

## NHS Shropshire and NHS Telford & Wrekin CCGs Governing Body Part 1 Meetings in Common

to be held on Wednesday 10 March 2021  
at 9.00am

via Teleconference using Microsoft Teams

### AGENDA

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

Item Number	Agenda Item	Presenter	Purpose	Paper	Time
GB-21-03.031	Apologies	Julian Povey	I	verbal	9.00
GB-21-03.032	Members' Declaration of Interests	Julian Povey	I	enclosure	9.00
GB-21-03.033	Introductory Comments from the Chair	Julian Povey	I	verbal	9.00
GB-21-03.034	Accountable Officer's Report	David Evans	I	verbal	9.05
GB-21-03.035	Minutes of Previous Meeting held on: <ul style="list-style-type: none"> <li>• Shropshire CCG Governing Body – 13 January 2021</li> </ul>	Julian Povey	A	enclosure	9.15
	Minutes of Previous Meeting held on: <ul style="list-style-type: none"> <li>• Telford and Wrekin CCG Governing Body – 13 January 2021</li> </ul>	Julian Povey	A	enclosure	
GB-21-03.036	Matters Arising of Previous Meeting held on: <ul style="list-style-type: none"> <li>• Shropshire CCG Governing Body – 13 January 2021</li> </ul>	Julian Povey	A	enclosure	9.20
	Matters Arising of Previous Meeting held on: <ul style="list-style-type: none"> <li>• Telford and Wrekin CCG Governing Body – 13 January 2021</li> </ul>	Julian Povey	A	enclosure	
GB-21-03.037	Questions from Members of the Public  Guidelines on submitting questions can be found at: <a href="https://www.shropshireccg.nhs.uk/get-involved/meetings-and-events/governing-body-meetings/">https://www.shropshireccg.nhs.uk/get-involved/meetings-and-events/governing-body-meetings/</a> and <a href="https://www.telfordccg.nhs.uk/who-we-are/our-governance-board">https://www.telfordccg.nhs.uk/who-we-are/our-governance-board</a>	Julian Povey	I	enclosure	9.30
<b>ASSURANCE</b>					
	<b><u>Quality &amp; Performance</u></b>				
GB-21-03.038	NHS Shropshire CCG and NHS Telford and Wrekin CCG Performance and Quality Report	Zena Young/ Julie Davies	S	enclosure	9.30

GB-21-03.039	Breast cancer services	Julie Davies	I	enclosure	9.55
GB-21-03.040	Maternity Update	Zena Young	S, I	enclosure	10.05
GB-21-03.041	<b><u>Finance</u></b> NHS Shropshire CCG and NHS Telford and Wrekin CCG Finance and Contracting Report, including Quality, Innovation, Productivity & Prevention (QIPP) schemes	Claire Skidmore	S	enclosure	10.15
GB-21-03.042	2021/22 Plan Update	Claire Skidmore	A,S	enclosure	10.35
GB-21-03.043	COVID-19 Update	Sam Tilley / Julie Davies / Steve Trenchard	A,S	verbal	10.45
<b>DECISION-MAKING</b>					
GB-21-03.044	Bridging arrangements for GP IT Futures	Claire Skidmore	A	enclosure	11.00
<b>BREAK</b>					11.10
GB-21-03.045	Update on the System Improvement Plan	David Evans/ Steve Trenchard	I	verbal	11.25
GB-21-03.046	Single Strategic Commissioner – Vision and Strategic Objectives	David Evans	A	enclosure	11.40
GB-21-03.047	Update on NHS Patient Safety Specialist	Zena Young	A, I	enclosure	11.55
<b>GOVERNANCE</b>					
GB-21-03.048	Joint Board Assurance Framework (BAF)	Alison Smith	S	enclosure	12.05
GB-21-03.049	CCG Wellbeing Guardian	Alison Smith	A	enclosure	12.10
<b>OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY</b> (Issues or key points to be raised by exception with the Chairs of the Committees outside of the Governing Body meetings)					
	Shropshire CCG & Telford and Wrekin CCG Joint Chair Reports:				12.20
GB-21-03.050	Audit Committees in Common – 20 January 2021		I	enclosure	
GB-21-03.051	Joint Strategic Commissioning Committee – 20 January 2021		S	enclosure	
GB-21-03.052	Finance Committees in Common – 27 January 2021		S, I	enclosure	
GB-21-03.053	Quality & Performance Committees in Common – 27 January 2021		S, I	enclosure	

	Shropshire CCG Reports Only:				
GB-21-03.054	South Shropshire Locality Forum – 6 January 2021		I	enclosure	
GB-21-03.055	Shrewsbury and Atcham Locality Forum – 21 January 2021		I	enclosure	
GB-21-03.056	North Shropshire Locality Forum – 28 January 2021		I	enclosure	
	Telford and Wrekin CCG Reports Only:				
GB-21-03.057	TWCCG Practice Forum – 19 January 2021		I	enclosure	
GB-21-03.058	Any Other Business	Julian Povey	I	verbal	12.25
	Date and Time of Next Meeting - Wednesday 12 May 2021, time and venue to be confirmed				
<b>RESOLVE:</b> <i>To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960).</i>					



**Dr Julian Povey**  
Joint CCG Chair



**Mr David Evans**  
Joint Accountable Officer

**Joint Members of NHS Shropshire CCG Governing Body and NHS Telford and Wrekin CCG Governance Board**

**Register of Interests - 3 March 2021**

Surname	Forename	Position/Job Title	Committee Attendance	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From (ie review date form completed)	To	
			JCCC = Joint Strategic Commissioning Committee FCiC = Finance & Performance Committees in Common QCiC = Quality & Performance Committees in Common PCCCiC = Primary Care Commissioning Committees in Common ACiC = Audit Committees in Common RCiC = Remuneration Committees in Common								
Ahmed	Astakhar	Joint Associate Lay Member for Patient and Public Involvement (PPI) - Equality, Diversity and Inclusion <b>Attendee</b>	JSCC, FCiC		X			Shared post across Shropshire and Telford and Wrekin CCGs	1.2.21	ongoing	Level 1 - Note on Register
Allen	Martin	Joint Independent Secondary Care Doctor Governing Body Member	Q&PCiC, FCiC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	22.1.21	ongoing	Level 1 - Note on Register
				X			Direct	Employed as a Consultant Physician by University Hospital of North Staffordshire NHS Trust,	22.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Member of CRG (Respiratory Specialist Commissioning)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Chair of the Expert Working Group on coding (respiratory) for the National Casemix Office	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the Royal College of Physicians Expert Advisory Group on Commissioning	22.1.21	ongoing	Level 1 - Note on Register
				X		Indirect	Wife is a part-time Health Visitor in Shrewsbury and employed by the Shropshire Community Health Trust	22.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions	
					X		Direct	Board Executive member of the British Thoracic Society	22.1.21	ongoing	Level 1 - Note on Register
	X		Direct	Member of the National Public Health England (PHE) TB Programme Board	22.1.21	ongoing	Level 1 - Note on Register				

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					X		Direct	NHSD. Member of CAB (Casemix Advisory Board)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	National Clinical Respiratory Lead for GIRFT NHS Innovation (NHSI)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Chair of Respiratory Expert Advisory Group Respiratory Network for the West Midlands	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the Long Term Plan Delivery Board (respiratory) with responsibility for the pneumonia workstream	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	National Specialty Advisor (NHSEI) for physiological measurement	22.1.21	ongoing	Level 1 - Note on Register
Braden	Geoff	Lay Member for Governance & Audit, for NHS Telford & Wrekin CCG - <b>Attendee</b>	FCiC, RCiC, ACiC,				Direct	None declared	20.1.21	ongoing	Left post on 31.1.21 as a Director in Royal Mail Group, which is not a contractor of Shropshire and Telford CCGs
Bryceland	Rachael	Joint GP/Healthcare Professional Governing Body Member	Q&PCiC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	26.1.21	ongoing	Level 1 - Note on Register
				X			Direct	Employee of Stirchley and Sutton Hill Medical Practice	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Medical Staffing in the West Midlands region	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Dream Medical in the West Midlands region	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is a provider of executive coaching and consultancy	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is CEO of Tipping Point Training, provider of Mental Health First Aid training	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Cawley	Lynn	Representative of Healthwatch Shropshire - <b>Attendee</b>	Q&PCCiC					None declared	1.2.21	ongoing	Level 1 - Note on Register
Davies	Julie	Joint Director of Performance - <b>Attendee</b>	PCCCiC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	1.2.21	ongoing	Level 1 - Note on Register
Evans	David	Joint Accountable Officer	PCCCiC, Shropshire North, S&A, South Loc Forums, TW Membership Forum, JSCC		X		Direct	Shared post - Joint Accountable Officer of Shropshire and Telford and Wrekin CCGs	2.2.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the Telford and Wrekin Health and Wellbeing Board	2.2.21	ongoing	Level 1 - Note on Register
						X	Indirect	Wife is an employee of Tribal Education Ltd, which contracts with the NHS, but is not a contractor of the CCG	2.2.21	ongoing	Level 1 - Note on Register

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James	Stephen	Joint Chief Clinical Information Officer (CCIO)	JSCC		X			Shared post across Shropshire and Telford and Wrekin CCGs	20.1.21	ongoing	Level 1 - Note on Register
MacArthur	Donna	Joint Lay Member for Primary Care	PCCCiC, RCiC, ACiC, JSCC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	20.1.21	ongoing	Level 1 - Note on Register
							Indirect	Son's partner is the daughter of a Director working at Wolverhampton CCG	20.1.21	ongoing	Level 1 - Note on Register
Matthee	Michael	Joint GP/Healthcare Professional Governing Body Member	North Localty Forum, FCiC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	1.2.21	ongoing	Level 1 - Note on Register
							Direct	GP Partner at Market Drayton Medical Practice	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
							Direct	GP Member of North Shropshire PCN	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Noakes	Liz	Director of Public Health for Telford and Wrekin - <b>Attendee</b>		X			Direct	Assistant Director, Telford and Wrekin Council	29.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
							Direct	Honorary Senior Lecturer, Chester University	29.1.21	ongoing	Level 1 - Note on Register
Parker	Claire	Joint Director of Partnerships - <b>Attendee</b>	PCCCiC, Shropshire North, S&A, South Loc Forums, TW Membership Forum		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	27.1.21	ongoing	Level 1 - Note on Register

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						X	Indirect	Daughter is working as admin staff for CHC Team and is line managed by the CHC Team.	27.1.21	1.03.21	Level 2 - Restrict involvement in any relevant commissioning decisions
Pepper	John	Joint GP/Healthcare Professional Governing Body Member	JSCC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	19.1.21	ongoing	Level 1 - Note on Register
				X			Direct	Salaried General Practitioner at Belvidere Medical Practice (part of Darwin Group)	19.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Belvidere Medical Practice is a member of Darwin Group of practices and Shrewsbury Primary Care Network	19.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	NHS England GP Appraiser	19.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions



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Povey	Julian	Joint Chair	PCCCiC, Shropshire North, S&A, South Loc Forums, TW Membership Forum	X	X		Direct	Shared post - Joint Chair of Shropshire and Telford and Wrekin CCGs	1.2.21	ongoing	Level 1 - Note on Register
				X			Direct	GP Member at Pontesbury Medical Practice	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Practice Member of Shrewsbury & Atcham Primary Care Network	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						X	Indirect	Wife is Member of University College Shrewsbury - Advisory Board	1.2.21	ongoing	Level 1 - Note on Register
				X			Indirect	Wife is Medical Director at Shropshire Community Health NHS Trust	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Pringle	Adam	Joint Vice Clinical Chair and GP/ Healthcare Professional Governing Body Member	PCCCiC, Shropshire North, S&A, South Loc Forums, TW Membership Forum		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	2.2.21	ongoing	Level 1 - Note on Register

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				X			Direct	GP Partner, Teldoc General Practice	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Teldoc is a Member of Teldoc Primary Care Network	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Work on a sessional basis for Shropshire Doctors Co-Operative Ltd (Shropdoc) an	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Property owner of Lawley Medical Practice site	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Robinson	Rachel	Director of Public Health for Shropshire - <b>Attendee</b>		X			Direct	Director of Public Health for Shropshire	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Shepherd	Deborah	Joint Interim Medical Director - <b>Attendee</b>	PCCCiC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	19.1.21	ongoing	Level 1 - Note on Register
Skidmore	Claire	Joint Executive Director of Finance	FCiC, ACiC, PCCCiC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	15.1.21	ongoing	Level 1 - Note on Register
Smith	Alison	Joint Director of Corporate Affairs - <b>Attendee</b>	ACiC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	25.1.21	ongoing	Level 1 - Note on Register

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						X	Indirect	Related to a member of staff in my portfolio structure who is married to my cousin. The individual is not directly line managed by me.	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Smith	Fiona	Joint GP/Healthcare Professional Governing Body Member	JSCC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	20.1.21	ongoing	Level 1 - Note on Register
				X			Direct	Advanced Nurse Practitioner at Shawbirch Medical Practice	20.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Shawbirch Medical Practice is a Member of Newport/Central PCN	20.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Indirect	Son-in-Law works as a technician for the Audiology Team at SaTH	17.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Tilley	Samantha	Joint Director of Planning - <b>Attendee</b>	JSCC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	27.1.21	ongoing	Level 1 - Note on Register
						X	Indirect	Brother in Law holds a position in Urgent Care Directorate at SATH	27.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Timmis	Keith	Lay Member for Governance for NHS Shropshire CCG	FCiC, ACiC, QCiC, RCiC	X			Indirect	Wife is an Archivist for Shropshire Council	19.1.21	ongoing	Level 1 - Note on Register
Trenchard	Steve	Joint Interim Executive Director of Transformation	JSCC, PCCC		X		Direct	Shared post across Shropshire and Telford and	22.1.21	ongoing	Level 1 - Note on Register
Vivian	Meredith	Joint Deputy Chair and Joint Lay Member for Patient & Public Involvement (PPI)	Q&PCiC, RCiC, ACiC, PCCCiC		X		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	26.1.21	ongoing	Level 1 - Note on Register

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				X			Indirect	Wife is a part-time staff nurse at Shrewsbury & Telford Hospital NHS Trust (SATH)	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Young	Zena	Joint Executive Director of Quality	JSCC, F&P, PCCCiC		X		Direct	Shared post across Shropshire and Telford and Wrekin CCGs	22.1.21	ongoing	Level 1 - Note on Register
<b>MEMBERS WHOSE BOARD ROLE HAS CEASED OR WHO HAVE LEFT THE CCGs WITHIN THE LAST 6 MONTHS</b>											
Fortes-Mayer	Gail	Director of Contracting & Planning	CCC, F&P					None declared	18.1.19		Left the CCGs on 30.10.20
McCabe	Julie	Joint Independent Registered Nurse Clinical Governing Body Member	JSCC, Q&PCiC		X			Shared post across Shropshire and Telford and Wrekin CCGs	1.8.20		Left the CCGs on 31.1.21
Turner	Gary	Joint Lay Member - Primary Care	PCCC, RCiC, ACiC, JSCC			X	Indirect	Wife is employed by the CCG as PA to Chair, AO, Medical Director and Interim Executive Director of Transformation	1.8.20		Left the CCGs on 18.9.20
						X	Direct	Chair of The Priory School Trust (Education)	1.8.20		
Wilde	Nicky	Director of Primary Care	PCCC, CCC			X	Indirect	Husband's family members are nursing staff (general and midwife) at Shrewsbury & Telford Hospital NHS Trust (SATH)	25.4.19		Left the CCGs on 3.11.20

## MINUTES

### **NHS Shropshire CCG and NHS Telford and Wrekin CCG Governing Body Meetings in Common**

**Wednesday 13 January 2021 at 9.00am**

**Using Microsoft Teams**

#### **Present from NHS Shropshire CCG:**

<b>Dr Julian Povey</b>	Joint CCG Chair for Shropshire and Telford and Wrekin CCGs
<b>Mr David Evans</b>	Joint Accountable Officer for Shropshire and Telford and Wrekin CCGs
<b>Mrs Claire Skidmore</b>	Joint Executive Director of Finance for Shropshire and Telford and Wrekin CCGs
<b>Dr Adam Pringle</b>	Joint Vice Clinical Chair, GP/Healthcare Professional Governing Body Member
<b>Dr John Pepper</b>	Joint GP/Healthcare Professional Governing Body Member
<b>Dr Michael Matthee</b>	Joint GP/Healthcare Professional Governing Body Member
<b>Mrs Rachael Bryceland</b>	Joint GP/Healthcare Professional Governing Body Member
<b>Ms Fiona Smith</b>	Joint GP/Healthcare Professional Governing Body Member
<b>Dr Martin Allen</b>	Joint Secondary Care Doctor Governing Body Member
<b>Mrs Julie McCabe</b>	Joint Registered Nurse Governing Body Member
<b>Mr Steve Trenchard</b>	Joint Interim Executive Director of Transformation for Shropshire and Telford and Wrekin CCGs
<b>Mrs Zena Young</b>	Joint Executive Director of Quality for Shropshire and Telford and Wrekin CCGs
<b>Mr Meredith Vivian</b>	Joint Lay Member for Patient and Public Involvement
<b>Mrs Donna MacArthur</b>	Joint Lay Member for Primary Care
<b>Mr Keith Timmis</b>	Lay Member for Governance for Shropshire CCG

#### **Present from NHS Telford and Wrekin CCG:**

<b>Dr Julian Povey</b>	Joint CCG Chair for Shropshire and Telford and Wrekin CCGs
<b>Mr David Evans</b>	Joint Accountable Officer for Shropshire and Telford and Wrekin CCGs
<b>Mrs Claire Skidmore</b>	Joint Executive Director of Finance for Shropshire and Telford and Wrekin CCGs
<b>Dr Adam Pringle</b>	Joint Vice Clinical Chair, GP/Healthcare Professional Governing Body Member
<b>Dr John Pepper</b>	Joint GP/Healthcare Professional Governing Body Member
<b>Dr Michael Matthee</b>	Joint GP/Healthcare Professional Governing Body Member
<b>Mrs Rachael Bryceland</b>	Joint GP/Healthcare Professional Governing Body Member
<b>Ms Fiona Smith</b>	Joint GP/Healthcare Professional Governing Body Member
<b>Dr Martin Allen</b>	Joint Secondary Care Doctor Governing Body Member
<b>Mrs Julie McCabe</b>	Joint Registered Nurse Governing Body Member
<b>Mr Steve Trenchard</b>	Joint Interim Executive Director of Transformation for Shropshire and Telford and Wrekin CCGs
<b>Mrs Zena Young</b>	Joint Executive Director of Quality for Shropshire and Telford and Wrekin CCGs
<b>Mr Meredith Vivian</b>	Joint Lay Member for Patient and Public Involvement
<b>Mrs Donna MacArthur</b>	Joint Lay Member for Primary Care
<b>Mr Geoff Braden</b>	Lay Member for Governance for Telford and Wrekin CCG

#### **Attendees for both meetings:**

<b>Dr Julie Davies</b>	Joint Director of Performance for Shropshire and Telford and Wrekin CCGs
<b>Miss Alison Smith</b>	Joint Director of Corporate Affairs for Shropshire and Telford and Wrekin CCGs
<b>Mrs Sam Tilley</b>	Joint Director of Planning for Shropshire and Telford and Wrekin CCGs
<b>Ms Claire Parker</b>	Joint Director of Partnerships for Shropshire and Telford and Wrekin CCGs
<b>Dr Deborah Shepherd</b>	Joint Interim Medical Director for Shropshire and Telford and Wrekin CCGs
<b>Dr Stephen James</b>	Joint Chief Clinical Information Officer for Shropshire and Telford and Wrekin CCGs
<b>Mr Ash Ahmed</b>	Joint Associate Lay Member for Patient and Public Involvement - Equality, Diversity and Inclusion
<b>Mrs Rachel Robinson</b>	Director of Public Health for Shropshire
<b>Mrs Liz Noakes</b>	Director of Public Health for Telford and Wrekin
<b>Ms Lynn Cawley</b>	Chief Officer, Healthwatch Shropshire
<b>Mrs Sandra Stackhouse</b>	Corporate Services Officer – Minute Taker

- 1.1 Dr Povey welcomed Governing Body members and the public to the NHS Shropshire CCG and NHS Telford and Wrekin CCG Governing Bodies meetings in common that was being live-streamed via YouTube, a recording of which would also be available on the CCGs' websites following the meeting.

### **Minute No. GB-21-01.001 - Apologies**

2.1 Apologies were noted from:

Mr Paul Shirley            Chief Officer, Healthwatch Telford and Wrekin

### **Minute No. GB-21-01.002 - Declarations of Interests**

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

<https://www.shropshireccg.nhs.uk/about-us/conflicts-of-interest/>

<https://www.telfordccg.nhs.uk/who-we-are/publications/declaration-of-interest>

Members were asked to confirm any additional conflicts of interest that they had relating to the agenda items. There were no further conflicts of interest declared.

### **Minute No. GB-21-01.003 - Introductory Comments from the Chair**

4.1 Dr Povey referred to the response to the COVID-19 pandemic and the increases in positive cases, hospital admissions and deaths seen nationally. Shropshire, Telford and Wrekin were slightly behind the national curve but there had been a dramatic rise in positive cases above the levels seen previously.

4.2 The Governing Body and the public were reassured that everyone would receive their COVID-19 vaccination as soon as possible and that all residents in care homes would be vaccinated by the end of the month. 10,000 vaccinations had so far been given locally and this number was increasing on a daily basis as more services came on stream. Two Primary Care Networks (PCNs) had signed up to the COVID-19 vaccination Direct Enhanced Service (DES) and all other practices were working with the CCG and STP partners at looking at ways of improving the speed and delivery of the vaccinations.

4.3 The CCGs' Governing Bodies would also discuss the CCGs' financial position, and performance and waiting times, which had also been impacted upon by COVID-19.

4.4 An update on the OCKENDEN REPORT: Emerging Findings and Recommendations from the Independent Review of MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST ("the Ockenden Report") would be given by the CCGs' Executive Director of Quality. Dr Povey expressed that the CCGs' thoughts were with the families and the patients affected by the issues raised in the interim report. The report was very humbling and highlighted the worry, stress and hurt that the families affected had been through. The CCGs would continue their work with the acute trust, system partners, regulators, patients, and the local Maternity Neonatal Service Review, to act upon lessons learnt to improve maternity services.

4.5 It was reported that Mrs Julie McCabe had accepted an appointment at a senior level working for NHS England/Improvement's (NHSE/I) Quality Directorate. Mrs McCabe was thanked for the work she had undertaken and the Governing Body Members wished her well for the future. As a result of Mrs McCabe leaving, the CCGs would need to recruit another Registered Nurse for the Joint Board.

### **Minute No. GB-21-01.004 – Accountable Officer's Report**

5.1 Ockenden Report - Mr Evans reinforced Dr Povey's comments and on behalf of the CCGs' Governing Bodies said that he was very sorry for the distress, hurt and pain that had been caused to the parents, mothers, and babies concerned. The CCGs would need to wait for the publication of the second Ockenden Report but there would be lessons for a number of system partners, including the regulators.

5.2 COVID-19 – Mr Evans reported that the situation was getting increasingly challenging. Prevalence rates were significantly higher than they had been previously and had increased over the last two weeks, particularly since Christmas.

5.3 All systems had been asked to include increased critical care capacity in their contingency plans. As one of the measures that the system had taken, RJAH had ceased the majority of elective surgery, with the exception of cancers, so that the number of critical care beds could be increased at SATH.

5.4 COVID-19 vaccination programme – The number of vaccination sites was being increased and every vaccine that came into the county was being used. It was recognised that vaccination centres were not in operation in all areas and although these were in the process of being signed off, it did appear that some areas may be receiving vaccines and others were not. Mr Evans assured the Governing Bodies and

members of the public that where a Primary Care Network (PCN) had achieved delivery of all of its over-80s population, rather than moving on to the next cohort down, the PCN was being asked to begin to vaccinate the over-80s in neighbouring areas. The local vaccination programme had been recognised by NHSE/I as being robust and strong. The system had been congratulated on its approach to that and a lot of staff were working hard around the clock to deliver the vaccination programme.

- 5.5 The management of change process for staff continues and all staff that were placed at risk were being interviewed for suitable alternative employment. The CCGs were hopeful that this process would be completed in time for the establishment of the new CCG on 1 April 2021.
- 5.6 A meeting had taken place with NHSE/I last week around the conditions attached to the CCGs' application to create a new CCG, which had not raised any particular concerns and the CCGs were on target to deliver all of the conditions asked of NHSE/I.
- 5.7 An application made on behalf of the system to create an Integrated Care System (ICS) had been submitted on 11 January. The draft would be circulated to Governing Body Members for information. This would remain in draft until it had been signed off by NHSE/I. Initial feedback was that NHSE/I had seen the amount of work that had been undertaken. A regional panel meeting was scheduled for 18 January and a national panel meeting for 25 January and Governing Body Members would be updated on the outcome of those meetings.
- 5.8 Mr Vivian raised that the public had been concerned by the lack of communication on the vaccination process. It was understood that there was not always new information to convey but in the absence of available information it was inevitable that people would become anxious. Mr Vivian asked if the CCGs could communicate something even if it was not everything.
- 5.9 Mr Evans explained the comms messages were being tightly controlled by NHSE/I. Mr Evans said that he would like to say more to give that assurance to members of the public. However, he had been trying to convey as much as he could to the public, for example, during the last week, by speaking on Radio Shropshire and also taking part in a Facebook Live Event organised by Telford and Wrekin Council.
- 5.10 There were key messages for the public to adhere to the lockdown rules because of the higher prevalence rates being seen. This was unavoidable for instance for staff working in hospitals and care homes. There was a vaccine but it would take some time to vaccinate everyone. The more that individuals limited their contact with others, the quicker society could return to some degree of normality.
- 5.11 Mrs Noakes said that she understood the position locally but there was a need to give assurance and confidence to the public. NHSE/I needed to be more open and transparent about how the vaccine was being rolled out and what the numbers were locally. As Directors of Public Health, Mrs Robinson and Mrs Noakes did need to understand the uptake rates locally as part of their assurance processes.
- 5.12 Dr Matthee reported that he had been involved in the vaccination programme and stressed how hard the staff were working in organising and implementing the service, who were also at the same time, receiving lots of emails and enquiries about the prioritisation of patients, which was difficult to manage.
- 5.13 Dr Matthee said that the policy on providing vaccinations by categories rather than areas first was welcomed because areas needed to be at the same level to avoid risks of further outbreaks. More enquiries were certainly being received by Dr Matthee's practice about the current position regarding vaccines and central guidance was awaited.
- 5.14 Dr Povey reported that at a national meeting with the CCG Accountable Officers (AOs) and Chairs; and the national Chief Medical Officers; Chief Executive and representatives of NHSE/I; it had been confirmed that where sites had completed vaccinating their category 1 and 2 patients, they needed to provide resilience and support to neighbouring areas and sites that had not completed theirs and no areas should be dropping down a category until all the categories had been completed. A further national directive had been not to administer the second vaccine at 21 days because giving one vaccine to more people saved more lives than giving two vaccines to a limited number of people. The data quoted to support this theory was that for every 250,000 people in the upper two priority groups that were not given a vaccine, there were up to 1000 lives lost.
- 5.15 Ms Parker said that the CCGs had recognised that they had not sufficiently communicated with the practices and had started to provide more regular communications to the practices.

