down Beds / Reablement	1,111	1,294
Frail Elderly	Accredited Continuing Healthcare Providers	Continuing Health Care (dementia)	1,117	800
Total			**14,816**	11,362

Additional Non Recurrent funding was invested into the BCF for Winter Funding and additional Discharge Support, with particular regard to maintaining capacity post the end of the Hospital Discharge Programme Funding.

15. Related party transactions

Details of related party transactions with individuals are as follows:

	2021-22				2020-21			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Gary Free - Red Lion Surgery	533	0	21	0	559	0	2	0
Dr Annabel Onabolu - Nile Practice	1,282	0	83	0	1,248	0	0	0
Dr Mukesh Singh - Horsefair Practice	1,880	0	95	2	1,892	0	0	0
Dr Mukesh Singh - Sandy Lane Health Centre	1,413	0	45	0	1,503	0	0	0

Dr Gary Free, CCG Chair, is a GP Partner at Red Lion Surgery.
Dr Anna Onabolu, CCG Clinical Lead, is a GP partner at Nile Practice.
Dr Mukesh Singh, CCG Clinical Lead, is a GP Partner at Horsefair Practice and Sandy Lane Health Centre.

NHS Cannock Chase CCG operates a Joint Management structure with five other Staffordshire CCGs included in the list below (*) from 1st April 2018.

The Board posts as detailed in the Remuneration report are shared equally between each CCG.

The Department of Health and Social Care is regarded as the parent department. 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
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority
- NHS Clinical Commissioning Groups

Of those entities listed above, our main areas of expenditure has been with:

*NHS South East Staffordshire and Seisdon Peninsula CCG
*NHS Stafford and Surrounds CCG
*NHS Stoke-on-Trent CCG
*NHS North Staffordshire CCG
*NHS East Staffordshire CCG
Midlands Partnership NHS Foundation Trust
University Hospitals of Derby and Burton NHS Foundation Trust
The Royal Wolverhampton NHS Trust
West Midlands Ambulance Service Foundation Trust
Universal Hospital of North Midlands NHS Trust
Walsall Healthcare NHS Trust

16. Events after the end of the reporting period

Under the Health and Care Act 2022, Clinical Commissioning Groups (CCGs) are to be abolished and be replaced by Integrated Care Boards (ICBs). ICBs are due to take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities are due to transfer to NHS Staffordshire and Stoke On Trent ICB.

17. Financial performance targets

NHS Cannock Chase Clinical Commissioning Group has a number of financial duties under the NHS Act 2006 (as amended).

NHS Cannock Chase Clinical Commissioning Group's performance against those duties was as follows:

NHS Act Section		2021-22			2020-21		
		Target £000	Performance £000	Duty Achieved	£000	Performance £000	Duty Achieved
223H (1)	Expenditure not to exceed income	234,364	234,289	Yes	222,040	221,561	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	0	0	N/A	0	0	N/A
223I (3)	Revenue resource use does not exceed the amount specified in Directions	233,865	233,790	Yes	221,500	221,021	Yes
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	N/A	0	0	N/A
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	N/A	0	0	N/A
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	2,607	2,553	Yes	2,609	2,598	Yes

As per the Allocations Directions in 2021-22 the maximum resource target will be calculated as being the in year allocation.

18. Losses and special payments

The clinical commissioning group had no losses or special payments in 2021-22