- 5.16 Dr Pringle commented that a uniform provision over the local area might not be the best process because it may result in delaying care to some patients and the risks were often different in different practices, for example, very urban areas had higher rates than the more rural areas.
- 5.17 Dr Povey replied that NHSE/I had acknowledged that there were some groups that would be more at risk than in any of the tiers but the pragmatic approach had been to prioritise the tiers of at risk groups nationally and data had been provided to support this approach.
- 5.18 Mr Evans advised that a small number of second dose vaccinations had been administered in a care home where, because of transportation issues, would have otherwise been wasted.

**ACTIONS: Mr Evans to arrange for a copy of the draft ICS application to be circulated to Members for information.**

**Mr Evans to double-check whether the draft ICS application can be published in the public domain.**

**Mr Evans to update Governing Body Members on the ICS application and the outcome of the regional and national panel meetings.**

#### **Minute No. GB-21-01.005 – Minutes of the Previous Meetings – 11 November 2020**

- 6.1 The minutes of the previous NHS Shropshire CCG and NHS Telford and Wrekin Governing Body meetings in common held on 11 November 2020 were presented and approved as a true and accurate record of the meeting subject to the following two amendments:

Page 5, paragraph 2, line 1: change 'Mrs Skidmore' to 'Ms Parker'.

Page 7, paragraph 9.15, line 6: change: 'maternity obstetrically' to 'modified early obstetric'.

***RESOLVE: Governing Body Members of NHS Shropshire CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Shropshire CCG held on 11 November 2020.***

***RESOLVE: Governing Body Members of NHS Telford and Wrekin CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Telford and Wrekin CCG held on 11 November 2020.***

**ACTION: Mrs Stackhouse to action the two agreed amendments to the minutes as noted in paragraph 6.1 above.**

#### **Minute No. GB-21-01.006 – Matters Arising from the Minutes of the Previous Meetings held on 11 November**

- 7.1 Dr Povey referred to the matters arising from the last meetings, noting that some actions were marked as complete, and the following additional verbal updates were given:

**GB-20-11.121 – Matters Arising [b/f from GB-20-01-010 – Shropshire CCG Strategic Priorities]**. Mr Trenchard confirmed that the data on the ambulance crew on-scene timings had been chased and work was on-going. A tactical sub group had been formed that reported into the Urgent and Emergency Care Working Group that captured the data and this included working more closely with the ambulance service.

**GB-20-11.123 – Quality and Performance Report** – Dr Shepherd advised that for a point of accuracy the cancer lead named in the update at the top of page 4 was Dr Steve McKew who was a consultant 'haematologist' and not a consultant 'oncologist'.

**GB-20-11.128 – Joint CCG Board Assurance Framework** – Following the announcement of the UK/EU trade agreement, a separate item on the EU Exit had not been included on the agenda. Mr Evans reported that there had not been any constraints seen so far in terms of supplies of vaccines, which had been a particular concern, particularly as the Pfizer vaccine was manufactured in Belgium.

#### **Minute No. GB-21-07.007 – Minutes of the Previous Meetings – 9 December 2020**

- 8.1 The minutes of the previous NHS Shropshire CCG and NHS Telford and Wrekin Extraordinary Governing Body meetings in common held on 9 December 2020 were presented and approved as a true and accurate record of the meeting.



***RESOLVE: Governing Body Members of NHS Shropshire CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Shropshire CCG held on 9 December 2020.***

***RESOLVE: Governing Body Members of NHS Telford and Wrekin CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Telford and Wrekin CCG held on 9 December 2020.***

**Minute No. GB-21-01.008 – Matters Arising from the Minutes of the Previous Meeting held on 9 December 2020**

9.1 Dr Povey referred to the matters arising from the last meetings and noted the following:

**GB-20-12.142 – Single Strategic Commissioner – Close Down and Transition Plan.** Miss Smith confirmed that the March dates in the timeline summary had been reviewed, which had been re-presented to an Extraordinary Audit Committees in common meeting on 18 December 2020 and had been approved. Work would be progressed at the Audit Committees in common March meetings.

**Minute No. GB-21-01.009 – Public Questions**

- 10.1 Dr Povey referred to the questions that had been received for the meeting held on 11 November 2020, a copy of which was attached to the minutes with the responses provided by the CCGs' Executive Team.
- 10.2 Questions had been received from the public for this meeting and responses to those questions would be provided by the Executive Team within two weeks following the meeting and would be published on the CCGs' websites.

**ASSURANCE**

**Minute No. GB-21-01.010 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report**

- 11.1 **Performance** – Dr Davies presented the Performance section of the joint Quality and Performance Report, which was taken as read. Since the report had been finalised the position in performance had changed. The content of the report remained valid but the context around the pandemic had changed.
- 11.2 Owing to the significant increase in COVID-19 cases across the country, and the requirement to increase critical care capacity, RJAH had paused their elective programme, which would also be the case for SaTH. Therefore, a lot of the work quoted in the report around the planned improvements, particularly around Diagnostics, non-COVID and urgent care would have been affected. The work around urgent care and particularly the EDs continues.
- 11.3 The local system had undertaken a good piece of work in implementing the NHS 111 First project and although in its infancy and there were small numbers, it was definitely having the required impact of directing appropriate patients away from the ED, and particularly into increased booked appointments into the urgent treatment centres and a small number to primary care, where appropriate.
- 11.4 The over 1 hour ambulance handover delays continued to be a challenge especially when there was a high density of ambulances attending. There have been 12 hour breaches and over 1 hour ambulance handover delays which are all linked because of the demand of patients presenting in the Emergency Departments (EDs) and SaTH's ability to manage that.
- 11.5 The work with the ambulance service that had been restarted had been temporarily placed on hold because of the emergency pressures. However, the Governing Bodies were reassured that as soon as the CCGs were able to re-engage with the ambulance service's operational leads they would do so.
- 11.6 The issues around the Referral To Treatment (RTT) and planned care targets would unfortunately be affected because of the current pressures.
- 11.7 Regarding cancer services, everything was being done as a system and there were now detailed negotiations with the Nuffield Hospital to gain access to the extra capacity there to continue to deliver treatment for the urgent, elective and cancer patients. The particular challenge within the breast cancer service at SaTH was because of infection control issues and capacity. There was some estates work being carried out at SaTH, of which Dr Davies had been chasing a completion date. Unfortunately, there

was still no confirmed date for completion of the work but the CCGs had been informed that it would be within 1-2 weeks at which time it was expected that the capacity in the breast cancer service would return to the equivalent of pre-COVID-19 levels.

- 11.8 Dr Povey expressed concern about the numbers of the breast cancer service waiting times and asked if the CCGs were sure that the capacity was going to be sufficient to clear the backlog. Patients were supposed to be seen within 2 weeks and some of the data and feedback received about waits was very challenging. Reference was made to the earlier discussions on communication and the need to be open with the public about the present position. It was also unacceptable for there not to be a completion date for the estates work.
- 11.9 Mr Evans suggested that it might be beneficial to take lessons learnt from systems whose performances were more successful on breast cancer services in particular.
- 11.10 Dr Pepper referred to the breast cancer diagnostic rates and understood that the current 2 week wait was at present at 35 days. Dr Pepper sought a better understanding of what the infection control issues were and why the breast cancer service was challenged compared to other specialties. Dr Pepper also referred to the weekly calls with the West Midlands Cancer Alliance and asked whether there was an option of out of area support to help the flow of patients to avoid further escalation of the waiting list.
- 11.11 Dr Matthee voiced concern that it was not just that the 2 week waits were not being achieved but asked if the format of the breast cancer clinics had changed from the One Stop Clinic model where patients received all the investigations at the same time. Some patients had reported that they had waited to be seen and then had been required to wait for another appointment to receive an ultrasound x-ray.
- 11.12 Dr Davies explained that the main reason for the infection control issues was the sheer volume of breast cancer patients. The infection control issues were within the waiting areas and also the processing through the One Stop Clinic and the diagnostics. Therefore the imaging, etc. had been a challenge, which was why it had been affected disproportionately.
- 11.13 Regarding the question about whether there was an option to treat patients out of county, Dr Davies reported that with the exception of the breast service, Shropshire, Telford and Wrekin, had done better than other areas in continuing its cancer treatment through the two waves of the COVID-19 pandemic. Further information was being sought but it did feel like local patients were not being given the same access to the regional hubs for cancer treatment particularly for any complex cases because of the pressures of COVID-19. There was therefore a big piece of work to be undertaken to look at this issue and to seek assurance that there was fair access to treatment offered by the regional hubs compared to other parts of the region.
- 11.14 The CCGs were also ensuring that all cancellations of any cancer treatment were being tracked and that the appointments have been rescheduled. There are also close links into the quality process of any harm in any long standing issues in outcomes for patients. The CCGs were doing everything that they could to maximise capacity at the Nuffield Hospital and had continued to have breast surgery clinics there.
- 11.15 Dr Davies agreed that there should be a confirmed date on when the estates work would be completed. Dr Davies had continued to chase SaTH on a regular basis and would keep the Governing Body Members informed as soon as a timeline was received.
- 11.16 The service have been covering the extra lists that would help get through the backlog and so returning that physical capacity back to previous levels would be sufficient.
- 11.17 In answer to Dr Matthee's question, Dr Davies said that she was not aware of any formal changes to the format of the breast clinics but would look into this.
- 11.18 Dr Shepherd added that part of the issue with the breast cancer service was that it should only be for patients with suspected cancer but all patients with breast symptoms were required to be seen within 2 weeks. The team had taken steps to increase the advice to primary care on management of benign breast symptoms. They were also increasing the availability of the consultants to provide guidance to primary care on how to manage those symptoms before or instead of referring, so that they could ensure that they were focussing on the patients of most concern who were most likely to have suspected cancer.
- 11.19 Dr Shepherd believed that there were some challenges in providing the One Stop Clinic because of the physical capacity of the clinic. Dr Shepherd had been assured that the team were liaising with the Radiology department on a daily basis to ensure that they can streamline the investigations as much as possible for them to be carried out at the same time, or if not, in a very brief space of time. It was thought

that there were some challenges to the One Stop Clinic model as well because of the physical limitations but SaTH were working hard to try and make it as streamlined as possible.

- 11.20 Mrs McCabe referred to the 52 week waits and noted that when the numbers of patients of the CCGs were compared, there was a significant difference, and queried the reason for the differential in numbers.
- 11.21 Dr Davies explained that the differential related to population size and that Shropshire's population was twice the number of Telford and Wrekin's and therefore would have a higher proportion. The referrals were being managed based on clinical priority across the system. Clinicians were working to bring together system-wide patient waiting lists on to a single list with the plan to introduce elective hubs but because of current pressures this work had temporarily been paused. This was not just in Shropshire, Telford and Wrekin, but was a regional and national response to ensure that the patients with the greatest need received the appointments first wherever that capacity was across the system. Mrs McCabe was assured that that work was in place to provide equity of access based on clinical prioritisation, and in particular the orthopaedic work, which was being co-ordinated by Mark Brandreth, Chief Executive of RJAH.
- 11.22 Dr Povey highlighted that the issue around the EDs and the ambulance handovers had been an issue for a number of years and voiced concern that the report stated that the work was being restarted because work had been carried out on this in the past.
- 11.23 Dr Davies explained that what was meant by restarting the work was that the regular operational meeting between the whole system partners and the ambulance service had been paused due to pressures of the first response to the pandemic. The meetings had only just restarted but then had to be paused again due to the response to the second wave of the pandemic because the operational staff and the ambulance staff were not available to continue that work.
- 11.24 Dr Davies further reported that there had been significant number of over 1 hour ambulance handover delays across the region, which was volume related. Mr Evans was working with the Chief Executives in the region to look at this issue and the batching of ambulances, which needed to be addressed at a regional level. Mr Evans was in discussions with Paul Maubach, Chief Executive Officer, Black Country and West Birmingham CCGs, who was responsible for the integrated commissioning of urgent care and ambulance services. The ambulance handovers were critical and was focussed upon very closely and continually through the Urgent and Emergency Care delivery groups and to the CCGs' Governing Bodies.
- 11.25 It was agreed that Mr Evans would raise directly with Louise Barnett, Chief Executive of SaTH, the CCG Governing Bodies' significant concerns about the rates of performance and the challenges in the breast cancer service. Dr Davies would present an update on the recovery of the breast cancer service and cancer performance to the next meeting.

**ACTIONS: Mr Evans to raise the Governing Bodies' concerns about the Breast cancer performance direct with Louise Barnett, Chief Executive of SaTH.**

**Dr Davies to update the Governing Bodies on the timeline for the Breast cancer estates when received.**

**Dr Davies to look into whether the format of the Breast clinics have been changed.**

**Dr Davies to present an update on Breast cancer and cancer performance to the next Governing Body meeting.**

- 11.26 Quality – Mrs Young presented the Quality section of the Quality and Performance Report and assumed the paper as read. Mrs Young drew Members' attention to the points as listed below.
- 11.27 Mrs Young advised that because of the activity within the Quality and Transformation Teams and the work the CCGs were undertaking in support of the COVID-19 vaccination programme, a number of staff had been deployed into those services to make those schemes work.
- 11.28 SaTH remained the most challenged provider in the system which was of the most concern and the CCGs did maintain a high level of oversight and presence within the quality governance arena for SaTH, which had been increased over the past month.
- 11.29 SaTH had received an unannounced visit from the Care Quality Commission (CQC) on 8 January 2021, which had focused on the Intensive Care Unit, ED, Maternity and Stroke. It was understood that there had been no concerns raised for immediate attention and the report from that visit was awaited.

- 11.30 Since the last reporting period, the CCG had reviewed the risk registers at SaTH for maternity specifically and also more generally and had made some recommendations for the Trust to consider in order that they could demonstrate improved governance.
- 11.31 In response to Dr Povey's earlier question about the 39 12 hour breaches that had been reported since November, the CCG continued to undertake a review of the HARMS process and had undertaken the ED 12 hour breach HARMS review process with the Trust to make sure that the detail of the harm was captured, not just in the moment, but in the longer term because often the impacts in terms of quality did not always become evident immediately.
- 11.32 The CCGs were very much sighted on the HARMS review process for all of the providers and the Quality and Performance Committee received a quarterly report dedicated to that subject and also received a dedicated quarterly serious incidents report looking at the trends and themes rather than just in the month reporting.
- 11.33 Falls remained an area of concern at SaTH. There was a detailed action plan in place. SaTH had national expertise to support them with that but it was about delivering that through the staff at SaTH and was work in progress.
- 11.34 Dr Pepper had asked a question about the Local Safety Standards for Invasive Procedures (LocSSIPs). In a previous report Mrs Young had expressed concerns about the assurance levels around the LocSSIPs work, which had been particularly in relation to a never event where a swab had been left in situ in a patient. The Trust had given verbal assurance that matters had improved and policies had been re-written but the level of assurance had not been provided. A quality visit had been planned to look at the actions related to the never event but the Regional Chief Nurse had requested the quality visit to be stood down and for the CCG to consider alternative ways of receiving assurance. This had been on the basis that the Trust had employed an external maternity governance advisor. The Trust had carried out their own quality visit which had shown poor compliance with the actions as part of the LocSSIPs work.
- 11.35 The CCGs needed to understand the Trust's actions around improving their compliance with that policy and the CCG now received update reports. SaTH had undertaken weekly audits which had showed 100% compliance across the audits. It was considered that the actions had been effective in driving an improvement and it was positive that the Trust had owned the steps in those actions, which required on-going monitoring.
- 11.36 Work was also being undertaken with Shropshire Community Health Trust (SCHT) around system-wide tissue viability improvements which would form part of the system quality surveillance agenda moving forward as would the Niche work on mortality and other work.
- 11.37 Dr Povey asked if there was an update on the Niche report on Mortality. Mrs Young confirmed that the work on the case reviews for stage 2 of the report had just taken place and was hopeful a report would be presented to the next meeting. Mrs Young clarified that the stage 1 report had not been adjusted as a result of the Ockenden Report but because Ockenden had a particular brief around women's mortality and had not been included in the Niche mortality review. This was not material to the wider system's understanding of mortality but it was important for the CCGs to receive back and the delay was because of availability of staff at SaTH agreeing the dataset which was being impacted by COVID.
- 11.38 Dr Povey referred to the Neurology service and although urgent referrals had been seen in ward based work asked what steps were being taken to review the quality impact on patient care in terms of not having an open Neurology service for two years and what steps were being taken to relieve the impact.
- 11.39 Mrs Young advised that this work was in progress and would be presented to the next Quality and Performance Committee meeting and an update would be referenced in the Quality section of the next report to the Governing Bodies.
- 11.40 Dr Povey referred to section 3.2 on safeguarding and sought confirmation of the work with Severndale School. Mrs Young apologised that there had been some text omitted from the report and clarified that following inspection, Severndale School had been rated inadequate in its management and its leadership, particularly around safeguarding. A recommendation had been made that the management of Severndale School was reconsidered and it would transfer to the Learning Community Trust (LCT), a Telford based multi-academy Trust. The CCGs were part of the group monitoring the actions for improvement and, although it was local authority led, there was a degree of health input by way of the school nurses, etc. Regular reports were being received on this through the safeguarding team, which were then reported to NHSE/I's regional team.

- 11.41 Reference was made to section 2.9 of the report where it stated that concerns had been raised about the Community Health and Eyecare Limited (CHEC) service in October and November 2020 but it had then stated that there had not been any further clinical concerns raised since February 2020. Dr Povey asked if this was because the main concerns were not clinical or was it a matter of the timing of different reports.
- 11.42 Mrs Young explained that there were two separate matters: the community eye service, and SaTH's ophthalmology service. A number of meetings had been held which had discussed the referral pathways initially and there were concerns about harms to patients. Mrs Young had felt it important to have this recorded in the minutes because it had been previously reported at SaTH's Board meeting that there had been concerns about harms which had been checked and were not found. The CCGs had since been notified of some concerns around the CHEC service specifically and those were being looked at as a separate matter.
- 11.43 Dr Povey pointed out that the dataset presented in Appendix 1 appeared to be different to that included in the Performance report and asked if this was due to the timing of the reports; or perhaps the data was from a SaTH point of view rather than from a CCG point of view. Dr Davies said she would double-check this.

**ACTIONS: Mrs Young confirmed that the work on the case reviews had just taken place and a report would be presented to the next meeting.**

**Mrs Young advised that this work was in progress and would form part of the paper on harms which would be presented to the next Quality and Performance Committee meeting, and an update would be provided at the next Governing Body meeting.**

**Dr Davies to confirm the reason for the difference between the two datasets contained in the main report and in Appendix 1.**

- 11.44 ASD and ADHD services – Mr Trenchard gave a verbal report on the ASD and ADHD services and explained that a few years' ago, patients would have been required to go out of county for an assessment but this was not the case now and there were two different models offered in the local system. In Shropshire there was the ASD Hub provided by the Cheshire & Wirral Partnership Trust; and for Telford and Wrekin, the Midlands Partnership Foundation Trust (MPFT) provided a service aligned to the BeeU service.
- 11.45 Currently there were significant waiting lists for both those services with 267 currently identified for Shropshire and 140 for Telford and Wrekin with a number of those cases close to two year waits. Funding had been identified to support a more sustainable model for this but the contractualisation of the model had been paused during the response to the COVID-19 pandemic in April 2020. In addition, as part of the long term plan investment, money had been identified to develop more robust and sustainable ASD pathways but because of the changes in the finance regime, the CCGs had not been able to deliver that work. Conversations were taking place with the providers to ensure that there was a system-wide ASD strategy that would identify the appropriate pathways for assessment and the post-diagnostics support.
- 11.46 A good model was being developed with Telford and Wrekin CCG which was aligned to schools in the form of a panel. It had previously been identified through the intensive support team six months after the BeeU service was established that there were problems with the culture of predominantly an over-medicalisation of tricky behaviours for young people and therefore inappropriate referrals had been to the providers. The panel provides an educational and developmental approach to schools and teachers through a partnership approach of the educational psychologists and with providers, which had shown good results. This work continues as a priority for the system. There was an opportunity to co-produce some of the pathways in a new way taking into account the experiences of young people and their families.
- 11.47 Dr Pepper said that he disagreed with the term 'inappropriate referral' because he was not sure whether any referral was ever totally inappropriate. It may not be that the initial point of referral was the most appropriate but there needed to be a solution to look at what the problem was; how it was best solved and at what speed. Dr Pepper referred to the waiting lists and MPFT reporting on their assessment process; and the trajectory of delivering to a standardised waiting time; and asked if the CCGs had set their expectations to the system on how and when this should be delivered.
- 11.48 Mr Trenchard fully accepted the point about the use of term 'inappropriate referrals'. It was reported that there was on-going work to ensure that the system had a needs-led rather than a criteria-led approach in resolving the mental health service. It was known that people with ASD and anxiety based disorders were

most affected by the pandemic and so it was expected that the number of referrals would increase. Currently there were contractual issues to be resolved and a waiting list initiative may be required. There would also need to be a review of the finances because of the on-going question about whose responsibility it was to fund the ASD and ADHD services. The current position was not acceptable and the CCGs' expectation was to have the long waiting list resolved as quickly as possible because and also the system had committed to resolve this issue as part of its Special Educational Needs and Development (SEND) Written Statement of Action.

- 11.49 Being mindful of the issues around contractual and commercial sensitivity, Mr Vivian sought a better understanding of the on-going conversations with the providers to find a sustainable solution.
- 11.50 Mr Trenchard reported that the providers were very willing to work with the CCGs. The system had providers working predominantly to the Cheshire and Wirral Partnership model that had been highlighted as one of the best practice models. It was believed that the issue was an unfortunate case of not being able to agree a contract because of the COVID-19 finance situation. The providers sought assurance that the CCGs were able to commit to the on-going investment, which was work to be completed, and therefore this was of top priority amongst the many priorities for the CCGs' mental health portfolio.
- 11.51 Ms Cawley had observed from her conversations with the CAMHS manager that it was not just a question of inappropriate referrals but it was known that a number of repeat referrals were received by the CAMHS service when schools and families had not received an answer that they expected. It was thought that there was an issue therefore around the re-referrals which added to the waiting list and took up time when CAMHS were unable to change their diagnosis just because it would be helpful.
- 11.52 Ms Cawley asked whether there was a wider issue with the availability of work with parents on parenting skills with very young children but also behaviour management in schools as a way of making sure that there was no over-medicalisation of poor behaviour and social problems.
- 11.53 Dr Povey referred to previous attempts to solve concerns with the pre-BeeU COMPASS service where there was integrated working with Shropshire Council in Tiers 1 and 2. Dr Povey concurred with Dr Pepper's comment that there were no 'inappropriate referrals' from a patient's point of view and that it was frustrating that CAMHS was reporting back about 'inappropriate referrals'. Patients had worries and the aim was for clinicians to support their patients in making a referral; the system then triaged to the most appropriate person to support them and the patients received support. It was hoped that there was not a return to the previous issue where parents received letters notifying them that their child did not qualify for specialist support, which was considered unacceptable.
- 11.54 Mr Trenchard explained that prior to the COVID-19 pandemic, some system work had been undertaken to consider how best to extend across all services a better understanding of adverse childhood experiences and to help services become more trauma-informed.
- 11.55 There was a challenge for the local system, particularly for young people with ASD with co-morbid mental health difficulties. There had been some long and difficult presentations and admissions into the acute services and into paediatric pathways, some of which had been due to the lack of availability of specialists. It had since become clear that there had been missed opportunities and there was a concern that there may be a trend returning around the notion of inappropriate referrals. The open door approach for all ages was still on-going work. It was difficult because services were so busy but without investment there would be longer waiting lists which was of real concern.
- 11.56 Mr Trenchard confirmed that there were parenting skills available. The investment in the system on the mental health in schools, ensuring that there was much greater access for children, or open to working to be referred into that provision, had been well received and there had been some good evaluation of it.
- 11.57 Mr Timmis referred to a discussion at the Finance and Performance Committee that there was still uncertainty about the basis for the contracts and finance going forward for next year and asked if there was going to be a further delay if the resolution depended on the contract being agreed.
- 11.58 Mr Trenchard confirmed that the investment was part of the finance that Mr Timmis had seen. The detail of how that investment was set against other priorities needed to be worked up given that there was now a better understanding of the pathways this time.
- 11.59 Ms Parker suggested that the approach should not be that a child needed a diagnosis to access help. They needed access to specific pathways if they had a diagnosis but also to ensure that they received the appropriate intervention and family support at an early stage, which linked into Ms Cawley's point about the parenting skills and making sure that the Tiers 1 and 2 and early intervention support was available.

- 11.60 Ms Parker reported that a paper was being taken to Gold Command on establishing a Children's and Young People's Partnership Board, which would be a one system partnership board that would bring the mental health and the physical health elements together and would include: parent and carer groups, Healthwatch, and schools to ensure prevention and easy access to support, and to avoid re-referrals. This would enable a strategic approach to Children and Young People's services because if the service was not planned right the system would fail in the future.
- 11.61 Dr Matthee raised three points: 1) concern about patients who have not been seen and triaged by letter; 2) concern that as a result of the COVID-19 restrictions and the schools lockdown, practices were being told that they could not refer unless it was through the school; and 3) concern that access to support for the early years in schools and their families was difficult with the change of roles of school nurses and health visitors.
- 11.62 Mr Trenchard considered that the Children's and Young People's Partnership Board was really important because there were different models and practices on both sides of the healthcare system and the partnership board would help to improve this. Both local authority directors of children's services were keen to bring the learning together for the most at risk groups, particularly Looked After Children, SEND and those who were out of county who the councils and the CCGs wanted to bring back as quickly as possible. Shropshire Council and Telford and Wrekin Council had recently invested in innovative models to target some of the most at need children that were aligned to two areas of the most deprived schools with the highest number of troubled families. There was therefore a concerted effort to pick up on breaking the cycle of on-going deprivation within families.
- 11.63 Ms Cawley reported that Healthwatch Shropshire had previously carried out a piece of work which had gathered experiences from patients on the Neurology service and suggested that it might be possible to do similar work with the CCGs. Mrs Young and Ms Cawley agreed to meet to further discuss Healthwatch running a Hot Topic on Neurology.
- 11.64 Ms Cawley explained that she had not wished to imply that there were any inappropriate referrals to the CAMHS and ASD services because all referrals were appropriate. Ms Cawley said that she was a member of the safeguarding network team who had made a recent plea for the health visitor and school nurse roles to be maintained and to not divert them into other formats of working so that they could cover the issues discussed around safeguarding children.

***RESOLVE: NHS Shropshire CCG NOTED the content of the Quality and Performance report and the verbal report on the ASD and ADHD services and the actions being taken to address the issues identified.***

***RESOLVE: NHS Telford and Wrekin CCG NOTED the content of the Quality and Performance report and the verbal report on the ASD and ADHD services and the actions being taken to address the issues identified.***

***ACTION: Mrs Young and Ms Cawley to meet to further discuss Healthwatch running a Hot Topic on Neurology.***

#### **Minute No. GB-21-01.011 – Maternity Update**

- 12.1 Dr Povey expressed that the CCGs' and Governing Body Members' thoughts were with the families that had been affected by the issues included in the Ockenden Report.
- 12.2 Mrs Young echoed the sentiments expressed by Dr Povey and thanked the families for contributing, participating and working with the Ockenden Maternity Services Review Team, which had taken a very sensitive approach to the families, which was very humbling and quite uncomfortable reading in parts.
- 12.3 The Maternity Update, previously circulated, which also discussed the Mothers and Babies: Reduce Risks through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report, perinatal mortality surveillance reports and the local neonatal system, was taken as read. The following points from the report were highlighted.
- 12.4 The first section of the Maternity Update, referred to the Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, which was published on 10 December 2020. This concerned the first 250 cases of interest and there were 1,862 cases that the Ockenden office would be reviewing and looking at the role of the regulators and commissioners within that.

- 12.5 The Ockenden Report quite rightly focussed on the perspective of the 250 families affected and would go on through a further report to scrutinise the work of the CCGs and other professional bodies as part of the oversight, regulation and management of quality and safety of maternity services within the local healthcare system. It is very likely that there will be some important actions for the CCGs to address in the report.
- 12.6 The Ockenden Report was welcomed and set out very clearly areas of concern and identified recommendations for all maternity services in England which were being taken forward at the highest nursing level in the country. Each of the provider organisations and their associated commissioners had been written to, to ensure that they have assurance on the 7 immediate and essential actions. There were 12 particular points within those that all providers of maternity services in England had to provide a return to NHSE/I. That work had been undertaken at the end of December 2020 with LMNS input and had been submitted. There was a requirement to provide an update in February and that work was in progress.
- 12.7 In addition to the 7 actions across the country, the Ockenden Report detailed 27 actions for local learning which were specific to SaTH. The themes had been detailed in the report and most were already under consideration and had schemes of work for improvement and some progress had been made on a number of those. Within these the use of Oxytocin had been highlighted as a trend in the Ockenden Report and required more understanding. The detail relating to the 27 Local Actions for Learning will be received to LMNS and CCG.
- 12.8 Within the Ockenden Report it was noted that the Neonatology areas were found to be satisfactory or good and at times excellent, which was positive. However, there were many areas of improvement that were required locally, which were around safety, listening to women and families, staff training, managing complex pregnancies, risk assessment management and foetal well-being, and ensuring that there is informed consent.
- 12.9 The second half of the CCG Maternity Update to the Governing Body discussed the MBRRACE perinatal mortality information published in December 2020, which pertained to the calendar year 2018 data. The information in the tables provided a RAG scoring by CCG against the expected outcomes by 2023. The target was ambitious but showed the current position against where the CCGs needed to be. It was noted that the amber category pertained to data sets that were within 10% each way of the average for the comparator groups.
- 12.10 The data sets per CCG included in the report relate to all mothers registered to GP practices in Telford and Wrekin and Shropshire respectively, regardless of birth location. Data sets contained in the appendix were SaTH specific up until 2017. SaTH's own data was awaited and therefore there was no update available on the 2018 position but this would be included in the reports presented to the Quality and Performance Committee.
- 12.11 Generally the rates of perinatal mortality have reduced year on year and are below the England average, however, the reported rates for Telford and Wrekin are above the England average which may pertain to areas of greater deprivation, which are known to be a risk factor in terms of poorer outcomes for mothers and babies. There are specific schemes of work that are reliant on the maternity transformation programme to deliver in order that outcomes for mothers and babies are improved.
- 12.12 Both the Ockenden and MBRRACE reports refer to the Local Maternity and Neonatal System (LMNS) to take forward schemes of transformation and improvement and there were a number of work streams to do that. The Ockenden Report made reference to the LMNS being a standalone system and makes a recommendation that the system should not have a single provider. Work was on-going to understand how the systems might work differently with the neighbouring LMNS's in order to gain a greater degree of shared learning and oversight, which would be reported to the LMNS. There were schemes of work around continuity of care in particular and progress reports were received from the Trust. This was an area of focus that the CCG was pressing the Trust to move at pace. However, it was clear that the requirement for every staff member to be mobilised to deliver frontline care in response to the COVID-19 pandemic was impacting on the project work and the associated audit work for that.
- 12.13 Mrs McCabe commented that the neonates and infants were often the most vulnerable patient and most critically ill in any trust. Mrs McCabe accepted the point about the Ockenden Report not picking up any specific issues and there was some exemplar care in neonatal care at SaTH. However, the outcomes for neonates in the West Midlands were optimal and particularly because improvement often focussed on maternity care. Sometimes neonatal care could be under the auspices of paediatric services and so there needed to be a joined-up approach. Mrs McCabe also appreciated that the delivery of the national neonatal critical care findings was aimed at improving outcomes for neonates.



- 12.14 Mrs McCabe advised that the national neonatal audit surveillance programme gave more up-to-date information and also included quality metrics on care delivered to neonates and how outcomes for neonates could be optimised.
- 12.15 Dr Povey added that despite the positive report on neonatology there were some local actions around neonatal services also.
- 12.16 Mrs Young reported that the reviews of stillbirths and neonatal incidents was a matter that had been raised with the Trust who provided detailed reports to their internal Maternity Quality and Oversight Committee and was part of their Clinical Negligence Scheme for Trusts (CNST) requirements. Discussions had taken place about how the CCGs could check the robustness of the Trust's self-assessments and a process had been agreed that the CCGs would join the Trust's Board Members to undertake a review. SaTH's Board was required to sign off the CNST and discussions had been held on how they would assure themselves that the data was accurate given the history the Trust had around reports received previously that had been inaccurate in content. The methodology was being worked up but the Trust did have an external review of incidents by a clinician from Walsall. It was considered therefore that there was an oversight and robust review of cases. There would be learning points but it was important to look at the trends and themes.
- 12.17 A further piece of work the Trust had been asked to look at was in relation to a sample of their neonatal mortality reviews to look at any trends and themes over time, re. the process, population, demographics, etc. rather than standalone neonatal mortality reviews.
- 12.18 Dr Pepper highlighted that the MBRRACE report was based on data from 3 years before and noted on page 7, paragraph 21 of the report, the new perinatal quality surveillance model that NHSE/I had highlighted as an urgent action, involving the LMNS, STP and ICS. Dr Pepper asked if this was going to be the means which would offer more real time information and also if there was already a sense of the new perinatal surveillance model being set up.
- 12.19 Mrs Young confirmed that there was work in progress. Guidance which set out some principles had just been received. Mrs Young was revising the quality governance for both maternity and more generally for the system quality governance and the two needed to dovetail to avoid duplication of work and in order to hold the right levels of conversations. Mrs Young believed that detailed discussions around maternity incidents did take place however, the recommendations from the Ockenden Report stated that this needed to go through the LMNS. Mrs Young was currently looking at how the systems could share learning and improvements, which would be reported back to the LMNS.
- 12.20 The Maternity Clinical Quality Review meeting would be reformed to take account of quality and safety. Mrs Young explained that she was now a full member of SaTH's internal Maternal Quality Oversight Committee and would be able to work through where there was duplication; where the level of assurance was, and to put the challenge in and request the group to take certain actions. What needed to come from the Serious Incident Review Group moving forward was an output which reported both to the LMNS and through to the CCGs' quality and performance routes. The LMNS would also receive the detailed datasets around performance as well as the Trust's Maternity Quality Oversight Committee. It was often the sub-group's work around neonatal in particular, and there was a clear neonates work stream that had a strong work programme which the Trust was very much engaged with.
- 12.21 Mrs Noakes asked if there was an update on the work on the maternity hubs in the areas of greatest need and health inequalities.
- 12.22 Mrs Young explained that the work on the maternity hubs had been undertaken some time ago and in order to progress this work it required approval to go out to public consultation. The CCGs were awaiting the national approvals process and it was a matter of on-going attention.
- 12.23 Mrs MacArthur referenced the second recommendation in the report which was how the CCGs would ensure that they had all the appropriate monitoring and oversight of quality improvements. Mrs MacArthur sought an understanding from Mrs Young's perspective what her recommendations were and if she felt that there were sufficient processes in place for the CCGs to gain the appropriate assurance.
- 12.24 Mrs Young explained that in terms of shaping the quality oversight it had been too soon to include recommendations in the report primarily because the documents had been published in December. Discussions were still on-going with the LMNS and discussions with the Welsh system were also required. Mrs Young's intent would be to implement an over-arching governance structure that would be brought back to the LMNS and the Governing Body and shared with the system and neighbouring

providers. It would take some time to develop into a final document not because of the time limits but because of the COVID-19 activity. In the meantime, there was on-going oversight even though it may not be in the format of what the final structure needed to be.

- 12.25 Dr Pringle commented that there appeared to be a lot of process and discussions and asked if there could be a list of objectives, outcomes and timelines so that progress could be measured to enable the Governing Bodies to be fully assured that there would not be another Ockenden Report in the future.
- 12.26 Mrs Young explained that the work of the LMNS and the CCG did overlap in that the progress on transformation was measured and monitored through the LMNS and then was onward reported through to the ICS Shadow Board. The CCG needed to be reviewing the data provided but one of the challenges was that the CCGs did not have a way of checking the datasets SaTH reported because they did tend to change. Mrs Young had previously expressed concern to the Quality and Performance Committee and the Governing Bodies about SaTH's data quality. The Trust was going to implement a new electronic data system, Badgernet, which would provide an electronic maternity record that can be accessed and shared by partners, which was a positive development. The LMNS had now invested in a data analyst resource and a dashboard was being developed by the system, which it was hoped would help in providing robust datasets going forward.
- 12.27 Dr Povey raised a question regarding the MBRRACE data and the combining of the CCGs' data and asked how the CCGs would ensure that when the data was combined it would reflect the difference that was being seen between the different populations. The concern was that once the data was combined with the STP data, the contrast between the two areas would not be visible.
- 12.28 Mrs Young said that this needed to be considered. Once the CCGs become a new single CCG there would be one report and it was important that the CCG would need to understand the information at a more granular level. Mrs Young considered it was important to get place-based reporting functioning well not just for maternity but for all the CCG's clinical commissioning. It was really important with the health inequalities and was the basis of the CCGs' commissioning priorities.
- 12.29 Dr Davies added that there were a lot of areas where the data was combined across the two CCGs which balanced each other and the CCGs would be keen to retain the place-based variation because this was really critical to the local populations.

***RESOLVE: NHS Shropshire CCG NOTED the contents of the report and DISCUSSED how the CCGs can ensure appropriate monitoring and oversight of quality improvement activity.***

***RESOLVE: NHS Telford and Wrekin CCG NOTED the contents of the report and DISCUSSED how the CCGs can ensure appropriate monitoring and oversight of quality improvement activity.***

## **FINANCE**

### **Minute No. GB-21-01.012 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Finance and Contracting Report including Quality, Innovation, Productivity and Prevention (QIPP) schemes**

- 13.1 Mrs Skidmore presented the combined Finance and Contracting report for the period up to the end of the Month 8 position, which was taken as read. The following key headlines were focussed upon:
- 13.2 The finance regime this year had been particularly challenging and, as nationally, the CCGs had been developing the financial modelling during the year. For the period Months 1-6 the CCGs had been given sufficient budget to break even their position, however, locally the CCGs had not been able to achieve this. A plan had been submitted in October that showed a deficit of £15.4m across the two CCGs but had not yet been signed off by NHSE/I who were encouraging the CCGs to review their forecasts to try and refine the position to get as close to the break even position as they could.
- 13.3 The forecast spend position of the two CCGs is £881.8m. When the CCGs had produced this position at Month 8, a lot of work had been carried out on the areas of the forecast that the CCGs were able to refine outside of the block arrangements with the trusts and were able to reduce the initial deficit the CCGs had been given. The £881.8m spend compared to the plan delivers a deficit of just under £11m, which equated to approximately £6m deficit for Shropshire CCG and approximately £4m deficit for Telford and Wrekin CCG. This did exceed the requirement to achieve a break even position but was an improvement.
- 13.4 The reasons that the CCGs had been able to refine the adjustment to the initial assessment included:

- Prescribing forecasts were refined on the basis that more data was received from the Prescription Pricing Authority which offered more confidence to the CCGs on the spend trajectories.
- Refinements to the individual commissioning forecasts and ensuring that the information captured for the packages of care for patients on the Broadcare system was correct, which had given the CCGs more confidence in reassessing their finance position;
- There was also an estimated call against the system COVID-19 reserve for the remainder of the financial year. By working with the Primary Care Team and other areas, the CCGs had been able to refine their estimates and pay back some monies to the system pot.

13.5 It was also important to note that the current forecast position did not include a recently notified reduction to the primary care fair shares allocation. The CCGs had been expecting to receive £2.4m that had been previously notified but had only received £1.3m. The original £2.4m had been committed with primary care providers and therefore the late reduction in allocation was a significant risk. This change had been a national change to the allocation that the CCGs were not able to influence and was currently being worked through and discussed with NHSE/I.

13.6 The QIPP programme had been an extensive programme and a lot of the work has had to be placed on hold because of the pandemic response. Mrs Skidmore had been pleased to report, however, that the CCGs were on target to deliver approximately £6m worth of efficiencies through predominantly the prescribing and individual commissioning teams, which was to be commended given the pressures that the teams faced. Focus on grip and control was being maintained and some good results were being seen through the reports from those teams.

13.7 The planning guidance nationally had slipped significantly and without operating planning guidance and financial guidance it was hard for the CCGs to set a budget. Focus at present was on making sure that there was a solid description of the on-going spend as the CCGs moved into the next financial year. Estimates were being made on what the allocations might be but until the final notification was received this position was unclear.

**RESOLVE: NHS Shropshire CCG NOTED the information contained in the financial report.**

**RESOLVE: NHS Telford and Wrekin CCG NOTED the information contained in the financial report.**

#### **Minute No. GB-21-01.013 – COVID-19 Update**

14.1 Mrs Tilley presented a verbal update on the current position of the response to the COVID-19 pandemic. There had been sharp increases in prevalence rates in the lead up to and since Christmas with some of the largest daily increases in reported cases seen during the pandemic. There had been some recent fluctuations in the rates but it was too early to call this a plateauing or downward trend. It was hoped the rates would decrease as a result of the lockdown measures that have been taken.

14.2 The increase in prevalence rates was being tracked through to increases in hospital admissions and increases in death rates, which was creating pressures in the acute trust. Mrs Tilley emphasised the messaging for staff and the public to follow the COVID-19 hand hygiene and social distancing guidelines.

14.3 There has been a national request to increase the critical care capacity which was being enacted across the local health system. This required some difficult decisions about scaling back certain services and to release staff to support the critical services the system would be providing.

14.4 The public and staff were being encouraged to access swab testing at the earliest sign of symptoms and the uptake had been good. Lateral flow testing continued to be utilised with front line staff across health and social care, which had provided some benefit. Staff absence rates had increased across all providers, which was being monitored, but was adding to the pressure in the system.

14.5 The COVID-19 vaccination programme is the most significant vaccination programme in the history of the NHS with many complex and logistical issues as part of the roll out. The programme commenced on 8 December 2020 utilising the Pfizer vaccine. There have been limits on the numbers that can be vaccinated because of the way it can be administered but all vaccines that have come into the county have been utilised.

14.6 Vaccination sites have been set up at the conference centre at RSH, via the South East Shropshire PCN in Bridgnorth, via the PCN in Telford and a further hospital hub has commenced at RJA. Further sites are due to come online, which are subject to stringent NHSE/I assurance processes.

- 14.7 There is a large scale recruitment programme aligned to the vaccination programme with a requirement for 600 staff for Shropshire, Telford and Wrekin to deliver the programme as set out by the Government.
- 14.8 There is a huge communications task associated with the programme with some challenges. Key messages were being communicated and capacity for comms for this programme would be increased.
- 14.9 Agencies were being inundated with enquiries from individuals, members of the public and organisations about when they would be able to access the vaccine. It was stressed that the cohort schedule as set out by the Joint Committee on Vaccinations and Immunisation (JCVI) and NHSE/I was being followed. Some enquiries received had been confrontational, which was difficult for staff to manage. Members of the public were asked to be patient and would be invited to attend when it is their turn to access the vaccine but it would take a considerable amount of time to work through everyone. Staff were working around the clock to ensure that the programme is rolled out across the county as quickly as possible.
- 14.10 There are three strands to the vaccination programme: the local rollout; the seven mass vaccination sites across the country; and a third stream operating from pharmacies. A pharmacy vaccination service was commencing in Woodside, Telford. The latter two strands were nationally commissioned services and were not part of the local provision and booking for those services would be via the national system.
- 14.11 Mrs MacArthur enquired as to the impact on primary care during this second wave. It was known that particularly during the first wave patients who should have been presenting to general practice had not been and Mrs MacArthur sought an understanding of the current position during this second wave and whether there had been any messaging about this.
- 14.12 Dr Povey reported that NHSE/I had written to practices about pausing work on the QOF requirements and around appraisals but had asked the practices also to maintain the level of activity on emergencies, long term conditions and the elderly health checks. It was too early to see the full impact to practices but they were keen to carry out activities as normal and to be part of local partnerships to deliver vaccines.
- 14.13 Dr Pepper declared a conflict of interest in that he had a first degree relative who received haemodialysis treatment on a regular basis. Dr Pepper asked if there was any current provision for the over-80s patients, and in particular, for those who were attending hospital appointments for on-going treatment and therefore potentially increased their nosocomial infection risks.
- 14.14 Dr Povey reported that this question had been raised on a national call with the Chief Medical Officers, Chief Executive of NHSE/I, and the Chair of JCVI in attendance, whose message was that although there were groups within the cohorts that would benefit from the vaccination, the priority levels needed to be followed, which were currently those patients in cohort vaccination groups 1 and 2, therefore did not include sub-stratification of people within those groups who may or may not be at different levels of risk.
- 14.15 Mrs Bryceland commented that feedback she had received from those sites she had attended had found the vaccination process to be excellent and very slick. Mrs Bryceland also reported that the GPs were receiving letters from patients requesting to be placed in the higher risk groups which was taking time to review and reply to. Mrs Bryceland suggested that this was an issue about what information could be conveyed to the public who needed to understand that there was a plan to vaccinate the population.
- 14.16 Dr Povey acknowledged this point and suggested that if patients wished to change from the at risk groups to the clinical extreme vulnerable groups they should meet the shielding requirement and should have received a letter stating this. People needed to be encouraged that they were either in the at risk of flu group 6, unless their age was a factor or they were shielding and then they were in group 4.
- 14.17 Mr Ahmed asked if consideration had been given to those people from the Black, Asian and Minority Ethnic (BAME) group who were disproportionately affected and vulnerable to contracting COVID-19.
- 14.18 Dr Povey confirmed that although there were groups within those sub groups that were more at risk, the biggest risk was age and the current national approach was to adhere to the targeted groups and to vaccinate people in care home and the over-80s age group.
- 14.19 Mr Vivian highlighted that it could not always be assumed that everyone will have seen a communication and had absorbed the information and therefore repetition was always very helpful. Mr Vivian also sought clarification of how people were going to be invited to attend for their COVID-19 vaccination. It was confirmed that letters would be sent from the national team and also practices may contact patients directly to advise on what appointment were available locally.

- 14.20 Dr Matthee reported that he had received his first vaccination but had also received a letter inviting him to have the vaccine and therefore there was some duplication, which was understandable in the present circumstances. Particularly with regard to patients in nursing homes and the preparation of the vaccine, Dr Matthee asked if the vaccines supplied presently were all Pfizer vaccines.
- 14.21 Mrs Tilley advised that Shropshire did have supplies of the AstraZeneca vaccine but had not received in the quantities expected but the supply for this vaccine was in its early stages. An increase in supplies was expected and there would be more vaccination sites coming online in the next few weeks. It was therefore hoped that the programme would be expanded significantly because the AstraZeneca vaccine was more stable than the Pfizer vaccine.
- 14.22 Dr Matthee voiced concern that as more vaccination sites opened practices might lose staff who would go to work in the larger centres. The rollout of the programme was good news but it was pointed that there was still the need to staff it.
- 14.23 Dr Povey said that GPs would like the vaccinations administered from their practices but there was a government directive for this to be carried out via the PCNs. Discussions continued with the regional team to expand delivery of the vaccine to smaller sites, however, a further message from the national call was that the biggest issue was the constraint on vaccine delivery, which was expected to improve.
- 14.24 Regarding the COVID-19 vaccination, Telford and Wrekin Public Health had been inundated with enquiries also and Mrs Noakes reiterated the point that there needed to be far more proactive communications with the public. Messages had been sent out asking the public not to contact their GP or the NHS when in fact the messages should have stated that patients had not been forgotten and they would be contacted when their vaccine was available. There should be a collective efficient response to those enquiries but also to inspire confidence with the public, residents, patients and stakeholders.
- 14.25 Mrs Noakes reported that Telford and Wrekin had now breached 1,000 cases in one week and so were now at a rate of 555 per 100,000 population. The rate of increase had slowed slightly in the all age group. However, in the over 60s age group this continued at pace and in the last 7 days had doubled and now stood at 404 per 100,000 population, which was a real concern. In terms of 7 day infection rates, Telford and Wrekin was now the 6<sup>th</sup> highest area in the West Midlands. Public Health Telford and Wrekin had been very strong in their communications promoting the 'Stay at Home' and 'Protect the NHS' message; testing and the immunisation programme. It was also estimated that over half of confirmed cases were probably the new variant of COVID-19.
- 14.26 Mrs Robinson concurred with Mrs Noakes' comments about the importance of communicating more with the public. Shropshire Public Health had also been inundated about the positioning of vaccination centres and where people sat with their priorities.
- 14.27 Shropshire's prevalence rates were also disappointing. On 27 December 2020, Shropshire's had been approximately 100 a day and now it was 472 and therefore had risen from a peak in November of 150 cases a day to 300 cases a day. The reason for the increase was thought to be the new variant with the public mixing over the Christmas period. There was a particular concern about Shropshire's care homes where a rapid spread had been seen and outbreaks seen in workplaces where people returned to work following the Christmas holidays.
- 14.28 There needed to be a real drive on the messaging, particularly around testing, and both Public Health Shropshire and Public Health Telford and Wrekin were working to support the key workers and those who cannot stay at home to get lateral flow testing in their communities, which had been well received. There was also a really good uptake of home testing in Shropshire with over 40% tests carried out at home.
- 14.29 Public Health Shropshire was working hard on getting messages out to the public around support for mental health and welfare which both councils had a significant offer around as well as the wider system.
- 14.30 Further to Dr Matthee's earlier comment, Dr Pringle reported that he had also received two invitations to receive the vaccine, one through Malinslee Medical Practice where he had received his vaccination and one through the central staff vaccination programme.
- 14.31 Dr Pringle also highlighted that his practice had co-located dentists, community staff and hospital staff on its list who would be eligible to vaccinate. At present, it was understood that the practice could only vaccinate their own patients and staff, which meant that patients on their list who were in category group 2 but who were working for other organisations were required to travel to a different site. As the programme rolled out further afield there would be lots of people who could be vaccinated at a local centre but potentially would be required to travel to a different centre. Dr Pringle suggested that the

guidance should be changed to enable those patients who were registered with practices and who qualified, and staff, could be vaccinated at practice-based hubs or at hospital-based hubs.

**RESOLVE: NHS Shropshire CCG noted the content contained in the verbal report.**

**RESOLVE: NHS Telford and Wrekin CCG noted the content contained in the verbal report.**

**Minute No. GB-21-01.014 – Update on Phase 3 Restoration and Recovery with validated October position and unvalidated November position**

- 15.1 Dr Davies and Mr Trenchard presented the report previously circulated, which was taken as read. The next two items would be presented together because the work covered was closely linked.
- 15.2 Dr Davies referred to the two questions raised earlier by Dr Povey around the work carried out by the Nuffield Hospital and that seeing 20 cases per week seemed low and explained the context. In the initial wave of the COVID-19 pandemic, the private sector capacity gave access to 20 theatre sessions per week. Following the revised national negotiations in the second half of the pandemic last year, that number had decreased to 10 sessions. The CCGs were currently in the process of negotiating more sessions to try to get back to the 20 sessions and had received support from NHSE/I to do that. There was also the option of seeking support from NHSE/I for further surgical capacity if required.
- 15.3 Owing to the nature of the cases approximately 20-25 patients were being treated on those 10 sessions. The CCG was working with SaTH and the Nuffield Hospital to improve the systems and processes to return the utilisation to between 80%- 85% which was above the national average.
- 15.4 Further to Dr Povey's earlier question about whether the 100% restoration of the services that provided gastroscopies and colonoscopies would be sufficient to clear the backlog of appointments, Dr Davies reported that the recovery on the Radiology service had been encouraging. Unfortunately the Endoscopy service continued to be a challenge because of workforce issues and the complexity of some procedures being aerosol generated, and the present pressure to expand the critical care capacity. The three Endoscopy treatment rooms located on each hospital site would be decreased to two on each site to enable SaTH to free up the critical care support.
- 15.5 Significant work would be required as part of what would become the Phase 4 recovery on Endoscopy because of the staffing limitations. At present, there were queries about the future of screening programmes, particularly bowel screening, and the changes going forwards. This work was awaiting further guidance before planning accordingly for those services.
- 15.6 As a result of the current pressures, the waiting times, and in particular the over 52 week waits, the position would continue to deteriorate. While the regional piece of work on elective recovery had been paused, the Governing Bodies were assured that the CCGs were doing all that they could to continue with the planning in the background until the pandemic pressures eased and SaTH were able to get back to the elective recovery as soon as possible.
- 15.7 Dr Shepherd referred to the data on Outpatients and said that she pleased to see that SaTH had been doing well, particularly on their follow-up appointments, and had started to implement other forms of follow-ups, including patient initiated follow-ups. It was noted that RJAH was not doing as well with their follow-up appointments and Dr Shepherd asked if there were any steps being taken to try to improve this.
- 15.8 Dr Davies acknowledged that historically the numbers of follow-up appointments at RJAH had been challenging. While SaTH had been one of the lead sites for the patient-initiated follow-ups, RJAH was also planning work on this and there was an intention to link those so that any lessons learned from the initial work that had been undertaken at SaTH could be shared with RJAH.
- 15.9 Dr Povey raised a query about MRI and CT capacity because it had been noted that SaTH's mitigation around Radiology was the transfer of CT and MRI scans to RJAH. Dr Povey asked how SaTH could be transferring work to RJAH when it was struggling to deliver on its own plan.
- 15.10 Dr Davies explained that the mutual aid was purely around the very urgent and cancer referrals. The main recovery for SaTH was because they had extended the loan of two additional MRI scanners for a further 3 months and were currently working on the business cases to do the same for CT scanners. SaTH would also have one of the national diagnostic pods that had additional CT and MRI scanners going forward. Regarding the longer term contingency of clearing the routine backlog, SaTH would be in a better position. Some image transfer issues with the Nuffield Hospital had been solved, which now meant that they could offer MRI capacity there.

- 15.11 Dr Davies confirmed that on page 5 of the report it should read that the Medical Director would review the session usage and case mix complexity and not the Clinical Chair.
- 15.12 Dr Povey acknowledged that it was hard to have a Phase 3 restore and recovery during a second wave of COVID-19, which would have an impact on the system. Mr Evans had already reported that RJAH had suspended surgery and with SaTH expanding its ITU capacity to up to 200%, this would have a knock-on effect on services. Dr Povey asked if there needed to be more open communications to patients because primary care had been receiving a lot of enquiries from patients about the current service provision.
- 15.13 Dr Davies agreed that it was difficult. The focus during the last week had been on the pressure around critical care. Mr Evans had particularly championed, through Gold Command, the request from the providers to help with that communication to patients. It was felt that discussions were required to use the capacity within the providers in terms of the booking staff to improve the communication and support the expectations of patients and the public
- 15.14 Dr Povey noted that there was a mismatch in the report which stated that some services had been restored when it was known that there was very little activity and asked if there was any clearer clarification on the services that were restored and partially restored.
- 15.15 Mr Trenchard explained that the report summarised the feedback received from the providers on a monthly basis. One of the key areas going forward, which would be tracked through Dr Davies' work, would be the on-going of services that might be stepped down again. A slightly different approach might be required going forward and it had been raised with NHSE/I whether this particular approach continued to be useful given the additional information that was being received and this would be kept under review.

**RESOLVE: NHS Shropshire CCG Governing Body:**

- ***NOTED the content of the summary report and presentation with regard to the STW systems Phase 3 recovery to date and the planned levels of recovery during Q4.***
- ***TOOK limited assurance on the delivery of some of the Phase 3 targets and that the system is working on further mitigation to improve the position with regard to OP and diagnostics at RJAH and the elective and new outpatient recovery for SaTH. Monthly updates on this will be taken to the Joint Strategic Commissioning Committee.***
- ***NOTED the submission of the NHSE/I return as at 4 January 2021.***
- ***NOTED the themes emerging from the three month review of restored services including the planned system performance meeting to triangulate all information and ensure data accuracy.***

**RESOLVE: NHS Telford and Wrekin CCG Governing Body:**

- ***NOTED the content of the summary report and presentation with regard to the STW systems Phase 3 recovery to date and the planned levels of recovery during Q4.***
- ***TOOK limited assurance on the delivery of some of the Phase 3 targets and that the system is working on further mitigation to improve the position with regard to OP and diagnostics at RJAH and the elective and new outpatient recovery for SaTH. Monthly updates on this will be taken to the Joint Strategic Commissioning Committee.***
- ***NOTED the submission of the NHSE/I return as at 4 January 2021.***
- ***NOTED the themes emerging from the three month review of restored services including the planned system performance meeting to triangulate all information and ensure data accuracy.***

**Minute No. GB-21-01.015 – Update on Shropshire, Telford and Wrekin System Restoration from COVID-19**

16.1 Please note the verbal update on this item was included in the minutes of the previous discussion above.

**Minute No. GB-21-01.016 – Digital Update**

- 17.1 Dr James talked through the Digital Update, using PowerPoint presentation slides, a copy of which had been previously circulated.
- 17.2 It was explained that all systems had been asked to think digital/virtual first and therefore the main point in the STW STP strategy was for Digital Health to be an enabler for the best possible care for patients. The main areas highlighted were grouped under the following headings: Key Achievements 2020; work for the next 12 months; the Wider System: ICS; and the Next Steps, which were:

- Move to a single commissioning organisation and make changes to the management/oversight of IMT including a review and refresh of CCG governance. Provide support to the transition process including any moves to physical location, development of agile working agenda and transition of IT contracts;
  - Development of a CCG IT strategy and operational plan (including relevant financial plan);
  - Forge stronger links with the system digital programme to ensure that the CCG is an active participant and that digital is prominent as a system priority.
- 17.3 Mr Vivian referred to the digital use of the ReSPECT form and the mention that it was widely used and asked if Dr James could provide more detail on this. Mr Vivian also wished to double-check whether the new shared record system provided by CareCentric would support the case management recently trialled.
- 17.4 Dr James' understanding from the feedback received from staff who were viewing the summary care record on a regular basis, including those in the community hospitals, was that it was widely available.
- 17.5 Dr James assured Mr Vivian that there was a module within the CareCentric system that specifically supported care coordination. Dr James would need to double-check that the CCGs had contracted for the full package of modules but certainly the CCGs were joining Staffordshire as part of their model instance of CareCentric and they did have access to all the modules.
- 17.6 Dr Povey asked about the monitoring of the CareCentric roll out and reported that nationally there had been an issue the day before when it had not been possible to use both the phones and the computers in the practice at the same time as there had not been sufficient bandwidth. Dr Povey asked if it was known whether there was any improvement in bandwidth following the transfer from N3 to the Health and Social Care Network (HSCN) system and whether there had been any feedback received from practices.
- 17.7 Dr James explained that the speeds were being monitored. There had been initial problems experienced by some practices with a reduction in speeds as the system moved to HSCN but part of the problem was a contractual issue. Mrs Skidmore would ask the IT Team to raise with the contractor at their weekly meeting the question regarding the bandwidth speeds.
- 17.8 Dr Povey thanked Dr James for the update and acknowledged that the work undertaken over the last 12 months had been significant. In terms of the ICS plan, it was known that SaTH had a number of high risks around their IT systems and they needed to have their IT systems up to date to enable the system to work, Dr Povey asked if there was any further information available about this.
- 17.9 Dr James said that a lot of work was being carried out on SaTH's IT systems. The integrated care record would go live over the next few months. The system would need to wait for SaTH to join the digital system at a time when they had implemented the new administration system and patient record system. SaTH had had targets to have their systems in place in the EDs and in the hospital but unfortunately these had been delayed. Their target of implementing the patient and administration system later this year would also be affected as a result of the pressures of the COVID-19 pandemic.
- 17.10 A brief discussion took place on the digital ReSPECT form, which was an EMIS template form that populated the demographic details of the patient, to which could be added notes of discussions with the patient. Dr James advised that a communication had been previously circulated to practices about the use of the form and would arrange to have this communication recirculated to practices, for information.
- 17.11 Dr Pringle commented that it was one thing to have the form in digital format but unless the ambulance service could view it, it would not be serving its purpose. Dr James confirmed that the ambulance service should be able to view the document through the summary care record with additional information, through GP Connect, and copies could be printed also and given to the patient.
- 17.12 Mrs Skidmore reported that she was looking to strengthen the governance generally around IT and also to raise the profile of the work across the two CCGs. The governance would include reporting to the executive team to see and agree developments and a quarterly update would be provided to the Governing Bodies.

**RESOLVE: NHS Shropshire CCG Governing Body Members NOTED the content of the Digital update, SUPPORTED the next steps, and AGREED to receive a Digital update on a quarterly basis.**

**RESOLVE: NHS Telford and Wrekin CCG Governing Body Members NOTED the content of the Digital update; SUPPORTED the next steps; and AGREED to receive a Digital update on a quarterly basis.**



**ACTIONS:** Dr James to double-check whether the case management will be supported by the new shared record system.

Dr James to arrange to have the information on the digitised ReSPECT form re-circulated to practices, for information.

Mrs Skidmore to request the IT Team to raise with the contractor at their weekly meeting the question regarding bandwidth speeds.

Dr James to present a Digital Update report to the Governing Body meetings on a quarterly basis.

Digital Update Report to be included on the Governing Body meeting May agenda.

#### **Minute No. GB-21-01.017 – Update on System Improvement Plan**

- 18.1 Mr Evans presented the Update on the System Improvement Plan previously circulated, which was part of the system response to assisting SaTH in the CQC challenges. Mr Evans explained that the document was purely an update on the current position and invited questions.
- 18.2 Dr Povey referred to the training of 100 Trauma Risk Management (TRiM) practitioners and noted that in the report it was marked green. Dr Povey asked if there was an update on the process and asked if the support was available for primary care staff who were presently under pressure and stress.
- 18.3 Mr Trenchard confirmed that there had been additional slippage monies from NHSE/I for key psychological and health and well-being support for all health and care staff. The green rating in the report indicated that the next cohort of practitioners was being trained to be trauma informed and were aligned to coaches. There was live website where staff could access those coaches and Mr Trenchard would arrange for the link to be included in the next Primary Care Newsletter.
- 18.4 Dr Povey referred to the heading 'Growing our local workforce' on page 8 of the report where it stated that there would be a 'total increase of 308 wte workforce of which 307 wte is substantive workforce' and asked what impact the international COVID-19 travel restrictions were having on international recruitment.
- 18.5 Mr Evans confirmed that the travel restrictions internationally had had an impact on recruitment. The reason that this measure was categorised as green indicated that the recruitment had taken place but the staff had not yet arrived in the UK. A significant cohort had arrived before the lockdown last year and some in the intervening period but much of that recruitment had ceased currently.

**RESOLVE: NHS Shropshire CCG NOTED the content and changes in the System Improvement Plan.**

**RESOLVE: NHS Telford and Wrekin CCG NOTED the content and changes in the System Improvement Plan.**

**ACTION: Mr Trenchard to arrange to include in the Primary Care Newsletter the link to further information on psychological health and well-being support for staff.**

#### **Minute No. GB-21-01.018 – SEND Inspection Report and Written Statement of Action (WOSA)**

- 19.1 Ms Parker presented the SEND Inspection Report and WOSA previously circulated, which was taken as read. It was explained that the report was presented for completeness because the final document had not been available for the last meeting but had since been published on the CCGs' websites. An action from the last meeting was to provide a comprehensive update to the Governing Body meeting in May.
- 19.2 Dr Povey queried the last line of page 8 of the report where it stated that the CCGs' Governing Bodies reported directly into the STP Board, which was not a statutory body. Ms Parker apologised for this error and would arrange for this to be amended outside of the meeting.
- 19.3 Dr Pepper commented that it was good that one of the ambitions was for 100% of children referred into the neuro developmental pathway were seen within 18 weeks by April 2022. It was also stated that prior to that the increase in the percentage of children who were assessed for ASD and ADHD in Shropshire was in the 'with the average by our statistical neighbours by July 2021'. Dr Pepper thought that the targets appeared ambitious considering the waiting times and asked how confident Ms Parker was for Shropshire to achieve those targets.

- 19.4 Ms Parker explained that there had been a lot of input from NHSE/I and Ofsted around what the national targets were and Ms Parker thought that it was right that those targets should be included in the WSOA. The governance had been set up to enable that accountability. There was now a better system to look at the ambitious targets, risks and to enable mitigation to those risks. Ms Parker felt that at this stage the targets were achievable because there was a partnership approach now that involved all stakeholders.

**RESOLVE: NHS Shropshire CCG NOTED the update presented as information on progress.**

**RESOLVE: NHS Telford and Wrekin CCG NOTED the update presented as information on progress.**

**ACTION: Ms Parker to amend the statement included on page 8 of the report which incorrectly states that the CCG Governing Bodies report directly into the STP Board.**

**Ms Parker to present an update on SEND to the Governing Body's meeting in May.**

#### **Minute No. GB-21-01.019 – Integrated Urgent Care Implementation Review Final report**

- 20.1 Ms Parker presented the report on the implementation of the integrated urgent care procurement, which it was explained was the 6 month review element.
- 20.2 Ms Parker reported that a meeting had taken place with SCHAT and Shropdoc to review the report and an update had been included in the cover sheet of the report presented. There had been agreement that the implementation phase was now complete. It was important to recognise that the CCGs should have engaged more with the public on the procurement of the integrated urgent care service but equally the CCGs needed to be realistic about what workforce and finances were available going forward.
- 20.3 Mr Vivian noted that the paper stated that, as a result of the integrated urgent care procurement, the CCGs had a close relationship with their statutory partners. Mr Vivian explained that what had underpinned the whole process was a very poor relationship with Shropshire's patients and public around the engagement and the procurement for this service. From reading the paper, it did not feel that very much had been done to improve the CCGs' relationship with the public in this context. Mr Vivian asked what actions were going to be taken for the next procurement exercise to ensure that engagement with the public was well planned beforehand.
- 20.4 Ms Parker confirmed that one of the agreements had been that the engagement process would be started now on the back of the implementation report and that for the next procurement there would be a much stronger engagement and consultation process than previously.
- 20.5 Mrs Skidmore said that one of the assurances was that the engagement for the procurement would now be part of the cycle of discussions with the public before a formal procurement process takes place. The providers had signed up to a commitment that would help this process and therefore would not involve the traditional formal dialogue, which would make it much more meaningful and effective because it would be carried out in partnership with the providers.
- 20.6 Mr Vivian asked if the CCGs could commence early engagement with the public in the planning of the integrated urgent care service well in advance of the next procurement process.
- 20.7 Ms Cawley reported that Healthwatch Shropshire and Healthwatch Telford and Wrekin had conducted a survey on patients' experiences of accessing palliative care and the palliative care helpline that had been provided by Shropdoc. The report was currently being drafted and a request had been made for a CCG response to that report before it was published. A 3-month survey on accelerated discharge and the discharge hub had also just closed and a report would be drafted on this in the next two weeks.

**RESOLVE: NHS Shropshire CCG APPROVED the final report and the end of the implementation phase and NOTED the position about patient engagement moving forward particularly for the out of hours service.**

**RESOLVE: NHS Telford and Wrekin CCG APPROVED the final report and the end of the implementation phase and NOTED the position about patient engagement moving forward particularly for the out of hours service.**

**ACTION: Ms Parker to confirm whether the palliative care service is commissioned by SaTH or the CCGs.**

**Minute No. GB-21-01.020 – Appointments to the NHS Shropshire CCG and NHS Telford and Wrekin CCG Governing Bodies**

21.1 Ms Smith presented the paper previously circulated on the Appointments to NHS Shropshire CCG and NHS Telford and Wrekin CCG Governing Bodies, which was taken as read.

21.2 On behalf of the Governing Bodies, Dr Povey welcomed and congratulated Mrs MacArthur and Mr Braden on their appointments.

**RESOLVE: NHS Shropshire CCG Governing Body:**

- ***NOTED the recent joint appointment to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG and to the new single CCG, which will be created in April 2021, of Mrs Donna MacArthur as the new Lay Member for Primary Care; and***
- ***NOTED the appointment of Mr Geoff Braden as the Lay Member for Governance to the new single CCG, which will be created in April 2021.***

**RESOLVE: NHS Telford and Wrekin CCG Governing Body:**

- ***NOTED the recent joint appointment to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG and to the new single CCG, which will be created in April 2021, of Mrs Donna MacArthur as the new Lay Member for Primary Care; and***
- ***NOTED the appointment of Mr Geoff Braden as the Lay Member for Governance to the new single CCG, which will be created in April 2021.***

**OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY**

22.1 The following reports from the Chairs of the Governing Body Committees were received and noted for information only:

**NHS Shropshire CCG and NHS Telford and Wrekin CCG Joint reports:  
Minute Nos. GB-21-01.021 to GB-21-01.025**

Audit Committees in Common – 18 November 2020  
Joint Strategic Commissioning Committee – 18 November 2020  
Finance & Performance Committees in Common – 25 November 2020  
Quality & Performance Committees in Common – 25 November 2020, 23 December 2020  
Primary Care Commissioning Committees in Common – 2 December 2020

**For: NHS Shropshire CCG Only:  
Minute Nos. GB-2020-01.026 to GB-2020-01.028**

South Shropshire Locality Forum – 5 November 2020  
Shrewsbury and Atcham Locality Forum – 19 November 2020  
North Shropshire Locality Forum – 26 November 2020

**For: NHS Telford and Wrekin CCG Only:  
Minute No. GB-21-01.029**

Telford and Wrekin CCG Practice Forum – 17 November 2020

***RESOLVE: NHS Shropshire CCG Governing Body RECEIVED and NOTED for information the Committee Chairs' reports as presented above.***

***RESOLVE: NHS Telford and Wrekin CCG Governing Body RECEIVED and NOTED for information the Committee Chairs' reports as presented above.***

***ACTION: Ms Parker and Miss Smith to review the format of the reports received from the Committees Chairs of the Locality Forums so that they are aligned.***

**Minute No. GB-21-01.030 – Any Other Business**

23.1 There were no further items raised.

**DATE OF NEXT MEETING**

It was confirmed that the date of the next scheduled Governing Body Part 1 meeting is: Wednesday 10 March 2021 – time, venue and modality of the meeting to be confirmed nearer the time.

Dr Povey officially closed the meeting at 1.00pm.

**SIGNED** ..... **DATE** .....

DRAFT

**Shropshire Clinical Commissioning Group (SCCG) and Telford and Wrekin CCG (TWCCG)**  
**ACTIONS FROM THE GOVERNING BODY PART 1 MEETINGS IN COMMON – 13 JANUARY 2021**

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
<b>GB-21-01.004 – Accountable Officer’s Report</b>	Mr Evans to arrange for a copy of the draft ICS application to be circulated to Members for information.  Mr Evans to double-check whether the draft ICS application can be published in the public domain.  Mr Evans to update Governing Body Members on the ICS application and the outcome following the regional and national panel meetings.	Mr David Evans  Mr David Evans  Mr David Evans		
<b>GB-21-01.005 – Minutes of the Previous Meeting – 11 November 2020</b>	Mrs Stackhouse to action the two amendments to the draft minutes as noted in paragraph 6.1.	Mrs Sandra Stackhouse		Complete
<b>GB-21-01.006 – Matters Arising</b> <i>[b/f GB-20-01-010 – Shropshire CCG Strategic Priorities]</i>	Dr Davies to share the data on the ambulance crew on-scene timings with Members when received. [Updates provided by Dr Davies: 09.09.20 Information has been requested to include data from April, which was expected to be received for presentation at the next meeting. 11.11.20 WMAS have still not provided the data requested – this has been escalated to the Regional Commissioner]	Dr Julie Davies / Mr Steve Trenchard	Next meeting	This data has now been received and the CCG BI team are currently analysing it. Verbal update on findings to be given at the meeting
<i>b/f GB-20-07.084 – [Update on SEND Inspection Report]</i>	The Executive Team to agree a process for providing the Governing Body with assurance around SEND.	Ms Claire Parker	May meeting	Quarterly update to report – monthly updates to QPP - next report in May with presentation on progress - Complete

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
<i>b/f GB-20-11.123 –</i> [Quality and Performance Report]	Mrs Young to bring back findings from the Niche consultancy report into the SI processes at SaTH and the system deaths analysis.	Mrs Zena Young	April/May meeting	The Niche report is delayed due to COVID-19 activity impacting on staff availability.
<i>b/f GB-20-11.126 –</i> [Update on Shropshire, Telford & Wrekin System Restoration from COVID-19]	Mr Trenchard to present a short written update report for future meetings.	Mr Steve Trenchard	Next and Future meetings	March meeting - combined in COVID-19 Update with Mrs Tilley and Dr Davies verbal updates.
<i>b/f GB-20-11.127 –</i> [NHS Patient Safety Specialist]	Mrs Young to look into Healthwatch Shropshire and Healthwatch Telford and Wrekin involvement in the System Oversight Group and to discuss directly with the Healthwatch representatives.	Mrs Zena Young		This is a new and evolving meeting. Current membership will be maintained. This request will be reconsidered when the new system oversight arrangements are implemented - Complete.
	Mrs Young to provide an update on progress during Quarter 4 at the March 2021 Governing Body meetings.	Mrs Zena Young		Included on March Part 1 meeting agenda - Complete
<b>GB-21-01.010 – Performance and Quality Report Performance</b>	Mr Evans to raise the Governing Bodies' concerns about the Breast cancer performance direct with Louise Barnett, Chief Executive of SaTH.	Mr David Evans		Complete
	Dr Davies to update Governing Body on the timeline for the Breast cancer estates work when received. [Update forwarded to the Governing Bodies on 26.01.21.]	Dr Julie Davies		Estates work required in the breast clinic to increase capacity has been

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
<b>Quality</b>	Dr Davies to look into whether the format of the Breast clinics has been changed.	Dr Julie Davies	April/May meeting	completed and the new larger clinics started on 25.01.21 - Complete
	Dr Davies to present an update on Breast cancer and cancer performance to the next Governing Body meeting.	Dr Julie Davies		Included on March Part 1 meeting agenda - Complete
	Mrs Young confirmed that the work on the case reviews had just taken place and a report would be presented to the next meeting.	Mrs Zena Young		Included on March Part 1 meeting agenda - Complete
	Mrs Young advised that this work was in progress and would form part of the paper on HARMS which would be presented to the next Quality and Performance meeting, and an update would be provided at the next Governing Body meeting.	Mrs Zena Young		The Niche report is delayed due to COVID-19 activity impacting on staff availability
	Dr Davies to confirm the reason for the difference between the two datasets contained in the main report and in Appendix 1.	Dr Julie Davies		Included in Quality and Performance Report for March meeting - Complete
	Mrs Young and Ms Cawley to meet to further discuss Healthwatch running a 'Hot Topic' on Neurology.	Mrs Zena Young / Ms Lynn Cawley		Due to the timing of data sets – dates have been added to this month's report to clarify  Update: A meeting has been arranged with a Quality Team member

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
<b>GB-21-01.016 – Digital Update Report</b>	<p>Dr James to double-check whether the case management will be supported by the new shared record system.</p> <p>Dr James to arrange to have the information on the digitised ReSPECT form re-circulated to practices, for information.</p> <p>Mrs Skidmore to request the IT Team to raise with the contractor at their weekly meeting the question regarding the bandwidth speeds.</p> <p>Dr James to present a Digital Update Report to the Governing Body meetings on a quarterly basis.</p> <p>Digital Update Report to be included on the Governing Body May agenda.</p>	<p>Dr Stephen James</p> <p>Dr Stephen James</p> <p>Mrs Claire Skidmore</p> <p>Dr Stephen James</p> <p>Mrs Sandra Stackhouse</p>	<p>1 February 2021</p> <p>Quarterly – next meeting in May</p> <p>May meeting</p>	<p>Dr James confirmed that the Integrated Care Record, CareCentric, contains a module called Care Flow Connect which supports case management and multidisciplinary team (MDT) working. It is accessible to MDT members via the web or an app.</p> <p>Complete</p>
<b>GB-21-01.017 – Update on System Improvement Plan</b>	<p>Mr Trenchard to arrange to include in the Primary Care Newsletter the link to further information on psychological health and well-being support for staff.</p>	<p>Mr Steve Trenchard</p>	<p>As soon as possible</p>	
<b>GB-21-01.018 – SEND Inspection Report and Written Statement</b>	<p>Ms Parker to review and amend outside of the meeting the statement included on page 8 of the</p>	<p>Ms Claire Parker</p>		<p>Complete</p>



Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
<b>of Action (WSOA)</b>	<p>report which states that the CCG Governing Bodies report directly into the STP Board (now the Shadow Integrated Care System Board).</p> <p>Ms Parker to present an update on SEND to the Governing Body's meeting in May.</p> <p>An item on SEND to be included on the May agenda.</p>	<p>Ms Claire Parker</p> <p>Mrs Sandra Stackhouse</p>	<p>May meeting</p> <p>May meeting</p>	
<b>GB-21-01.019 – Integrated Urgent Care Implementation Review Final report</b>	Ms Parker to confirm whether the palliative care service is commissioned by SaTH or the CCGs.	Ms Claire Parker	March meeting	tbc
<b>GB-21-01-026-029 – Shropshire CCG and Telford and Wrekin CCG Joint Committee Reports – Shropshire CCG Locality Forums and Telford and Wrekin CCG Practice Forum</b>	Ms Parker and Miss Smith to review the format of the reports received from the Chairs of the Locality Forums so that they are aligned.	Ms Claire Parker / Miss Alison Smith		Continue as current arrangements - Complete

**Submitted Questions by Members of the Public  
for the Governing Body meetings in common on 13 January 2021**

Name	Submitted Questions	CCG Summary Response
<p>Rhiannon Davies and Richard Stanton</p> <p>Gill George</p>	<p>A number of questions were posed by members of the public relating to maternity services, maternity data and the maternity review.</p> <p>Whilst the Ockenden Review remains on-going, it is not possible to provide a detailed response to individual questions, as this may interfere with the work of the review. Our statement is included here.</p>	<p><b>Statement from for Shropshire and Telford and Wrekin CCGs:</b></p> <p>“It is with great sadness that we receive the interim Ockenden Report. This report contains a number of tragic incidents which have been devastating for patients and their families. Our thoughts remain with you all.</p> <p>“We would like to offer our reassurance that we are fully committed to cooperating with the review, and will provide all necessary documentation requested.</p> <p>“Further investigations will include the role of the commissioners, of which this CCG is an integral part, and will form part of these investigations. We will provide information to the review in support of this, including information on current commissioning practices to show how lessons have been learned and changes implemented. We will continue to work towards improving quality governance across Shropshire, Telford and Wrekin.</p> <p>“Until the outcome of the Ockenden Review, it is not possible to provide a detailed response to the many questions which are being raised, as to do so may interfere in the work of the review. It is hoped that the conclusions of the review will answer the questions raised.”</p> <p><b><i>Dr Julian Povey, Chair, and David Evans, Accountable Officer</i></b></p>
<p>Gill George</p>	<p><b>1. <u>Covid-19 Vaccination</u></b></p> <p><b>Will the CCGs make every possible effort to ensure that vaccination centres are accessible,</b></p>	<p>The CCG is working to stringent criteria set out by NHS England in determining the sites used for vaccinations. NHSE are responsible</p>

Name	Submitted Questions	CCG Summary Response
	<p><b>given that many of those to be vaccinated in the next few months will be elderly or in poor health?</b> (For example, I know there is consideration of Ludlow Racecourse as a site. The consensus from people I have discussed this with is that the out-of-town Racecourse would be a really poor choice. The Community Hospital would be an ideal site in terms of location. An alternative - slightly less good but with better access than the Racecourse - would be the Leisure Centre. Both GP surgeries are centrally located, although space is more limited.)</p> <p><b>Could the CCG commit to a quick discussion with local Councillors when the best venue may not be obvious?</b></p>	<p>for assessing sites and giving final approval for sites to be utilised. The vaccination model requires a range of different sites to be utilised from larger sites to smaller ones as well as a roving vaccination option for those who are housebound. Depending on the nature and scale of the vaccinations to be carried out at each site, assessments for suitability will include, amongst a range of things, elements such as: space for social distancing, space for equipment, traffic management, wider transportation considerations (accessibility as well as deliveries) ability to create the necessary clinical space to specified requirements as well as willingness of a venue to adhere to any physical changes that may be required.</p> <p>The CCG has been working with a range of agencies including the Local Authorities, Police and Health partners to develop the vaccination plan in line with the guidance and considering the local geography. We have an on-going communications work stream, again subject to NHSE guidelines and approval, but will continue to engage with local councillors and MPs as we continue to evolve and develop this extremely complex programme of work</p> <p><b><i>Mrs Sam Tilley, Director of Planning</i></b></p>
Sue Campbell	<p><b>Future Fit/ Hospital Transformation Programme</b></p> <p>This immensely troubled and unpopular programme has been limping along since November 2013 now. In the autumn of 2015, the original 'whole system' approach was abandoned when NHS England deemed it unaffordable, and it was replaced with an acute-focused programme. Public consultation on this took place over the summer of 2018, at a time when the capital cost of Future Fit was estimated at £312m.</p>	

Name	Submitted Questions	CCG Summary Response
	<p>Subsequently, Future Fit has been rebranded as the Hospital Transformation Programme. The estimated capital cost of Future Fit has slid about: rising to £498m in a report leaked in December 2019, reported to local MPs by SaTH to have risen to £580m in January 2020 (when the then SaTH Chair Ben Reid also described the project as 'botched'), but the cost was then said by STP Chair Sir Neil McKay to be £533m in July 2020. Any information available to the public has been via leaks. The level of secrecy around the project is considerable.</p> <p><b>What is the current estimated capital cost of implementing Future Fit/ Hospital Transformation Programme?</b></p> <p><b>If this is unknown, what is the <i>range</i> of capital costs under consideration?</b></p> <p><b>What level of capital funding has been authorised to date by NHS England and/or the Treasury? Is this still £312m? Is there an agreed (or even likely) funding source now identified?</b></p> <p><b>Is it the current intention that the OBC now under development – reportedly via a £6m 'draw down' - will include every major component – at both sites – that went to public consultation in the summer of 2018?</b></p> <p><b>Can the CCG guarantee that any funding shortfall will not result in a phased implementation of the</b></p>	<p>The Outline Business Case (OBC) is being developed and the final capital cost will not be clear until this has been completed. The CCGs are currently discussing with the Trust the timeline for the completion of the OBC. The CCGs and the Trust are working towards the implementation of the clinical model which was the subject of public consultation. It is not unusual in major capital schemes where there are elements of refurbishment for there to be a phased approach because of the complexities involved, it is not possible at this stage to say if that will be the case.</p> <p><b><i>Mr David Evans, Accountable Officer</i></b></p>

Name	Submitted Questions	CCG Summary Response
	<p><b>Future Fit/ Hospital Transformation Programme?</b></p> <p><b>Will you now share with the public – the people you serve – the fullest possible information on which elements of Future Fit may be dropped entirely and which may be delayed, and by how long?</b></p> <p><b>Draft Strategic Outline Case</b></p> <p>We know from small scraps of information that a draft Strategic Outline Case for Future Fit/ Hospital Transformation Programme was submitted to NHS England in November 2019.</p> <p><b>Will the CCGs now release this, and report the NHS England response?</b></p> <p><b>Will you additionally ensure that the public is kept properly updated on the progress of Future Fit/ Hospital Transformation Programme? If not, what is your reason for the on-going denial of information to the public?</b></p>	

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

Item Number:	Agenda Item:
GB-21-03.038	Performance and Quality Exception Report summary (QPC January & February 2021)

Executive Lead (s):	Author(s):
<p>Julie Davies Director of Performance <a href="mailto:Julie.davies47@nhs.net">Julie.davies47@nhs.net</a></p> <p>Zena Young Executive Director of Nursing &amp; Quality <a href="mailto:Zena.young@nhs.net">Zena.young@nhs.net</a></p>	<p>Charles Millar Head of Planning Performance and BI</p> <p>Helen Morris Senior Performance Analyst</p> <p>Niki Jones Senior Information Analyst</p> <p>Tracey Slater Interim Assistant Director of Quality <a href="mailto:Tracey.slater4@nhs.net">Tracey.slater4@nhs.net</a></p>

Action Required (please select):									
A=Approval	<input type="checkbox"/>	R=Ratification	<input type="checkbox"/>	S=Assurance	<input checked="" type="checkbox"/>	D=Discussion	<input checked="" type="checkbox"/>	I=Information	<input checked="" type="checkbox"/>

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

Executive Summary (key points in the report):
<p>Performance</p> <ul style="list-style-type: none"> <li>○ Recovery planning and achievement has been impacted by the current Covid cases surge and is likely to take longer than anticipated to recover</li> <li>○ Performance measure related to the Urgent and Emergency Care environment locally remain challenging in particular in relation to the 4 hour treatment standard for A&amp;E though overall numbers of A&amp;E attendances and emergency admissions are lower than last winter.</li> <li>○ Ambulance handover delays in excess of 1 hour remain a challenge</li> <li>○ Elective activity at local providers has been further compromised since Christmas by very high levels of Covid bed demand. Non-urgent elective activity remains paused at RJAH at least until mid March and further reductions on elective capacity at SaTH has been necessary.</li> <li>○ Consequently, waiting times for Elective care and Diagnostics continue to show high numbers of long waiters.</li> <li>○ Agreement has been reached with Nuffield to utilise available capacity there for clinically urgent and cancer treatments.</li> <li>○ In general cancer performance has held up reasonably well up to present but the current Covid</li> </ul>

surge is likely to present problems in maintaining this position.

- IAPT activity remains well below targeted levels due to lower levels of presentation and the CCGs will not achieve the year end cumulative target given the accumulated shortfall in performance to date.

#### Quality

- An update on quality impacts of commissioned services is provided. SaTH remain the most challenged provider and cause for concern within the health system.
- The CCG continue to request assurances that learning from all incidents is embedded in practice over time and is undertaking selective review of historical incidents at SaTH that pre-date the current Director of Nursing & Quality.
- A number of concurrent Covid-19 outbreaks have been reported in NHS providers managed in accordance with Incident Management Processes.
- The CCG have reviewed and provided responses to Quality Accounts for 2019/20 for our four major NHS providers,
- Quality Assurance visits across most providers have been postponed until March. Assurance from internal QA processes is being sought via CQRM's.
- Additional temporary staff for the Infection Prevention & Control Team is being engaged to assist with the system response to Covid-19.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

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

**Recommendations/Actions Required:**



- That CCG Governing Body:
- Note the content of this report



# 1 Performance







All metrics are at month 9 (December) unless otherwise indicated.

## 1.1 Urgent Care

Area	Indicator	Target or National rate	Latest Position		Change from last period	
			SCCG	TWCCG	SCCG	TWCCG
A&E	<b>4-hour A&amp;E</b> (SaTH, M10)	95%	<b>62.6%</b> (M10)			
	<b>Over 1 Hour Ambulance handover Delays</b>	0	<b>407</b> (M10)			











- Ambulance conveyances to A&E reduced during the first wave of Covid 19 but have since recovered. At RSH, daily numbers are very similar to pre-Covid typical levels.
- Walk –in attendance to ED are still significantly below previous and have fallen back again in January to be around 50% to 60% of the levels seen at the same period last year. This is presumably an impact from the national lockdown.
- The Covid 19 situation has meant changes in operational procedures for dealing with patients and has impacted on staff availability at times. Performance against the 4 hour standard has remained challenging with both sites continuing to show a declining performance. There has been an upturn in performance in the first week of February following some work carried out by SaTH in conjunction with ECIST to improve processes and facilitate patient flow. Whether these improvements can be embedded remains to be seen. Clinical views suggest the acuity of patients attending ED has increased.
- In January the Trust reported 134 over 12 hour breaches which were mainly linked to volumes of arrivals, Overall flow and the complexity of managing varying numbers of COVID +ve and –ve within the emergency department remains a very real operational challenge. The number of 12 hour breaches was lower than the same period last year, but needs to be viewed in the context of an overall reduction in activity.
- The Trust is continuing to work with ECIST to improve processes. SaTH will be seeking to adopt the learning from these process reviews into normal practice which should result in both improved flows out of the bed base thus improving flow in from ED.
- The NHS111 First project continues to operate and shows a definite ability, albeit small scale, to move activity successfully away from the ED.
- There remains no indication that the process has increased propensity for the local population to call NHS111 nor that more callers are being directed toward the ED department.
- In December SaTH reported 407 ambulance handover delays of over 1 hour with 62% (253) of these occurring at PRH. SaTH continue to work with WMAS and ECIST to develop processes to reduce handover delays.
- The system is required to develop an improvement plan that gets our local A&E performance at or above 85% during 21/22.

## 1.2 Waiting Times

Area,	Indicator	Target or National rate	Latest Position		Change from last period	
			SCCG	TWCCG	SCCG	TWCCG
RTT	<b>Referral to Treatment</b> within 18 weeks	92%	<b>61.9%</b>	<b>63.4%</b>		
	<b>Referral to Treatment</b> waits > 52 weeks	0	<b>1318</b>	<b>696</b>		
Diagnostic Waits	<b>Diagnostic waits</b> of more than 6 weeks	1%	<b>41.0%</b>	<b>48.2%</b>		



- The worsening position in respect of emergency hospital admissions for Covid seen in January following Christmas has meant a further sustained reduction in elective capacity. Elective work at RJAH, with the exception of urgent cancer and spinal cases, has been paused at least until mid-March to allow staff to be redeployed to support both emergency care and the vaccination programme.
- SaTH have confirmed a permanent expansion of critical care to 16 beds. Daycase activity numbers have held up reasonably well through the current emergency, but it must be noted that a substantial part of daycase activity is medical in nature and does not require theatre type facilities.
- Agreement has been reached with Nuffield for use of theatre and Outpatient capacity there to carry out cancer care and some other urgent elective work which is within the range of safe operating for the site. The Nuffield staffing is being supplemented by medical and nursing staff from SaTH where necessary including overnight medical cover. Some additional imaging (MRI and X-ray) is also being undertaken at the Nuffield to assist in providing additional capacity.
- Routine referrals from Primary Care remain around 30% lower than pre Covid levels, although there is some evidence of an increase in urgent referrals.
- Overall numbers of waiters have not increased as rapidly as first feared, but an increasing proportion of longer waits will continue to be a feature. Clinical prioritisation of patients with a decision to admit is taking place to ensure that those with greatest urgency are dealt with first.
- Like elective activity in general, performance for Diagnostic waits has been severely impacted by capacity restrictions resulting from Covid 19.
- Diagnostic Imaging capacity has been enhanced through extending working hours and provision of additional modular facilities which has meant activity, although below pre Covid, levels is slightly ahead of the expected levels. Endoscopy capacity, however, has been further challenged since Christmas due to the extraordinarily high levels of Covid patients and the expansion into theatre facilities this has necessitated. Where possible, additional diagnostic activity is being utilised at the Nuffield for MRI and x-ray and at RJAH
- The system has developed plans to deliver Time Critical Surgery which is being reviewed by NHSEI on 2<sup>nd</sup> March.
- A system clinical prioritization meeting (Chaired by Dr Jane Povey) is coordinating the equitable prioritisation of treatment across and within specialities. It is also overseeing the system approach to clinical harm review and mitigation.
- All providers are now working on their recovery plans whilst balancing the need to give staff some well- earned leave.



### 1.3 Cancer

Area	Indicator	Target or National Rate	Latest Position		Change from last Period	
			SCCG	TWCCG	SCCG	TWCCG
Cancer	<b>2WW</b> urgent referral	93%	88.3%	85.0%		
	<b>2WW</b> Breast	93%	12.1%	6.5%		
	<b>31 days</b> to cancer treatment (surgery)	94%	83.3%	82.4%		
	<b>62 days</b> from referral to cancer treatment	85%	65.4%	71.4%		
	<b>62 days</b> , referral from screening to treatment	90%	66.7%	83.3%		

- 2ww Cancer performance has deteriorated due to the capacity issues in the breast cancer service. A separate paper on that is on today's Governing Body agenda. The estates work required has now been completed and the waiting times are coming down, but this is expected to take some time to return to previous levels of performance. As much as possible of the surgery for this pathway continues to be directed to the Nuffield.
- At M9 62 day cancer performance has so far held up reasonably well but is likely to come under increasing pressure due to the impact of the current Covid surge. The CCG has requested from SaTH an impact assessment to understand the potential consequences of this.
- For both CCGs the 28 day faster diagnosis rate is just under 74% which is also holding up reasonably well in the current circumstances.
- Referrals decreased substantially during the first Covid 19 peak and there is some evidence of a similar reduction following the Christmas peak in case rates. Referral levels continue to be of concern in lung although they are increasing. The CCGs and SaTH are working together to try and understand what more can be done to encourage referrals for lung. Significant capacity issues in diagnostics have impacted on performance but cancer and other urgent cases are being given priority.
- SaTH reported 5.5 x 10<sup>4</sup> day waits at M9 but indications are that January and February numbers will show deterioration
- The CCG has appointed to its Elective and Cancer Performance assurance manager post, David Whiting and he is now doing a detailed piece of work across the main tumour sites to fully understand the underlying challenges to delivering improved performance. This will then be used to inform detailed improvement plans over the coming weeks and months which in turn will be reported to the Quality & Performance Committee and the Joint Strategic Commissioning Committee as required

### 1.4 Mental Health

Area	Indicator	Target or National Rate	Latest Position		Change from last Period	
			SCCG	TWCCG	SCCG	TWCCG
Mental Health	<b>Dementia</b> Diagnosis Rate (M9)	66.7%	63.1%	59.4%		

	IAPT Access	25% at year End	7.5% (Cumulative at M8)	7.3% (Cumulative at M8)		
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- Both CCGs remain below the target level for this measure but there has been a slight improvement from the previous month
- Focus in the Primary care team on delivery of their component of the Covid vaccination programme has prevented detailed investigative work on the factors behind the lower achievement levels but this will be picked up when resourcing permits.
- Access levels for IAPT have been slowly recovering month on month since the Covid Wave 1 period but numbers presenting are still significantly below normal levels despite efforts to encourage more presentation.
- Given the level of achievement against the target in Q1 and Q2 and the likely recovery pathways, it will be impossible for the CCGs to achieve the year-end target of 25 % access.

## **2 Quality**

### **Areas of concern, current position and actions**

#### **2.1 Shrewsbury and Telford Hospitals NHS Trust:**

Shrewsbury and Telford Hospitals NHS Trust (SaTH) remains the most challenged provider and cause for concern within the health system.

- Falls prevention remains a key focus of quality improvement work at the Trust. January data shows an increase in falls; the Trust has developed a comprehensive plan to address fall risks and is enacting this and monitored via CQRM.
- SaTH reported a Never Event in December 2020, whereby a NG Tube was incorrectly placed and the patient received enteral feeding. There are no immediate learning points identified and a full investigation is underway
- SaTH continue to report 12 hour breaches. The CCG continues to work with the Trust on reviewing assurance of care received by patients waiting extended periods for admission.
- Delays to allocating Diabetic Eye appointments and the pathway for these patients have been raised as a concern and the Trust has responded to the issues raised providing assurance around harm. This is being monitored via CQRM.
- The Quality Compliance and Regulation Report for CQRM 26/1/2021 summarised that the programme remains on track to provide sufficient evidence to support the case to request the lifting of some CQC Section 31 regulatory conditions by March 2021.
- Cancer services show an overall reduction in breaches in Q3. Breaches continue to undergo internal scrutiny and are reported to CCG via contracting route and any identified harm is reviewed by CCG Quality team
- The Trust is reporting a high number of overdue incidents requiring investigation. Plans to address this backlog will be discussed at March CQRM.
- The first Ockenden review report published 10 December 2020 identifies key themes and sets out a number of actions that SaTH will need to ensure are delivered at pace. A baseline assurance report on the 12 National actions was submitted to NHSEI at the end of December and updates to LMNS will be provided. Assurance work is in progress against the additional 27 actions that are SaTH specific.
- During the month of December the CCG quality leads participated in a joint Exemplar visit with SaTH colleagues to ward 21 - Postnatal. There is nothing by exception to report from this visit, a number of mothers on the ward at that time all reported they had no concerns and were happy with their care.
- SATH continue to address the Safeguarding elements to the CQC action plan and have shown significant progress in terms of MCA compliance which is subject to a monthly audit – further details will be provided for the Committee in the next quarterly Safeguarding Reports.
- The CCG Executive led Discharge Audit Focus work has now been completed with associated reports and improvement action plan due to be shared with the Task and Finish Group on 19 January 2021. The Audit has highlighted a number of key areas for improvement and it is anticipated that with,

a consolidated and collaborative approach, these will be progressed to improve the overall quality of discharge.

- The provision of neurology services continues to be discussed between RWT, SaTH and the CCG with the service now due to commence from April 2021. The CCG Quality Team is not aware of reports of any harm being incurred by STW registered patients. There have been 6 PAL's issues raised between June 2020 and February 2021.

## **2.2 Robert Jones and Agnes Hunt Orthopaedic Hospital**

- The trust has deployed significant numbers of staff to support both SaTH and the vaccination programme. There are no significant quality concerns to report by exception

## **2.3 Midlands Partnership FT**

- Bee-U Services Shropshire: Waiting Times for Assessment continues to be a PAL's theme. Responsiveness to concerns is being taken forward by MPFT
- CHEC (Community Eye Care Service) - a number of issues have been raised in relation to the Optometrist patient pathway resulting in the potential for delays in treatment. Collaborative working with SaTH and CHEC and the respective CCG referral management centres is ongoing to refine and streamline the pathway ensuring universal clarity and adherence to documentation and defined terminology.
- MPFT have received a Regulation 28 letter from HM Coroner relating to an incident in October 2020, which was predominately around security in the garden at the Redwoods Centre. MPFT have responded and mitigation has been put in place to address issues raised. The CCG has reviewed the MPFT response to HM Coroner and are satisfied the actions taken have addressed the concern.
- Admissions to SaTH paediatric unit for children and young people who require access to Tier 4 services continues to be very challenging. The impact that this has on the other children in a paediatric ward is of concern. It is also reported by SaTH that an increasing number of these young people have significant eating disorders requiring care, intervention and treatment beyond the scope and skills of a DGH paediatric ward. The increasing number of young people with eating disorders and disordered eating is a nationally recognised problem, It is pertinent to note that the CCG does not commission T4 beds.

## **2.4 Shropshire Community Healthcare NHS Trust**

- There are no significant quality concerns to report by exception.

## **2.5 GP led Out of Hours Services** (SCHT leads on OOH contract, subcontracting Shropdoc since 1st Oct '18.)

- There are no quality concerns to report by exception.

## **2.6 Primary Care**

- Annual Health Checks: The CCG and partners are continuing work to improve the uptake and quality of Annual Health Checks for people with Learning Disabilities. There is significant variation in uptake of AHCs across the system.

## **2.7 West Midlands Ambulance Service (WMAS)**

- There are no quality concerns to report by exception.

## **2.8 Care Homes**

- There are currently no care homes under level 4 scrutiny. The CCG's continue to provide the care sector with infection prevention & control advice and support in collaboration with Public Health England, CQC and Local Authorities.

## **2.9 Independent Providers**

- Falck (Non-Emergency Transport Provider): Ongoing concerns about increased demand and capacity have been escalated via Silver Command and a prioritisation process for non-urgent requests agreed.
- CHEC (Community Eye Care Service: A further LHE meeting was held on 27 January 2021 chaired by STW CCG Interim Medical Director with senior representation from SaTH and CHEC. This forum provided an opportunity to reflect on the improving working relationship between both providers with regular meetings now being held to discuss and address ongoing issues. It was agreed that both SaTH and CHEC would undertake an audit of the Urgent and Cataract Referrals Pathway to ensure adherence to process during February 2021. A further action was agreed to review the Minor Eye Condition (MECs) triage process via the Optometrist service given that SaTH raised concerns about inappropriate referrals received via this route.

## **2.10 Safeguarding**

- Child Neglect: Following concerns about an increase in child protection concerns under the category of neglect; Shropshire Safeguarding Partnership Board have commissioned an external review of how well services are identifying and meeting the needs of vulnerable children.

## **2.11 Infection prevention and control**

- Covid-19 outbreaks continue to be reported in NHS providers and care homes. The CCG IPC team have undertaken supportive assurance visits to providers and care home who have experienced extended outbreaks and gain further assurance through attendance at incident management meetings. The CCG continues to work closely with the system Health Protection Board on the model for surveillance and response to C-19 outbreaks in these settings. Additional temporary staff for the CCG Infection Prevention & Control Team is being engaged to assist with the system response to Covid-19.

## **2.12 Harms Review**

- A report on harms focussing on cancer waits and ED long waits was presented to QPC February meeting. It was agreed that further work be undertaken to assure the position of no reported harm associated with SaTH cancer breach delays to treatment.
- The provision of neurology services continues to be discussed between RWT, SaTH and the CCG with the service now due to commence from April 2021. The CCG Quality Team is not aware of reports of any harm being incurred by STW registered patients and will be monitoring this as the service changes provider.

## **2.13 Niche Review of Mortality**

Due to the impact of Covid-19, this report is not yet available and will be presented as soon as possible.

## **2.14 Patient Experience**

- **Friends and Family Test** – Data submissions for all acute and community providers has re-commenced from December 2020 with quarterly results to be made available in April 2021. Providers are not required to proactively ask patients to give feedback at those times specified in the guidance, but they should ensure that patients know that if they want to use the FFT to give feedback they can and develop their collection methodology aligned to IPC guidance to reduce the risk of C-19 transmission.
- **Cancer Patient Experience Survey** – NHSEI have taken the considered decision to not run the annual survey this year given the C-19 related pressures on services and staff. Trusts are able to undertake the survey on a voluntary basis with guidance developed in support.
- **Commissioner Led Audiology Patient Experience Survey:** A summary report has now been produced from which it is evident that the majority of the 157 respondents rate the Audiology service very highly.

## Appendix 1 Exception Reporting: Priority Areas

### 1. A&E Waits at Shrewsbury and Telford Hospitals (Month 10, 2020/21)

Local Lead	Key Performance Indicator	Target or National Rate	Latest Position		Change from last period	Last achieved
			Official	Un-validated		
SC/EP	A&E attendances admitted/ treated/ discharged in 4 hours	95%	62.6%		↓	n/a
	>1 Hour Handover delays	0	407		↓	

### 2. RTT and Diagnostic Waits (Month 9 2020/21)

Local Lead	Key Performance Indicator	Target or National Rate	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
AP	Referral to Treatment within 18 weeks	92%	61.9%		↓	Nov 2018	63.4%		↓	Dec 2018
AP	Referral to Treatment > 52 weeks	0	1318		↓	Feb 2020	696		↓	Mar 2020
AP	Diagnostic test waits > 6 weeks	1%	41.0%		↑	June 2019	48.2%		↑	Feb 2019



### 3. Cancer Waits (Month 9 2020/21)

Local Lead	Key Performance Indicator	Target or National Rate	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
HR	2WW Urgent	93%	88.3%		↑	Aug 2020	85%		↑	Sept 20
HR	2WW Breast	93%	12.1%		↓	Aug 2020	6.5%		↓	July 20
HR	31-day wait for cancer treatment (surgery)	94%	83.3%		↓	May 2020	82.4%		↑	Oct 20
HR	62-day wait from GP referral to cancer treatment	85%	65.4%		↓	July 2020	71.4%		↓	Dec 2018
HR	62-day wait for treatment after referral from cancer screening	90%	66.7%		↓	Nov 2020	83.3%		↓	Nov 2020

### 4. Dementia Diagnosis Rate (Month 9 2020/21)

Local Lead	Key Performance Indicator	Target or National Rate	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
FS	Dementia Diagnosed, as a proportion of estimated prevalence in over-65s	66.7%	63.1%		↓	Apr 2020	59.4%		↑	Mar 20

## 5. IAPT Access Rate (Month 8 2020/21)

Local Lead	Key Performance Indicator	Target or National Rate	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
CD	Access to IAPT services for the section of the at risk population	<b>25% by year end</b>	<b>7.5% at M8</b>			New target level for 20/21	<b>7.3% at M8</b>			Dec 19



**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.039	<b>Cancer performance – update on recovery of performance for the 2 week wait Cancer Waiting Times (CWT) standard for suspected breast cancer</b>

<b>Executive Lead (s):</b>	<b>Author(s):</b>
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<b>Action Required (please select):</b>									
A=Approval		R=Ratification		S=Assurance	S	D=Discussion		I=Information	I

<b>History of the Report (where has the paper been presented:</b>		
<b>Committee</b>	<b>Date</b>	<b>Purpose (A,R,S,D,I)</b>
Quality & Performance Committees	24/02/21	S, I

<b>Executive Summary (key points in the report):</b>
<ul style="list-style-type: none"> <li>• SaTH have kept the breast service open to patients for new referrals and treatment throughout COVID</li> <li>• Since COVID began, the breast service was initially able to deal with the reduced demand but the first appointment time began to go above 14 days from August 2020 onwards</li> <li>• SaTH were initially only able to offer reduced numbers of slots per session due to Infection Prevention &amp; Control requirements for the pandemic, down from 25 to 15, but this has now recently returned to full capacity</li> <li>• SaTH are currently failing both the suspected breast cancer standard and the symptomatic breast standard</li> <li>• All referrals are seen in the order that they are received, regardless of which referral pathway is used</li> <li>• The suspected cancer and symptomatic referrals have different referral criteria but both have a target to be seen within 14 days</li> <li>• The suspected breast cancer target is a right under the NHS Constitution but the symptomatic target is not as it is not a referral for suspected cancer</li> <li>• The currently waiting time for patients on either pathway for their first appointment is 21 days which has come down from a longest wait of 35 days which it grew to in January 2021</li> <li>• Numbers of referrals are nearly back to pre-COVID levels, with symptomatic referrals now increasing to 1/3 of the total (this may partly be the impact of the breast screening service being suspended by NHSEI in the first wave of the pandemic)</li> <li>• Nearly all patients are seen in a one-stop clinic which includes access to mammography and radiology</li> <li>• SaTH have completed estates work that allows patients to access radiology services safely and to utilise full capacity</li> <li>• SaTH are looking to increase capacity wherever possible to see more people but generally demand matches current capacity with no means of bringing down waiting times</li> <li>• This means that the waiting times will take some time to get back down to 14days and some degree of delay will continue</li> <li>• Further work is underway between the CCGs and SaTH to develop an improvement plan to ensure the delivery of the 14day target which will be taken to the Joint Strategic Commissioning Committee (JSCC) in March</li> </ul>

<b>Implications – does this report and its recommendations have implications and impact with regard to the following:</b>		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication? There may be a need for further staffing resources in secondary care in order to meet the expected ongoing demand for breast services, as well as the backlog for breast screening – this is subject to a further piece of work which needs to be undertaken within SaTH	Yes
3.	Is there a risk to financial and clinical sustainability? The demand for breast services compared to capacity risks the overall sustainability of the service, ways to address this will be considered in a paper to be taken to the JSCC in March 2021	Yes
4.	Is there a legal impact to the organisation?	No
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement? These proposals have had input from the SaTH breast team. Further engagement will be required with SaTH and collaboration will also be needed from Primary Care in order to support some actions contained within the report that will go to JSCC in March	Yes
7.	Is there a patient and public engagement requirement? The CCG is keeping GPs informed of the current waiting lists to ensure patients are fully aware of current delays. Once the improvement plan agreed and approved by JSCC in March then the CCG and SaTH will make a joint statement to the public, advising of ongoing delays and expected timescales for reducing waiting times back to under 14 days	Yes

<b>Recommendations/Actions Required:</b>
<p>The Governing Body is asked to;</p> <p>Note:</p> <ul style="list-style-type: none"> <li>• Infection and Prevention Control procedures due to COVID initially impacted on capacity in SaTH's breast clinics, reducing the number of slots from 25 to 15. There was initially also a drop in demand, but is now almost back to pre-COVID levels</li> <li>• The Estates work has now been completed at SaTH and capacity in the breast service is now back to the full pre-COVID levels and matches incoming demand. Extra capacity is being utilised by SaTH whenever available to bring down the waiting times</li> <li>• The service is currently booking at day 21, down from a highest level of 35 days in January 2021</li> <li>• Further action is required to bring the breast cancer waiting times down to 14 days and an improvement plan will be presented to the JSCC in March for approval</li> <li>• A further paper confirming the recovery trajectory for the 14day target will be taken to the March Quality &amp; Performance Committee</li> </ul> <p>To receive assurance that:</p> <ul style="list-style-type: none"> <li>• SaTH breast clinic capacity has been restored and the waiting times are reducing.</li> </ul> <p>And to receive limited assurance:</p> <ul style="list-style-type: none"> <li>• Regarding the degree of improvement in waiting times. Full assurance is dependent on the improvement plan and the trajectory to achieve the 14day target.</li> </ul>

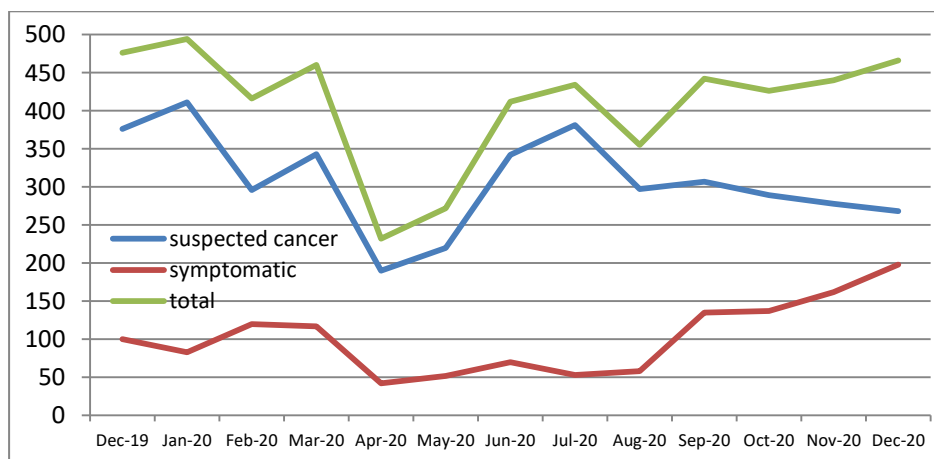
## 1. Introduction & Background

- 1.1 The [NHS Handbook to NHS Constitution for England](#) states that “(patients) have the right to be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected”. The target for suspected cancer urgent referral from referral to first outpatient appointment (2 week wait) is 93% (see appendix 1 for a summary of all Cancer Waiting Times standards).
- 1.2 There is an additional 2 week referral pathway for patients with breast concerns where cancer is not thought to be the cause by the referrer, known as the ‘breast symptomatic’ pathway, which also has a target of 93%. This in effect means that all patients with breast symptoms should be seen within two weeks, but only the referrals for suspected cancer are considered a constitutional right.
- 1.3 Throughout COVID, SaTH has continued to deliver the breast service to new referrals and current patients. The impact of COVID led to reduced numbers of referrals and reduced capacity in the service due to issues with staffing and reduced access to radiology due to the enhanced Infection, Prevention & Control (IPC) requirements, but referral numbers have now almost returned to normal. As a result of this combination of increased demand with reduced capacity the service has missed the target for seeing patients within 14 days of a referral since September and this has consequently impacted adversely on the 62 day referral to treatment standard.

## 2. Current Situation

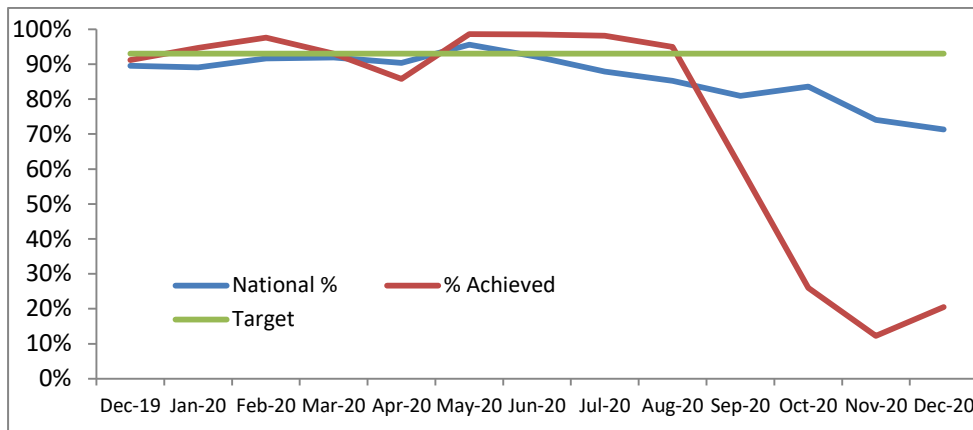
- 2.1 The number of people referred for a first outpatient appointment for either suspected breast cancer or breast symptoms dipped during the first quarter of 2020-21 (i.e. April-June 2020) but numbers recovered in the second quarter and returned almost to normal numbers in quarter 3. This was due to the reduction in referral demand during the first quarter of the year as a result of the pandemic.
- 2.2 Additionally, the breast screening service has a backlog to catch-up following a suspension of the service which means that the service needs access to its full mammography capacity. This backlog may also be contributing to extra 2ww referrals being made as women have not been able to access screening.
- 2.3 Note - the data for SaTH includes Powys patients which are 10% of total numbers seen. Almost all Shropshire and Telford and Wrekin patients are referred to SaTH, but there is no formal breakdown of these figures within Cancer Waiting Times (CWT) data.

**Figure 01 - Number of breast suspected cancer and symptomatic referrals (Dec 19-Dec 20)**



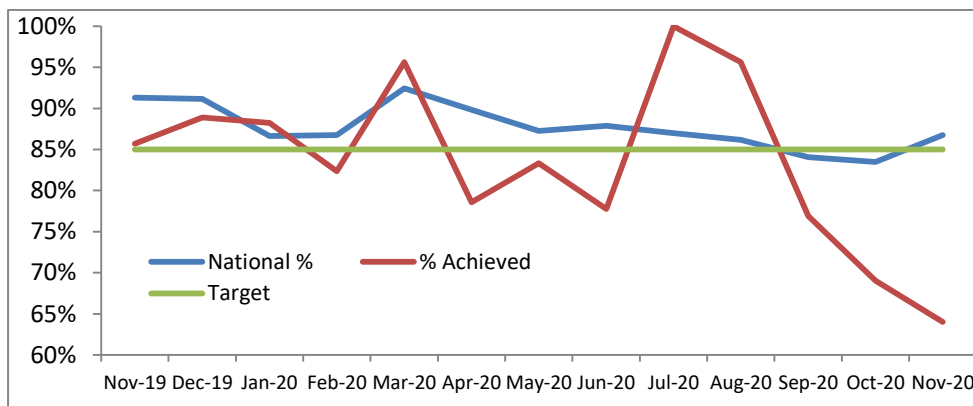
- 2.4 Performance against the 2ww standard for suspected breast cancer referrals for SaTH shows that there has been a marked fall off since September 2020. In the latest data for month 9 in 2020/21 (December 2020) this equated to 213 people referred for suspected breast cancer not being seen within 2 weeks with a further 179 on the symptomatic pathway and a maximum waiting time of 35 days for a first appointment.

**Figure 02 - SaTH performance against the 2ww suspected breast cancer standard (Dec 19-Dec 20)**



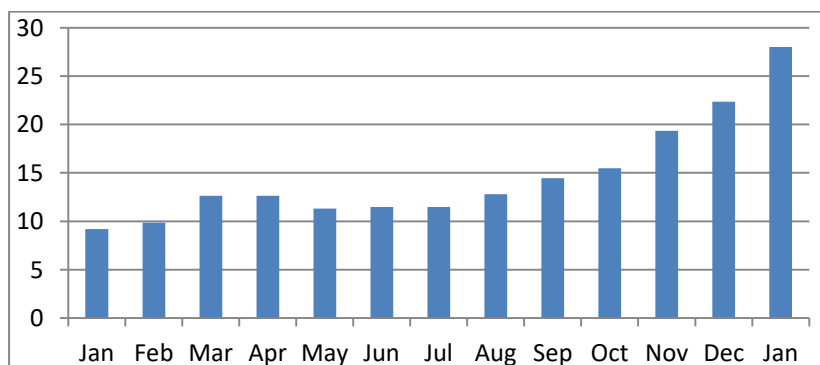
2.5 The 2ww performance has also impacted on performance against the 62 day standard. These pathways are linked because only patients originally referred for suspected cancer get included in the 62 day standard performance.

**Figure 03 - SaTH 62 day referral to treatment performance (Dec19-Dec20)**



2.6 The average day that all breast patients (both pathways combined) are booking at the end of January 2021 is 28 days. During January 2021 the wait reached a maximum of 35 days. This has now reduced to 22 days as at the middle of February 2021.

**Figure 04 - Average number of days wait until first appointment (all breast referrals) (Jan 20-Jan21)**



### 3. Current service provision

3.1 SaTH are now offering five 'one-stop shop' clinics a week with each having 25 patient slots. These are offered to a mixture of suspected cancer 2ww and symptomatic patients, in the order that referrals are received. Occasional extra clinics are being offered whenever there is staffing available to deliver them.

- 3.2 Due to COVID, there was an initial reduction in clinic capacity to 15 slots because of a combination of staff redeployment, staff self-isolating and reduced access to radiology due to needing dedicated COVID safe access. Initially, radiology required a separate entrance for COVID patients that reduced capacity, but following recent building estates work to increase access there are now protocols and systems in place to allow clinics to operate back to the full pre-COVID capacity of 25 slots.

#### **4. Summary and Conclusion**

- 4.1 The latest monthly number of referrals was 461 (both breast pathways combined), with 125 slots a week for new appointments being available which meets the numbers of referrals but does not provide any additional capacity to reduce the waiting time back down to 14 days.
- 4.2 There are a number of actions being worked on that will contribute to delivering the 14 day target for suspected cancer referrals, especially SaTH being able to offer extra clinics will impact on bringing the delays to first appointment down. These include actions for primary care and secondary care.
- 4.3 These current actions will take time to gradually bring the first appointment date down. This is not at sufficient pace for patients, the CCGs and SaTH so further additional actions are being considered in order to reduce the waiting times more quickly. A combined set of actions and the associated trajectory for recovery of the 14day standard will be presented in an improvement plan to the JSCC for approval in March 2021.

#### **5. Recommendations**

- 5.1 The Governing Body is asked to:

Note:

- Infection and Prevention Control procedures due to COVID initially impacted on capacity in SaTH's breast clinics, reducing the number of slots from 25 to 15. There was initially also a drop in demand, but is now almost back to pre-COVID levels
- The Estates work has now been completed at SaTH and capacity in the breast service is now back to the full pre-COVID levels and matches incoming demand. Extra capacity is being utilised by SaTH whenever available to bring down the waiting times
- The service is currently booking at day 21, down from a highest level of 35 days in January 2021
- Further action is required to bring the breast cancer waiting times down to 14 days and an improvement plan will be presented to the JSCC in March for approval
- A further paper confirming the recovery trajectory for the 14day target will be taken to the March Quality & Performance Committee

To receive assurance that:

- SaTH breast clinic capacity has been restored and the waiting times are reducing.

And to receive limited assurance:

- Regarding the degree of improvement in waiting times. Full assurance is dependent on the improvement plan and the trajectory to achieve the 14day target.

## Appendix 1

### Operational standards

The current measures and the operational standards are:

- Two weeks from urgent GP referral for suspected cancer to first outpatient attendance (93%)
- Two weeks from referral with breast symptoms (where cancer is not suspected) to first hospital assessment (93%)
- 28 days from urgent GP referral for suspected cancer, urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) or referral with breast symptoms (where cancer is not suspected) to the date the patient is informed of a diagnosis or ruling out of cancer (operational standard to be confirmed)
- 62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia) (85%)
- 62 days from urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to first treatment (90%)
- 62 days from a consultant's decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) due to a suspicion of cancer to first treatment (no operational standard set)
- 31 days from diagnosis (decision to treat) to first treatment for all cancers (96%)
- 31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery or radiotherapy) (94%)
- 31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (anti cancer drug therapy, eg chemotherapy) (98%)

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.040	Maternity Services Update

<b>Executive Lead (s):</b>	<b>Author(s):</b>
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<b>Action Required (please select):</b>			
A=Approval	R=Ratification	S=Assurance	/ D=Discussion / I=Information /

<b>History of the Report (where has the paper been presented):</b>		
<b>Committee</b>	<b>Date</b>	<b>Purpose (A,R,S,D,I)</b>
QPC	Feb 2021	S, D, I

<b>Executive Summary (key points in the report):</b>
<p>This report provides updates on key areas of Maternity Quality and Safety. The areas for escalation or noting this quarter are:</p> <ul style="list-style-type: none"> <li>• SaTH trust have submitted reports and information to both LMNS and NHSEI in relation to the Ockenden recommendations. Progress is being made, but is reliant upon recruitment to key governance roles. External senior support is in place at the moment. There is one return outstanding regarding Birthrate plus – the midwife staffing dependency tool and a position on this is expected soon.</li> <li>• STW LMNS has similarly submitted its report of compliance against ‘Principle 2’ - Strengthening LMNS and ICS role in quality oversight. System quality governance arrangements have been reviewed in light of Ockenden and also ICS requirements.</li> <li>• Whilst informal alignment of quality governance arrangements with other LMNS’s has been progressed, STW LMNS continues to seek a formal arrangement to partner with another LMNS and has requested regional NHSEI support with this.</li> <li>• Information on exceptions and escalations arising from the trusts maternity dashboard are presented along with details of the work of maternity CQRM. Exceptions identified have been further scrutinised with plans in place. Data quality and electronic audit capture remain an issue.</li> <li>• The CNST data submission period has changed from May to July 2021 and poses a risk to achieving compliance due to the need for additional auditing. There are a</li> </ul>

number of other risks associated. The CCG will undertake a quality assurance process of the significant volume of information.

- External review confirms progress is being made with implementing in full the Saving Babies Lives Care Bundle version 2.
- Continuity of Carer teams are being implemented, however the pace is slow and SaTH may not achieve the target in the timeframe set.
- MBRRACE reports for 2018 data show that STW system is rated red for stillbirths, neonatal deaths and extended perinatal mortality. At organisation level SaTH is rated Amber and UHNM also rated red for the same metric. SaTH have undertaken detailed analysis on their reports.
- Patient Experience reports show a good level of service satisfaction and a small number of complaints, some of these relate to the Ockenden Report period of review.
- The CCG/LMNS are still awaiting approval for public consultation on the Transforming Midwifery Care proposals and additional work in light of any change in requirements following the publication of the Ockenden report will be undertaken in the next reporting period.
- There are no particular areas of concern for escalation, however, the reliability of data quality remains an issue and the implementation of the Badgernet maternity record over the next few months will in large part address this. SaTH's internal maternity governance is at an early stage of maturity, still being reliant upon external support and subject to recruitment to some key governance positions and the responsiveness of the Trust to provide information can be quite slow.



**Implications – does this report and its recommendations have implications and impact with regard to the following:**

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

**Recommendations/Actions Required:**

That Quality and Performance Committee:

- Note the contents of the report and progress being made
- Note areas of concern and actions being taken to address

## **Maternity Services Update**

### **1.0 Ockenden Report Compliance**

During the last reporting period the Trust have submitted their second return of compliance to NHSEI against the Ockenden Report recommendations for Essential and Immediate Actions. This was reviewed by LMNS at the time of submission and feedback provided to the Trust which will strengthen subsequent submissions. Many of these actions are underway, but some are reliant upon recruitment to key roles such as audit midwives and the robustness of maternity governance which is still in early stages of maturity with external support in place. The frequency of further reporting to NHSEI has yet to be announced, LMNS will receive quarterly progress updates.

There are additionally 27 Local Actions for Learning regarding SaTH specifically. The Trust is collating the information for these actions and again LMNS will receive this in due course. Both elements of these reports are also presented to the Trust's internal governance forum – Maternity Quality Operational Committee (MQOC) which the CCG is a member since January 2021.

There is one return outstanding regarding Birthrate plus – the midwife staffing dependency tool and a position on this is expected soon.

There are discussions being held on how LMNS transformation schemes can dovetail to the trusts Midwifery Transformation Programme (MTP) to identify common areas of work and avoid duplication.

The STW LMNS has submitted its report of compliance against 'Principle 2' - Strengthening LMNS and ICS role in quality oversight, in response to the Ockenden Report to NHSEI. Significantly, the dashboard development and reporting ability will assist with data quality.

The overarching STW Quality Governance, including Perinatal Quality Surveillance arrangements and the links to LMNS have been reviewed and developed in line with National Quality Board and NHSEI guidance and will be included in the ICS Quality Strategy which will be shared to QPC in due course. The CCG have agreed to invest in some additional staffing resource to appoint to posts specifically to focus on the maternity components of commissioned services, however our Management of Change process is delaying the recruitment to these positions.

Whilst alignment of quality governance arrangements with other LMNS's has been progressed, STW LMNS continues to seek a formal arrangement to partner with another LMNS and has requested regional NHSEI support with this.

The regional Perinatal governance arrangements are also under review as part of the Ockenden report recommendations.

## 2.0 Maternity CQR dashboard – January 2021 (November data) selected exceptions/escalations

The main areas for noting are:

- **Bookings less than 13 week gestation** – 86.6% (target >90%) Following a review, changes have been made to the booking process which includes offering booking appointments upon notification if these are available.
- **The induction of labour (IOL) rate** continues to be high over the last two reporting years at 36.7% (41.6% previous year) against a target of 28.5% (NMPA data). A deep dive into the reasons for this was previously received to CQRM in December 2020. This report identified the inclusion criteria for IOL at SaTH was broader than for other units (included ToP and all gestations, NMPA data was for term pregnancies only). Data quality was a significant concern with information stored in different locations in patient care records and no universal electronic capture methodology; a number of data fields including reason for IOL in 14.2% of cases were not completed. Policy changes have impacted on a rising IOL rate (Reduced Fetal Movements – SBLCBv2). Inconsistent data precludes reliable data comparisons. Implementation of the Badgernet maternity record will help considerably with this audit.
- **Smoking at delivery** – 12.6% (target 6%). Public Health face to face contacts have stopped during Covid and CO monitoring also ceased; this data is a patient self-reported measure. As reported further below, the CCG has met with Local Authorities to agree a short-term funding solution for smoking cessation services for 21/22.
- **C-Section rate** - overall at 26.9%, this rate is close to the NMPA target rate of 25%, however elective C-sections at around 13% continue to be less than the expected figure or target of below 25% for this measure. Emergency C-Section rates average around 12%, which is higher than the local target of below 10%. The higher figure for emergency C-sections is triangulated with other quality and safety indicators such as birth trauma, postpartum haemorrhage, and brain injuries.
- **Born Before Arrival (to hospital) BBA** – There were 7 cases reported for November (total 17 in a rolling 3 month period). A deep dive into the reasons for this has previously been received to CQRM in September 2020, relating to data for January to June 2020 (23 cases). This report detailed the majority of cases showed rapid onset of labour and birth; 1 woman was a planned home birth but birthed her baby before the midwifery team could arrive; 7 women delivered in the ambulance or car in transit to the unit. There were 2 occasions where BBA could have been avoided (Mother either sent home, or advised to stay at home). Recommendations included: triage team to consider parity, distance and contractions when sending patients home in early labour. A reaudit for Q3 activity is underway.
- **Delivery Suite red flags** – staffing levels were suboptimal on 5 occasions during November, vacancy rates were a factor. Delays to IOL's being a repeated reason for reporting red flags. No adverse outcomes were reported in association with the staffing red flags and there is a process for prioritising and monitoring women during this time.

Further work is ongoing with regard data accuracy and validation within reports received from the Trust. A new Trust-level maternity dashboard will be implemented in April 2021 and the CCG has provided feedback in the development of this. Data accuracy will also be supported with the implementation of the Badgernet Maternity system across the maternity service. This is anticipated in late spring/ early summer 2021.

In the last reporting period (Q3) in addition to standing items for maternity dashboard, SI reports, patient experience reports, CNST and SBL updates, workforce, etc, Maternity CQRM has received assurance reports regarding the following items:

- 1:1 Care in Labour
- Postpartum Haemorrhage (PPH)
- Perinatal Mortality
- LocSSIPs report – maternity theatres
- Maternity Risk Register Review

### 3.0 CNST

The reporting period of the Maternity Incentive Scheme action was deferred during 2020 and the scheme restarted on 1st October 2020. The submission date planned for May 2021 was moved to July 2021 by NHS Resolution; this introduces a requirement for additional auditing to take place to ensure compliance over the additional time period and may be a risk to achievement of standards. A number of standards are on track to be complaint and completed. Recruitment to obstetric anaesthetic cover is a challenge, although there has been recent recruitment success; there is a risk to achieving the required level of training for each staff group with the impact of Covid on training plans; achieving 35% Continuity of Carer requires 7 teams and only two are currently in place.

The CCG will undertake a quality assurance process of the significant volume of information to be submitted and is awaiting joining instructions for this iterative process.

### 4.0 SBLCBv2

The national ambition is to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2025. The Saving Babies Lives Care Bundle (SBLCB) version 2 brings together five elements of care that are widely recognised as evidence-based and/or best practice with the aim of reducing perinatal mortality across England. The second version of the Care Bundle was introduced in March 2019 and extended its scope to include preterm birth. Unless all 5 elements of the SBLCB are fully implemented the Trust will not meet CNST compliance. The new SBLCB v2 survey (October 2020) is a brief assurance survey designed to gather information on progress towards full implementation of SBLCB v2. SaTH's self-reported position:

Criteria	Survey 2	Survey 3 (Oct 2021)	
Reducing smoking in pregnancy	50%	50%	The CCG has met with Local Authorities to agree a short-term funding solution for smoking cessation services for 21/22.
Detecting fetal growth restriction	50%	70%	SaTH introducing a Risk Assessment step to pathway.
Reduced fetal movement	80%	80%	Data capture issues.

<b>Fetal monitoring during labour</b>	<b>86%</b>	<b>100%</b>	<b>Fully compliant.</b>
<b>Reducing pre-term birth</b>	<b>67%</b>	<b>100%</b>	<b>Fully compliant.</b>

The Maternity and Neonatal Clinical Network undertook a review of the Trust's self-assessed Survey 3 position and gave an overview that there are still areas of non-compliance, however some gaps have been resolved and the Trust are working on the remaining requirements. The key issues are around the development, review and appraisal of new or revised guidelines. SaTH have submitted a small number of policies for Network review as they deviate from NICE guidance and the Clinical Network have approved these with some additional caveats which will be followed up at CQRM to ensure these conditions are met.

The reviewer noted that progress had definitely been made against the implementation of SBL and this should be recognised by the LMNS Programme Board, especially achieving this during the pandemic period when staff were deployed to front line duties. It was noted that it is positive that the Trust now have both an SBL and Fetal Medicine lead, the reviewer feels confident that the Trust will meet all the necessary requirements. Further support has been offered by the Clinical Network and accepted by the Trust in relation to Survey 4 which is due to be submitted in February 2021.

## 5.0 CoC (Continuity of Carer)

The ambition for CoC is that by March 2021, 35% of women booked for maternity care are placed on to continuity of carer pathways. As previously noted, SaTH have introduced two CoC teams and the Trust are seeking to expand out and launch two more teams, however the additional pressures of Covid and staffing availability have made it challenging to achieve this and there is a risk that this ambition will not be achieved locally.

FY20/21 Continuity of Carer Report

Bookings upto: **28/10/2020**

TRUST	All Patients	BAME	Deprivation
Number of Bookings	2735	174	273
Booked less than 28 weeks	2580	163	248
Booked onto a Continuity of Carer Pathway	319	23	12
% on CC Pathway (of all bookers)	11.7%	13.2%	4.4%

National ambition is for all women to benefit from Continuity of Carer where:

- Black, Asian and mixed race are targeted first
- Women living in the lowest decile of deprivation are targeted first.

In line with national policy, the Trust will be targeting BAME Communities and those residing in socially deprived areas in future roll-out plans.

## 6.0 MBRRACE reports

There are three recently published national reports that can be accessed via the following link: <https://www.npeu.ox.ac.uk/mbrrace-uk/reports>

These cover stillbirths and neonatal deaths (2018 data), maternal deaths and finally a report on twins. The key messages from the stillbirths and neonatal deaths report are:

- STW STP is one of four Midlands STP's rated Red (>5% higher than UK average for stillbirths, neonatal deaths and extended perinatal mortality).
- SaTH is rated Amber (up to 5% higher or up to 5% lower than the UK average).
- The neonatal pathway for STW is United Hospital of North Midlands NHS Trust (UHNM) which is also rated as Red.

The MQOC meeting in February received detailed presentations on the 2018 deaths for stillbirths and neonatal deaths, with analysis of cases and learning identified. In one of the 7 neonatal death cases the change in location of the MLU as a now 'alongside' unit was felt to be a significant safety feature. One area of discussion was around assurance on risk assessments being undertaken at each contact to ensure the mother-to-be is on the correct pathway for birth location. There was not full confidence this assessment is undertaken at every contact (an Ockenden recommendation). Whilst manual audits preclude a full audit of all contacts until the implementation of Badgernet, an audit of MLU documentation is underway for assessment compliance and the Director of Midwifery confirmed that around 10% of records are reviewed each month at a risk meeting. There remains low birth numbers at the Wrekin MLU presently and the right of mothers to have choice in birth location also needs to be respected.

Detailed analysis of stillbirths and neonatal deaths for 2019 and 2020 will be received to the March MQOC and the latter two MBRRACE reports will also be received in due course.

## **7.0 Service user feedback**

FFT: SaTH have reintroduced the monthly nationally paused Friends and Family Feedback Test (FFT) survey. Of a total number of nearly 300 forms received, the following were noted:

- Wrekin MLU Births - 55.3% responses rate, with 100% recommending this service
- Consultant Unit Births - 16.9% response rate, with 98% recommending their service
- Postnatal - 9 responses, with 100% recommending their service
- Antenatal - 222 responses, of these 99.5% would recommend their service
- The majority of women and their family classed the services as very good or good
- There were no poor responses and 1 response didn't know.

Maternity survey: A separate maternity survey is underway. The survey is given to every postnatal woman on that day on labour ward, postnatal ward, Wrekin MLU and in all community maternity areas.

Complaints: The Obstetrics and Maternity Service received 3 new complaints in December 2020, a decrease on the previous month. One each complaint relating to clinical treatment; patient care; and values and behaviour of staff. These are currently under investigation. The Service had 7 open complaints during December 2020 and closed 4 complaints.

PALS: during December the Obstetrics and Maternity Service received 10 new PALS contacts covering a variety of themes, including families affected by the issues raised as part of the Ockenden Report.

Maternity Voices Partnership (MVP) provide feedback to SaTH on women's experiences of pregnancy care and are increasingly involved in co-production with SaTH.

## **8.0 Transforming Midwifery Care**

The position remains that the CCG/LMNS is awaiting approval from NHSEI at national level in order to go out to public consultation on the proposals for Midwifery Hubs that were drafted during 2019. Whilst the CCG has been actively engaging with NHSEI for a response, we are not likely to receive approval at this time, ahead of the publication of the second and final Ockenden Report – expected towards the end of 2021. In the meantime, NHSEI have asked the CCG to review the reconfiguration proposals in light of the Ockenden report and this work will be taken forward over the next reporting period.

## **9.0 Conclusion**

The above report provides an overview of the scope of information routinely monitored by the CCG and LMNS. It covers updates on the main quality and safety areas, both in terms of performance and achievements, and also identifies where improvements are needed.

There are no particular areas of concern however, the reliability of data quality remains an issue and the implementation of the Badgernet maternity record over the next two reporting periods will in large part address this. SaTH's internal maternity governance is at an early stage of maturity, still being reliant upon external support and subject to recruitment to some key governance positions and the responsiveness of the Trust to provide information can be quite slow.

Similarly the CCG and ICS quality governance arrangements are undergoing review and subject to recruitment to key governance positions.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs  
Governing Body Meetings in Common Held in Public on  
10 March 2021**

Item Number:	Agenda Item:
GB-21-03.041	2020/21 Month 10 Financial Position

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

History of the Report (where has the paper been presented):		
Committee	Date	Purpose (A,R,S,D,I)
Month 10 Figures presented to Finance Committee	24.02.21	S I

Executive Summary (key points in the report):
<p>The Combined CCGs 20/21 forecast expenditure is currently £887.3m (£597.6m Shropshire, £289.7m Telford and Wrekin).</p> <p>The combined 20/21 annual budget allocated is currently £897.6m. This includes £4.7m of anticipated HDP income. This is also based on a plan submitted by the CCGs in late 2020 and includes £15.4m budget in excess of what had been identified by NHSEI. This budget is not signed off by NHSEI and we have been asked to work on reducing our spend in order to move towards a breakeven position.</p> <p>If the CCGs were to achieve breakeven this would mean that our forecast spend would need to reduce to £882.3m. Our current forecast of £887.3m produces a deficit of £5m spend in excess of break even (£3.2m Shropshire, £1.8m Telford and Wrekin).</p> <p>The £5m deficit includes an assumption that we will receive £4.7m of Hospital Discharge Programme income retrospectively for Months 9-12. HDP income has now been received for Months 7 and 8.</p> <p>There has been an overall improvement to the forecast outturn since last month of £4.4m. The main reasons for the in-month movement are:</p> <ul style="list-style-type: none"> <li>- (£1.7m) Individual Commissioning improvement due to reduced activity and cost in Broadcare and a reduction in the average price used for forecasting due to the latest information available.</li> <li>- (£0.1m) overall improvement to the Mental Health NCA position</li> <li>- (£1.9m) improvement due to the release of prior year accruals after a thorough review of the balance sheet</li> </ul>



- (£0.5m) improvement in acute expenditure due to a delayed start date for the Neurology service.
- (£0.2m) improvement in the overall system growth position due to an improvement in the Shropshire Community Trust position.

The forecast position includes forecast QIPP delivery of £6.8m.

System allocations are being administered through Shropshire CCG. Providers are receiving these payments through adjustments to their block contracts. At a system level there will be close monthly monitoring of both COVID and winter expenditure to ensure that funding flows across the system to where it is required.

There is potential additional mitigation to the position in the area of Individual commissioning and the forecast in this area is currently subject to a deep dive review.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

1.	Is there a potential/actual conflict of interest? <i>(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).</i>	No
2.	Is there a financial or additional staffing resource implication? <i>Yes, financial cost pressures to the CCG are described throughout the report. Overall financial risk is highlighted in the Governing Body Assurance Framework.</i>	Yes
3.	Is there a risk to financial and clinical sustainability? <i>Yes, implications to the financial position and longer term financial sustainability of the CCG are described throughout the report</i>	Yes
4.	Is there a legal impact to the organisation? <i>(If yes, how will this be mitigated).</i>	No
5.	Are there human rights, equality and diversity requirements? <i>(If yes, please provide details of the effect upon these requirements).</i>	No
6.	Is there a clinical engagement requirement? <i>(If yes, please provide details of the clinical engagement).</i>	No
7.	Is there a patient and public engagement requirement? <i>(If yes, please provide details of the patient and public engagement).</i>	No

**Recommendations/Actions Required:**

The Governing Bodies are asked to:

**Note** the information contained in this report.

Tables included in this report:

<i>Table 1: Financial Performance Dashboard</i> .....	<b>Error! Bookmark not defined.</b>
<i>Table 2: Combined financial position Month 10</i> .....	6
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## **NHS Telford and Wrekin CCG/NHS Shropshire CCG – Combined position**

### **2020/21 Month 10 Financial Position**

#### **Introduction**

1. The Combined CCGs 20/21 forecast expenditure is currently £887.3m (£597.6m Shropshire, £289.7m Telford and Wrekin).
2. The combined 20/21 annual budget allocated is currently £897.6m. This includes £4.7m of anticipated HDP income. This is also based on a plan submitted by the CCGs in late 2020 and includes £15.4m budget in excess of what had been identified by NHSEI. This budget is not signed off by NHSEI and we have been asked to work on reducing our spend in order to move towards a breakeven position.
3. If the CCGs were to achieve breakeven this would mean that our forecast spend would need to reduce to £882.3m. Our current forecast of £887.3m produces a deficit of £5m spend in excess of break even (£3.2m Shropshire , £1.8m Telford and Wrekin).
4. The £5m deficit includes an assumption that we will receive £4.7m of Hospital Discharge Programme income retrospectively for Months 9-12. HDP income has now been received for Months 7 and 8.
5. There has been an overall improvement to the forecast outturn since last month of £4.4m. The main reasons for the in-month movement are:
  - (£1.7m) Individual Commissioning improvement due to reduced activity and cost in Broadcare and a reduction in the average price used for forecasting due to the latest information available.
  - (£0.1m) overall improvement to the Mental Health NCA position
  - (£1.9m) improvement due to the release of prior year accruals after a thorough review of the balance sheet
  - (£0.5m) improvement in acute expenditure due to a delayed start date for the Neurology service.
  - (£0.2m) improvement in the overall system growth position due to an improvement in the Shropshire Community Trust position.
6. The forecast position includes forecast QIPP delivery of £6.8m.
7. System allocations are being administered through Shropshire CCG. Providers are receiving these payments through adjustments to their block contracts. At a system level there will be close monthly monitoring of both COVID and winter expenditure to ensure that funding flows across the system to where it is required.

8. There is potential additional mitigation to the position in the area of Individual commissioning and the forecast in this area is currently subject to a deep dive review.

## **Financial Performance Dashboard**

9. The CCG financial performance dashboard is shown in Table 1.
10. At Month 10 following the expected retrospective top ups, the CCGs at a combined level will be operating below the YTD plan and FOT plan submitted to NHSEI in October. The plan delivers a total £15.4m deficit compared to the allocations provided in 2020-21 and the current forecast is a £5m deficit (including system underspends). However, it is important to note that this plan has not been accepted by NHSEI and the target that we should be working to is a position of break even. During this year there has been significant non recurrent support provided to the CCGs due to the COVID pandemic so the underlying position for 2020-21 is a key consideration when thinking ahead to future years and is explained later in the report.
11. During the COVID pandemic, new rules were implemented around payments to suppliers, taking the target from payment within 30 days to 7 days. New guidance was issued on the 3<sup>rd</sup> February with the expiry of PPN02/20 which removed this requirement. However, the CCGs are still required to adhere to the Better Payment Practice code to pay suppliers within 30 days. Both CCGs continue to exceed this target with current performance in excess of 99%.
12. The cash target is to have a cash balance at the end of the month which is below 1.25% of the monthly drawdown or £250,000, whichever is greater. This was met for both CCGs in Month 10.

**Table 1: Financial Performance Dashboard**

Target/Duty	Target	CCG	RAG
Statutory Duty to Break Even	Break Even	SCCG	R
		TWCCG	R
		Combined	R
Control Total	FOT £11.871m deficit	SCCG	G
	FOT £3.575m deficit	TWCCG	G
	FOT £15.356m deficit	Combined	G
Performance against submitted plan	YTD £5.071m deficit	SCCG	G
	YTD £2.716m deficit	TWCCG	G
	YTD £7.586m deficit	Combined	G
Cash	1.25% monthly drawdown	SCCG	G
		TWCCG	G
Better Payment Practice within 30 days (no of invoices)	>=95%	SCCG	G-99.1%
		TWCCG	G-99.5%

## Summary Financial Position

13. Table 2 shows the summary year to date financial position for both CCGs combined. Tables 3 and 4 show this split between allocation that is held by the CCGs for use by the whole system and that which is fully attributable to the CCG.

**Table 2: Combined financial position Month 10**

<b>Combined</b>						
<b>Category</b>	<b>YTD Budget</b>	<b>YTD Actual</b>	<b>YTD Variance</b>	<b>Annual Budget</b>	<b>Forecast</b>	<b>Forecast Variance</b>
	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>
Allocations received	673,640	673,640	-	826,795	826,795	-
Anticipated HDP Income	2,493	2,493		4,723	4,723	
System allocations	41,937	41,937	-	50,747	50,747	-
Planned Deficit	7,787	7,787	-	15,356	15,356	-
<b>Total Allocations</b>	<b>725,857</b>	<b>725,857</b>	<b>-</b>	<b>897,621</b>	<b>897,621</b>	<b>-</b>
			-			-
Acute	346,708	345,275	1,433	425,872	424,296	1,576
Community	61,822	61,545	277	74,890	74,644	246
Individual Commissioning	61,105	56,523	4,583	77,340	72,115	5,225
Mental Health	64,671	63,371	1,300	81,112	79,083	2,029
Primary Care	90,491	88,637	1,854	109,801	107,915	1,886
Other	30,612	31,801	- 1,189	41,873	41,100	773
Running Costs	9,554	9,563	- 10	11,519	12,335	- 816
Primary Care Co Commissioning	60,894	61,142	- 248	75,214	75,870	- 656
<b>Total Expenditure</b>	<b>725,857</b>	<b>717,857</b>	<b>8,001</b>	<b>897,621</b>	<b>887,357</b>	<b>10,264</b>
<b>Deficit/Surplus</b>	- 0	8,000	- 8,001	0	10,264	- 10,264

**Table 3: System Financial Position Month 10**

System						
Category	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000
System- COVID	9,184	9,184	-	18,361	18,361	-
System - Growth	5,843	5,843	-	4,954	4,954	-
System - Top Up	18,287	18,287	-	27,432	27,432	-
						-
<b>Total Allocations</b>	<b>33,314</b>	<b>33,314</b>	-	<b>50,747</b>	<b>50,747</b>	-
			-			-
SATH	24,083	24,083	-	36,123	36,123	-
RJAH	3,327	3,327	-	6,072	4,992	1,080
Shrop Comm	2,642	2,642	-	4,214	3,964	250
CCG	3,262	3,262	-	4,338	4,338	-
<b>Total Expenditure</b>	<b>33,314</b>	<b>33,314</b>	-	<b>50,747</b>	<b>49,417</b>	<b>1,330</b>
<b>Deficit/Surplus</b>	-	-	-	-	1,330	- 1,330

**Table 4: CCG combined financial position Month 10 (excluding system reserves)**

CCG Only						
Category	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Allocations received	679,001	679,001	-	822,457	822,457	-
Anticipated HDP Income	2,493	2,493		4,723	4,723	
System allocations	3,262	3,262	-	4,338	4,338	-
Planned Deficit	7,787	7,787	-	15,356	15,356	-
<b>Total Allocations</b>	<b>692,543</b>	<b>692,543</b>	-	<b>846,874</b>	<b>846,874</b>	-
			-			-
Acute	319,287	317,854	1,433	383,664	383,168	496
Community	59,180	58,903	277	70,676	70,680	- 4
Individual Commissioning	61,105	56,523	4,583	77,340	72,115	5,225
Mental Health	64,642	63,342	1,300	81,062	79,033	2,029
Primary Care	89,235	87,381	1,854	108,294	106,408	1,886
Other	28,646	29,835	- 1,189	39,105	38,332	773
Running Costs	9,554	9,563	- 10	11,519	12,335	- 816
Primary Care Co Commissioning	60,894	61,142	- 248	75,214	75,870	- 656
<b>Total Expenditure</b>	<b>692,543</b>	<b>684,543</b>	<b>8,001</b>	<b>846,874</b>	<b>837,940</b>	<b>8,934</b>
<b>Deficit/Surplus</b>	- 0	8,000	- 8,001	0	8,934	- 8,934

## **Year to Date Position**

14. At Month 10 the CCGs reported a combined year to date underspend against plan of £8m. This position includes anticipated income for the Hospital Discharge Programme of £2.5m.
15. Key variances that make up the year to date underspend of £8m (£6.3m underspend for SCCG and £1.7m underspend for T&W CCG) are below:
- (£5.9m) YTD underspend on Individual Commissioning and Mental Health. During Month 10 there have been reductions in Broadcare activity relating to the period and the average price of packages has also fallen.
  - (£1.9m) YTD underspend on primary care due to reduced spend in prescribing compared to the position when the plan was set at M7
  - (£1.4m) YTD underspend on acute due to a full review of the balance sheet and reversal of prior year accruals
  - (£0.3m) YTD underspend on community due to reversal of prior year accruals
  - £1.2m YTD overspend on other due to a Telford budget phasing issue that will be corrected at Month 11
  - £0.2m YTD small overspend on primary care co commissioning
16. At Month 10 there is a total of £25.9m COVID related expenditure included in the position. £4.7m of this remains unfunded for the period M9-12 and a claim for HDP monies has been submitted to request this funding from NHSEI. The rest of our COVID spend was funded in M1-6 through retrospective top up allocations, for M7-8 through HDP retrospective allocations and through the system COVID allocation held by Shropshire CCG. The main areas of COVID expenditure year to date are:
- £15.3m Hospital Discharge Programme (HDP) CHC and LA spend
  - £2.1m Primary Care expenditure
  - £0.1m COVID recovery beds
  - £0.1m Running Costs
  - £0.6m Mental Health (inc S117)
  - £7.6m pass through costs to providers
17. At a system level we are monitoring COVID expenditure to ensure that funding flows across the system to where it is required.

## **Forecast Outturn Position**

18. As reported previously, following the release of the system financial envelopes and the M7-12 financial framework guidance, a system wide forecast outturn position was submitted to NHSEI in October 2020. This included a £15.4m deficit (£11.8m Shropshire CCG, £3.6m Telford CCG) for the CCGs which is the plan that has been uploaded to our ledgers and upon which our budgets have been set.
19. During Month 8 an overall improvement was made to the system forecast of £4.7m this improved again in Month 9 by a further £1.1m and this month has

improved again by £4.4m. This takes the overall deficit to £5m, a £10.4m overall improvement since the plan was set.

20. The main reasons for the in-month movement are :

- (£1.7m) Individual Commissioning improvement due to reduced activity and cost in Broadcare and a reduction in the average price used for forecasting due to the latest information available.
- (£0.1m) overall improvement to the Mental Health NCA position
- (£1.9m) improvement due to the release of prior year accruals after a thorough review of the balance sheet
- (£0.5m) improvement in acute expenditure due to a delayed start date for the Neurology service.
- (£0.2m) improvement in the overall system growth position due to an improvement in the Shropshire Community Trust position.

21. Note that within the current CCG forecast there is an assumption that the full £2.1m allocated for COVID19 will be spent. It would appear likely that this will not all be required by the CCG and therefore in future months, an element of this budget may be transferred back to the system reserve. This would allow the funds to be available for potential redistribution to other areas or to contribute to an improvement in the system position if not required.

## **QIPP**

22. The PMO team have captured the latest position and forecast for each of the projects within the joint QIPP Programme, paying particular attention to those schemes that are within the control of the CCGs. Forecast QIPP savings are reported as **£5,052k** for Shropshire CCG and **£1,728k** for Telford CCG.

23. As we approach the final two months of the year, there is confidence that forecasts will be delivered.

24. Pipeline schemes for future years still need to be defined, It remains a challenge for CCG teams to find the capacity to articulate future plans whilst holding a reduced workforce through the pandemic.

25. The initial meeting of the Systems Financial Sustainability Committee was held at the end of February, this will provide a collective oversight on the financial delivery of system programmes and will operate as a committee reporting to the ICS board with links to organisational boards.



**Table 5: QIPP Forecast Month 10**

	<b>Forecast Delivery Month 10 £000's</b>		
<b>Budget Area</b>	<b>Shropshire CCG</b>	<b>Telford &amp; Wrekin CCG</b>	<b>Total</b>
Primary Care Services	2,608	855	3,463
Individual Commissioning	2,067	625	2,692
Corporate Services	324	247	571
STP Programmes	0	0	0
Community Services	53	0	53
<b>Grand Total</b>	<b>5,052</b>	<b>1,728</b>	<b>6,780</b>

### **Run Rate and Underlying Position**

26. Although we have been recently notified that the national planning guidance has been paused due to the latest wave of COVID-19, the CCGs have been working closely with system partners and the NHSEI regional team to agree a process to develop a sustainable financial plan.
27. The first element of this process has been a detailed discussion and agreement about the underlying financial position for the organisations and ensuring that a consistent approach has been applied.
28. An underlying position of a £71.1m recurrent deficit for the CCGs has been modelled. This forms the CCG baseline element of our system modelling.

**Table 6: Underlying Position 2020/21**

<b>Combined</b>	<b>2019/20 Underlying</b>	<b>2020/21 Underlying</b>	<b>% change</b>
	<b>£'000</b>	<b>£'000</b>	
<b>Allocation</b>			
Programme	645,962	675,593	4.6%
Primary Care Co Commissioning	68,716	71,569	4.2%
Running Costs	10,396	9,178	-11.7%
Anticipated Income		4,200	
<b>TOTAL</b>	<b>725,074</b>	<b>760,540</b>	
<b>Within System expenditure:</b>			
Acute	- 310,118	- 321,383	3.6%
Community	- 64,848	- 66,277	2.2%
<b>System total</b>	<b>- 374,966</b>	<b>- 387,660</b>	
<b>Outside System Expenditure:</b>			
Acute	- 77,166	- 81,573	5.7%
Community	- 11,446	- 11,618	1.5%
Mental Health	- 70,504	- 78,070	10.7%
Individual Commissioning	- 58,672	- 65,100	11.0%
Primary Care	- 13,391	- 16,110	20.3%
Prescribing	- 79,545	- 80,760	1.5%
Other	- 25,512	- 27,960	9.6%
Running Costs	- 10,267	- 9,178	-10.6%
Primary Care Co Commissioning	- 68,911	- 73,600	6.8%
<b>Non System total</b>	<b>- 415,414</b>	<b>- 443,969</b>	
<b>TOTAL EXPENDITURE</b>	<b>- 790,380</b>	<b>- 831,629</b>	
<b>Deficit</b>	<b>- 65,306</b>	<b>- 71,089</b>	

29. Overall there has been a 5.2% increase in the recurrent expenditure level since 2019/20. Some of this increase in spend is explainable in terms of increased investment in mental health and primary care matched by increased allocations. However, overall the underlying cost base is increasing rather than stabilising or reducing.

30. Individual Commissioning is currently subject to a deep dive review as the position has been extremely complicated this year with the introduction of the Hospital Discharge Programme. All key assumptions are being tested and benchmarked with other CCGs.

31. The next steps in the process for budgeting for next year are to develop a sustainable financial plan for both the CCG and the system.

## **Risks and Mitigations (High Level)**

32. We have risk assessed the financial position reported.

**Table 7: Risks and Mitigations Month 10**

	Month 9			Month 10			In Month Movement	Explanation
	Risk	Mitigation	Net Risk	Risk	Mitigation	Net Risk	Net Risk	
HDP Income-claims outstanding	4.9		4.9				(4.9)	Now that HDP income has started to flow into the CCG this risk has been removed.
Individual Commissioning	1.5	(1.5)	-	2.0	(2.0)	-	-	Figures updated to reflect latest position. Individual Commissioning deep dive review underway and we may be able to remove risk or include mitigation in the bottom line position once this is complete.
Prescribing	0.9	(0.9)	-	0.9	(0.9)	-	-	It is still felt that the forecast covers additional risk as building in a % above EPACT
	<b>7.3</b>	<b>(2.4)</b>	<b>4.9</b>	<b>2.9</b>	<b>(2.9)</b>	<b>-</b>	<b>(4.9)</b>	

33. The previous risk highlighted in relation to hospital discharge income has now been removed as funding has now started to flow from NHSEI and allocations have been received for Months 7 and 8.

34. For Individual Commissioning and Prescribing, risk remains due to the volatility of these spend areas but there is now felt to be sufficient cover within the financial position to tolerate reasonable movements in the forecast.

35. As previously described there is a deep dive exercise currently underway in terms of reviewing the Individual Commissioning position and it is felt that this could improve the position in this area further. Once this review is complete we may be able to remove the risk and potentially take mitigation to the bottom line position.

36. The main risk that cannot currently be quantified is the impact of the latest COVID-19 developments on the financial position of the CCG.

37. The CCG overall current forecast spend is £887.3m. Now that net risk is zero the risk adjusted position is the same.

38. If risks materialised and mitigations didn't, the worst case scenario would be a spend position of £890.2m and a deficit of £7.9m. If mitigations occur and risks don't, the best case scenario would be a total spend of £884.4m and a deficit of £2.1m.

Worst Case £7.9m deficit	Most Likely £5m deficit	Best Case £2.1m deficit
-----------------------------	----------------------------	----------------------------

39. Due to the current situation with the COVID-19 pandemic the release of national planning guidance for 2021/22 has been delayed although some information is emerging slowly. As described earlier the system DoFs group is currently focusing on ensuring a full understanding of the system underlying financial position and the movements to run rate since 2019/20.

## **Conclusion**

40. At Month 10 the CCGs are collectively forecasting to spend £887.3m which is £10.4m lower than the submitted plan. This includes a £9m reduction in CCG specific expenditure and also £1.3m reduction in system spend. This still represents a £5m overspend against the NHSEI required break even position for the year.

41. Overall risk to the position is highlighted and scenarios around best and worst case illustrated.

42. This forecast position and more importantly the underlying position for 2020/21 forms the basis of the longer term CCG financial recovery plan and financial strategy as well as the system long term financial plan which is currently being refreshed.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs  
Governing Body Meetings in Common held in Public on  
10 March 2021**

Item Number:	Agenda Item:
GB-21-03.042	2021/22 Plan Update

Executive Lead (s):	Author(s):
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Action Required (please select):									
A=Approval	<input checked="" type="checkbox"/>	R=Ratification	<input type="checkbox"/>	S=Assurance	<input checked="" type="checkbox"/>	D=Discussion	<input type="checkbox"/>	I=Information	<input checked="" type="checkbox"/>

History of the Report (where has the paper been presented):		
Committee	Date	Purpose (A,R,S,D,I)
Finance Committee	24.02.2021	A/S/I

Executive Summary (key points in the report):
<p>The purpose of this paper is to update the Governing Bodies on the current system discussions around 2021/22 financial planning.</p> <p>Due to the ongoing situation with the COVID-19 pandemic the normal planning timetable has been postponed. The 2020/21 financial framework will therefore be rolled forward for the first 3 months of 2021/22 and the planning round will be deferred to quarter 1, with a focus on plans and financial regime commencing from 1 July 2021.</p> <p>The likely timescale for guidance/release of financial envelopes is currently thought to be:</p> <ul style="list-style-type: none"> <li>- February – further guidance on the quarter 1 rollover and associated requirements (this has not yet been received)</li> <li>- March- final quarter 1 envelopes confirmed (following confirmation of the funding settlement with the government)</li> <li>- Early April- Quarter 2-4 operational planning guidance issued</li> <li>- End of June- Quarter 2-4 final operational plans submitted.</li> </ul> <p>In the absence of national guidance, the local system continues to plan for 2021/22 with key assumptions agreed across the system which will be updated once guidance is received.</p>

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

<b>Recommendations/Actions Required:</b>
<p>The Governing Bodies are asked to:</p> <p><b>Note</b> the information contained in this report.</p> <p><b>Support</b> a 2021/22 Q1 operational budget for use within the CCG until guidance is received and this can be updated. This will be based on the outline Q1 figures presented in this report.</p>

Tables included in this report:

Table 1: High Level Q1 Position .....	4
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## **NHS Telford and Wrekin CCG/NHS Shropshire CCG – Combined position**

### **2021/22 Plan Update**

#### **Introduction**

The purpose of this paper is to update the Governing Bodies on the current system discussions around 2021/22 financial planning.

Due to the ongoing situation with the COVID-19 pandemic the normal planning timetable has been postponed. The 2020/21 financial framework will therefore be rolled forward for the first 3 months of 2021/22 and the planning round will be deferred to quarter 1, with a focus on plans and financial regime commencing from 1 July 2021.

The likely timescale for guidance/release of financial envelopes is currently thought to be:

- February – further guidance on the quarter 1 rollover and associated requirements (this has not yet been received)
- March- final quarter 1 envelopes confirmed (following confirmation of the funding settlement with the government)
- Early April- Quarter 2-4 operational planning guidance issued
- End of June- Quarter 2-4 final operational plans submitted.

In the absence of national guidance, the local system continues to plan for 2021/22 with key assumptions agreed across the system which will be updated once guidance is received.

#### **Quarter 1**

In the absence of any guidance or published financial envelopes, we are currently assuming for quarter 1 of 2021-22 that:

- The CCG will receive a quarter of the ring fenced running cost and primary care co commissioning allocations published for 2021/22 plus a programme allocation that is in line with that received in M7-12 of 2020/21 excluding the extra system pass through payments and uplifted by a notional 2.8% for 2021/22.
- That Q1 spend will be in line with spend modelled through the agreed 2021/22 planning assumptions with the system other than where block payments will be in place as a continuation from 2021/22.
- That the underlying position carried forward into 2021/22 will be in line with the system agreed position.
- That we will not continue to receive any funding for the Hospital Discharge programme.
- That we will continue to pay providers the block payments that they received in 2020/21.

At a very high level the table below shows the likely financial position for the new Strategic Commissioning Organisation in Quarter 1 recognising all of the assumptions raised above.

**Table 1: High Level Q1 Position**

	<b>Q1 £'000</b>	<b>Comments</b>
Allocation	£205,005	Based on 3/12 of M7-12 20/21 programme allocation issued plus notional 2.8% uplift, 3/12 of notified primary care co commissioning allocation and 3/12 of notified running cost allocation – all allocations subject to change – awaiting release of financial envelopes from NHSE/I.
Expenditure	£211, 927	Based on agreed system assumptions for modelling of 2021/22 plan including 2% overall inflation, agreed growth %'s for each category of spend, achievement of MHIS and assumption that no efficiency will be achieved in Q1. Assumption that acute block, independent sector and NCA arrangements will continue in Q1.
Deficit	£6,922	

The table above shows that on the basis of all of these assumptions there would be a £6.9m deficit in Q1 of 2021/22. However, it should be noted that allocation figures and block payment figures for NHS providers have not yet been released and we are not yet sighted on the assumptions that will underpin their construction.

This information was reviewed by the Finance Committees at their meeting in common on 24<sup>th</sup> February 2021. A proposition to seek support from the Governing Bodies for an operating budget set on this basis in the absence of further guidance was agreed.

If further information is released from the national team between the writing of this paper and the Governing Body meeting, a verbal update will be given at the meeting.

### **2021/22 System Planning**

As a system all partners have agreed to work together to develop a sustainable financial plan for 2021/22 and onwards.

The financial regime is changing with accountability for a whole system allocation across NHS partners. This requires a change in approach to managing financial recovery and ongoing financial sustainability at both system and organisation level.

A new financial framework for 2021/22 is being developed to ensure a more equitable distribution of funds across the system. A focus on cost rather than income is required to ensure ongoing financial sustainability.

We have set ourselves a target to achieve stabilisation in 2021/22 though much work needs to be done to test how this will be realistically achieved.



A 5 year recovery plan will be built with a focus on accelerating significant change in years 1-3. The system needs to build confidence with regulators that we can deliver an improvement plan including progress to financial sustainability.

As the development of this plan continues both the system and CCG elements of the plan will be presented to and discussed with the Finance Committee and Governing Body.

**Recommendation:**

In the absence of any firm planning guidance or financial envelope it is recommended that the Governing Bodies support a 2021/22 Q1 operational budget for use within the CCG until guidance is received and this can be updated. This will be based on the outline Q1 figures presented in this report.

Further developments regarding the 2021/22 CCG and system plan will be received by the Governing Bodies in due course.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs  
 Governing Body Meetings in Common held in Public on  
 10 March 2021**

Item Number:	Agenda Item:
GB-21-03.044	GP IT Futures Re-procurement of GP Clinical Systems

Executive Lead (s):	Author(s):
Claire Skidmore Executive Director of Finance <a href="mailto:claire.skidmore@nhs.net">claire.skidmore@nhs.net</a>	Antony Armstrong Primary Care IT Lead <a href="mailto:Antonyarmstong@nhs.net">Antonyarmstong@nhs.net</a>

Action Required (please select):									
A=Approval	<input checked="" type="checkbox"/>	R=Ratification	<input type="checkbox"/>	S=Assurance	<input checked="" type="checkbox"/>	D=Discussion	<input type="checkbox"/>	I=Information	<input checked="" type="checkbox"/>

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

Executive Summary (key points in the report):
<p>The national GP IT Futures Lot 1 Framework Agreement replaced the GP System of Choice (GP SOC) Framework from 1<sup>st</sup> January 2020 for the provision of GP practice IT solutions. Several suppliers were assessed as compliant from the beginning and were awarded Continuity Call Off Agreements (CCOA). These CCOAs were time bounded in the contract in the anticipation of a full procurement exercise; all expire at the end of March 2021.</p> <p>Due to the impact of the COVID-19 pandemic there has been insufficient time to enable a full national procurement process as originally envisaged in the Framework and therefore NHS Digital have been working to secure an interim arrangement to allow time for a full process to occur.</p> <p>The purpose of this paper is to seek approval from the Governing Bodies to sign Bridging Agreements that have been developed for the CCGs that extend arrangements until such time that a full procurement process can be conducted.</p> <p>This is to ensure that suitable contractual arrangements remain in place with suppliers for supply and support of solutions and to remain compliant from a data processing perspective.</p>

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

Recommendations/Actions Required:
<p>The Governing Bodies are asked to:</p> <p><b>APPROVE</b> the sign off of call off order forms for the suppliers listed in Table 1 in order that contractual bridging arrangements can be put in place ahead of a 2021/22 full procurement process.</p>

Tables included in this report:

<i>Table 1: Bridging Agreements</i> .....	4
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## **NHS Telford and Wrekin CCG/NHS Shropshire CCG GP IT Futures Re-procurement of GP Clinical Systems**

### **Introduction**

1. The national GP IT Futures Lot 1 Framework Agreement replaced the GPSoC Framework from 1st January 2020 for the provision of GP practice IT solutions. Several suppliers were assessed as compliant from the beginning and were awarded Continuity Call Off Agreements (CCOA) for each CCG that had GP Practices using those solutions. In total over 565 CCOA's were awarded nationally to those suppliers which include EMIS, TPP, DXS, Advanced, Informatica and Prescribing Services. These CCOAs are timebound in the contract and all expire at the end of March 2021. There is no legally compliant route to extend these specific CCOAs without a risk of challenge from other providers.
2. Due in large part to Covid-19 and the resultant re-focus of activities both at NHS Digital and at CCG and GP Practice levels there has been insufficient time to complete a full re-procurement as envisaged within the Framework and in the GP IT Futures Business Case. Further, and again, as a result of Covid-19, there are fewer suppliers currently who have completed compliance checks and therefore are available to procure from via the Buying Catalogue due to NHS Digital resource being used to support the Covid-19 response.

### **Bridging Arrangements**

3. To support CCGs in the short term, NHS Digital have created a procurement vehicle under the GP IT Futures Lot 1 framework, which allows Call Off Agreements to be awarded for values of up to £1.5M, covering both Foundation and non Foundation solutions.
4. These 'Bridging Agreements' are time bounded to a maximum of eighteen months, and therefore the CCG is expecting to complete a full re-procurement within this timeframe.
5. Working together, NHS Digital and the National Commercial and Procurement Hub (the Hub) have provided support and advice on this matter to the CCGs and have worked through the process on our behalf.
6. They have verified the estate data with the CCG, to ensure that it is up to date and, importantly, that all products in the estate are in use. The Bridging Agreement process was then executed, with a mini competition run by NHS Digital / the Hub on behalf of the CCGs.
7. The mini competition focussed on the timescales for change and cost of change associated with switching products in the short term. Following the mini competition,

NHS Digital / the Hub have provided the CCGs with order summaries, which outline the ongoing contractual position for the solutions in use. These order summaries and associated call-off order forms now require sign off which, according to CCG governance is after approval from the Governing Bodies. Upon signature, the call-off order form will form the contract between the supplier and the CCG.

## **Outcome**

8. The Bridging Agreement process has been completed for Shropshire, Telford and Wrekin CCG and the outcome of this is a proposed retention of **all** existing solutions within the GP IT estate:

**Table 1: Bridging Agreements**

<b>CCG</b>	<b>Supplier</b>
Shropshire	Advanced
Shropshire	Egton EMIS
Shropshire	Informatica
Shropshire	Eclipse
Telford and Wrekin	Advanced
Telford and Wrekin	Eclipse
Telford and Wrekin	Egton EMIS

9. The Bridging Agreements with each of our key suppliers will become effective from 1st April 2021 and will run for a maximum of 18 months. NHS Digital will continue to work with the CCG to procure the entire GP IT estate under the GP IT Futures framework ahead of the end of this period. Our next steps are to finalise an appropriate timeframe and parameters for our requirements.

## **Finances**

10. Allocations for this area of GP IT have historically been held centrally with NHSEI who have provided the CCG with regular information on spend so that it can be monitored locally. To date, any overspend has been covered by NHSEI but from 2021/22 onwards any excess spend above the allocation must be met locally.
11. This has been known about within the CCGs for some time and we have been anticipating in our finance plan a £90k per annum cost pressure to be taken on if we continue to procure exactly the same things as previously. Budget and spend are already included in the CCG baseline budget for 21/22. The IT team will be conducting a full review of IT expenditure (to also include other spend outside of the GP IT Futures Framework) in order to seek efficiencies in our spending and contribute to the reductions required in our overall cost base.

## **Recommendation:**

12. Governing Body members are asked to:

13. **APPROVE** the sign off of call off order forms for the suppliers listed in Table 1 in order that contractual bridging arrangements can be put into place ahead of a 2021/22 full procurement process.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.046	Single Strategic Commissioner – Vision and Strategic Objectives

<b>Executive Lead (s):</b>	<b>Author(s):</b>
David Evans Accountable Officer David.evans2@nhs.net	Alison Smith Director of Corporate Affairs <a href="mailto:alison.smith112@nhs.net">alison.smith112@nhs.net</a>

<b>Action Required (please select):</b>					
A=Approval	<input checked="" type="checkbox"/>	R=Ratification	<input type="checkbox"/>	S=Assurance	<input type="checkbox"/>
D=Discussion	<input type="checkbox"/>	I=Information	<input type="checkbox"/>		<input type="checkbox"/>

<b>History of the Report (where has the paper been presented):</b>		
<b>Committee</b>	<b>Date</b>	<b>Purpose (A,R,S,D,I)</b>
Not applicable		

**Executive Summary (key points in the report):**

In August 2020 the Jointly appointed Governing Body members of both CCGs undertook a series of board development workshops to support the transition into the new single CCG from 1<sup>st</sup> April 2021.

One of the outputs of these workshops has been the development of the new CCG's purpose statement and strategic objectives which are presented here for approval.

**Purpose Statement:**

We will identify healthcare outcomes for the people of Shropshire, Telford and Wrekin, ensuring services reflect the needs of the population. We will hold healthcare providers to account for the delivery of safe, high quality, value for money services that improve the health of the local populations.

**Strategic priorities:**

- 1.To understand the diverse health and care needs of our local population, making health and care services available when and where they are needed, in order to reduce health inequalities.
- 2.To facilitate joint working as a system, leading on the creation of a shared vision, purpose and narrative.
- 3.To achieve and maintain financial balance whilst improving efficiency and productivity.
- 4.To ensure that the care we commission improves health outcomes and is high quality, safe and sustainable.

The purpose of the report is to:

- 1) note the recent development work the Governing Body members have undertaken and the

outputs of these discussions

2) support and approve the purpose statement and strategic priorities outlined above for final adoption by the new single CCG Governing Body post 1<sup>st</sup> April 2021.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication? Costs for these appointments where applicable have already been taken into account within 2020/21 budgets.	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation?  The joint appointment to both CCG Governing bodies meets the requirements set out in legislation and regulations.	No
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

**Recommendations/Actions Required:**

**NHS Shropshire CCG Governing Body is recommended to:**

- 1) note the recent development work the Governing Body members have undertaken and the outputs of these discussions; and
- 2) support and approve the purpose statement and strategic priorities outlined above for final adoption by the new single CCG Governing Body post 1<sup>st</sup> April 2021.

**NHS Telford and Wrekin CCG Governing Body is recommended to:**

- 1) note the recent development work the Governing Body members have undertaken and the outputs of these discussions; and
- 2) support and approve the purpose statement and strategic priorities outlined above for final adoption by the new single CCG Governing Body post 1<sup>st</sup> April 2021.



**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.047	NHS Patient Safety Specialist Q4 Update

<b>Executive Lead (s):</b>	<b>Author(s):</b>
Zena Young – Executive Director Nursing and Quality	Tracey Slater- Interim Assistant Director of Quality

<b>Action Required (please select):</b>									
A=Approval	<input checked="" type="checkbox"/>	R=Ratification	<input type="checkbox"/>	S=Assurance	<input type="checkbox"/>	D=Discussion	<input type="checkbox"/>	I=Information	<input checked="" type="checkbox"/>

<b>History of the Report (where has the paper been presented:</b>		
<b>Committee</b>	<b>Date</b>	<b>Purpose (A,R,S,D,I)</b>
A report on the Patient Safety Specialist was brought to Board in November 2020; this paper provides an update on progress and has not been received elsewhere.	N/A	N/A

<b>Executive Summary (key points in the report):</b>
<p>The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, was published by NHSE/I in July 2019. This report provides an update on progress against the ambitions of the Strategy and details progress made and training plans.</p> <p>The recently published update to the Patient Safety Strategy continues to focus on the principles and high-level strategic objectives, however there has been an acknowledgement of the need for some shift in scope. Health inequalities, patient voice and vulnerable groups are all specifically referenced in the new plans.</p> <p>An outline training programme is described.</p> <p>A local update is provided which describes system commitment to delivering the Strategy, but notes that progress is delayed due to vacancy in key positions.</p> <p>The NHS Patient Safety Strategy: 2021 update is appended for information.</p>

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

<b>Recommendations/Actions Required:</b>
<p>That CCG Governing Body:</p> <ul style="list-style-type: none"> <li>- Note the content of this report.</li> <li>- Note the delay in recruitment to the role due to CCG Management of Change.</li> <li>- Approve the recommendation that an update to board is brought on a bi-annual basis.</li> </ul>

## **1 Background**

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, was published by NHSE/I in July 2019. The Strategy sits alongside the NHS Long Term Plan (LTP) and the LTP Implementation Framework. When the NHS Patient Safety Strategy was published there was a commitment to periodically updating it in order to maintain the focus of evolving healthcare landscape on activities that would have the greatest impact on patient safety. The NHS patient Safety Strategy 2021 update continues to focus on the principles and high-level strategic objectives however there has been an acknowledgement of the need for some shift in scope.

Since November 2020 organisations have identified their Patient Safety Specialists. Within STW CCG it was endorsed at the Governing Body meeting in November that a Patient Safety Specialist (PSS) had been nominated from within the CCG as an additional function to an existing role; PSS are involved in work to develop the role notably:

- The expansion of the Patient Safety Specialist network
- Publication of the patient safety incident management system
- Publication of the patient safety partners framework
- Patients safety syllabus
- Patient safety education and training
- Pilot phase of the adoption of the patient safety Incident Response Framework (early adopter sites)

## **2 National/Regional Update**

A year after establishing the 2019 Strategy initiatives, the impact of Covid-19 on implementation has resulted in several of the original timelines being disrupted. Whilst refreshed plans indicate the NHS are expected to restart work, there remains some uncertainty on the required pace of progress. Preparatory work by the NHS key-enablers work stream has managed to be maintained throughout the pandemic, with the development of networks of organisations and individuals working to achieve the Strategy goals.

The 2021 published update details the following changes:

- The Covid-19 pandemic has demonstrated the increasing evidence of disparities in healthcare outcomes and interactions. An explicit new objective is the development of an evidence base to identify how to effectively reduce health inequalities and address issues of equality, diversity and inclusion.
- There is also an opportunity to ensure that the patient voice from all communities, especially those with health inequalities is embedded through appropriate communication and engagement channels with diverse representation of Patient Safety Partners (PSP) within organisations that reflects the local population.
- In addition there is further ambition to meet the needs of specific vulnerable groups notably to address the safety issues faced by older people and people with learning disability.

## **3 Training**

There has been national progress with the role and the CCG representative has contributed to this. All PSS have been invited to attend a number of webinars, hosted on the Futures NHS Collaboration Platform. The CCG PSS has attended a number of webinars and MST meetings to discuss the role, and explore future initiatives.

There are a recognized training programmes to support growth of Patient Safety roles: the syllabus remains under development, but the below gives a high level description of current plans:

- L1– Launch by June 2021- this will be for all NHS staff to undertake and contributes to underpinning a culture of patient safety within the NHS
- L2- Educational module – launched by July 2021 for all PSS
- L3-L5 - Educational Modules – launched by March 2022 – for all PSS

#### **4 Local Update**

As a PSS there are opportunities to network and share insights and solutions both as a system but also regionally and nationally. The individual will work within their organisation to develop and create an environment where clinicians can practice safety. In order to achieve this, the first NHS wide patient safety syllabus is being developed and will be applicable to all staff. It reflects:

- best practice in building safe systems
- focus on prevention of harm whilst improving learning from incidents and applying system thinking
- encompasses all national safety initiatives including national alerts, key safety regulations and safety campaigns

In accordance with the NHS guidance the PSS role is required to be the equivalent of a whole time function within all organisations by April 2021. Within the CCG this role has been integrated into a combined new post. However although there is approved funding for this post, recruiting to this role has been delayed due to CCG management of change processes. This has resulted in a limited resource within the CCG which has impacted on pace of progress and will continue to do so until the vacancy is recruited to.

Nevertheless, despite both limited resource and the Regional meeting of PSS being paused due to Covid-19, STW maintained a local system meeting, this was well received with a proposed follow-up meeting.

The system Patient Safety Group is attended by all main provider Patient Safety Specialists and it is envisaged that over time this forum will become the system PSS platform to deliver the Strategy. This group will have Terms of Reference to include a remit for system learning and peer support and over time will establish links with Patient Safety Specialist's in smaller provider services across the system.

#### **5 Conclusion**

Work is restarting to invigorate the Patient Safety Strategy, taking learning from the Covid-19 pandemic experience. Our system remains committed to implementing the Strategy over time and has a platform to do this, however progress remains somewhat hampered due to lack key appointments to ensure progress is made at pace.

#### **6 Recommendation**

It is recommended that CCG Governing Body:

- Note the content of this report
- Note the delay in recruitment to the role due to CCG Management of Change and the consequent impact on pace of change
- Approve the recommendation that an update to board is brought on a bi-annual basis



# NHS Patient Safety Strategy: 2021 update

**Published February 2021**

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# Foreword

When we published the NHS patient safety strategy in 2019, we committed to updating it periodically to maintain our focus in an evolving healthcare landscape on those activities that will have greatest impact on safety improvement. While the principles and high-level objectives of the strategy remain unchanged, we have recognised the need for some shift in scope.

We have updated our tables of deliverables to include the extra work we will be doing. An explicit new objective I would like to highlight is the development of an evidence base to identify how we can most effectively contribute to reducing health inequalities. There is increasing evidence of disparities in healthcare outcomes and interactions between different ethnic groups, e.g. in [COVID-19](#) outcome, maternal mortality and mental health provision. Socioeconomic status and where in the country someone lives also impact on morbidity and mortality. Evidence about disparities in the safety of healthcare experienced by different groups is often lacking or inconclusive; this limits our ability to design system-level initiatives that may help to address these health inequalities. We must also look at our existing programmes and ways of working to ensure that we take every opportunity to address issues of equality, diversity and inclusion.

After a year establishing the strategy initiatives and adapting them for what is becoming the 'new normal', we expect to meet some significant progress milestones in 2021: expansion of the patient safety specialist network, publication of the patient safety partners framework and roll out of the new patient safety incident management system. As ever we are grateful for the continued support and energy of colleagues and patients in bringing such strategies to life, working towards a shared vision for patient safety in the NHS.



**Aidan Fowler**  
**NHS National Director of Patient Safety**

# A view from patient safety partners

We want to take the opportunity to highlight the importance of patients, carers and families not just as beneficiaries of the strategy but also key participants in delivering it. As patient safety partners (PSPs) and members of the strategy oversight committee, we bring our experiences and perspectives to steer implementation of this strategy across the board and ensure that the focus on patients is not lost among the progress reports, NHS jargon and wider strategic issues raised. We provide the opportunity to ensure that the patient voice from all communities – especially those with health inequalities – is being embedded into the Patient Safety Strategy through appropriate communication and engagement channels; the importance of which has been demonstrated over the last year by COVID-19 disproportionately affecting those from black, Asian and minority ethnic (BAME) communities.

Understandably, one of the strategy objectives closest to our hearts is the patient safety partner framework which aims to emulate this model of involvement of patients, carers and families in patient safety throughout the NHS. Our aspirations for this work include having a diverse representation of PSPs within organisations that reflects the local population, with the training and support available to enable this.

A clear enabler for this is to align work on the patient safety syllabus and the PSP framework.

The next few months provide a crucial window of opportunity to facilitate this, as we oversee in parallel how consultation feedback is reflected in the PSP framework, and how production of the patient safety syllabus (and broader education and training goals) reflect the patient and public voice.

There are many patient representatives besides us who are actively contributing to delivery of the patient safety strategy, and on behalf of the strategy oversight committee we thank them all for the valuable insight they continue to contribute in what is an especially challenging and hard time for us all.

Angela Hamilton, Khudeja Amer-Sharif and Neill Vinter

**Patient Safety Partners**



# What has changed and why?

## Equality, diversity and inclusion

The most significant strategy update is the new commitment to address patient safety inequalities, with a new objective added to the safety system strand of the strategy. We have also reviewed how we are implementing all other objectives to identify what more we can do to reduce inequalities.

We are committed to identifying whether and how current patient safety culture and mechanisms contribute to health inequalities, including by engaging with patient, staff and other stakeholder groups. We will then set specific actions for the national patient safety team, local stakeholders and individual clinicians to address inequalities in patient safety.

Our ambition to meet the needs of specific vulnerable groups continues in the improvement strand – notably the objectives to address the safety issues faced by older people and people with a learning disability. We recognise that a comprehensive plan to address patient safety inequalities must consider how multiple inequalities combine to affect outcomes for particular patient groups. For example, [last year's LeDeR annual report](#) said that in 2019 people with a learning disability from BAME groups “died disproportionately at younger ages than white British people. Of those who died in childhood (ages 4 to 17 years), 43% were from BAME groups.”

## Impact of COVID-19 on strategy implementation

We have revised several of the original strategy timelines to reflect the disruption and uncertainty arising from the pandemic. Some uncertainty continues and the new timelines are based on assumptions about colleague and service capacity to implement new initiatives in 2021 and beyond.

Disrupted plans aside, colleagues delivering the strategy workstreams have shown enormous adaptability.

- Our national patient safety insight team prioritised the identification of COVID-19 related risks to support the system's rapid learning as it responded to the pandemic.

- The national patient safety improvement programmes focused on supporting the NHS COVID-19 response, e.g. how to manage deterioration.
- Medical examiners provided their acute trusts with invaluable on the ground support.
- The national team issued a regular COVID-19 patient safety update for patient safety leaders.

The COVID-19 response has underlined the value that medical examiners and patient safety specialists could have in any future pandemic response or other national health crisis. We have sought to accelerate the rollout of these programmes. The Royal College of Pathologists adapted the medical examiner training for online delivery, and the patient safety specialist initiative was launched.

We continue to issue regular (monthly) communications to patient safety colleagues, to keep our growing community of patient safety specialists sighted on national patient safety news.

## Patient safety infrastructure

This refresh translates the high-level objectives for the safety culture and safety system strands of the strategy into more tangible deliverables. We will create a dedicated space to share insight on safety culture indicators and offer guidance on how to identify and address culture issues. We do not intend safety culture indicators to be used to assess organisation performance or for regulatory purposes. The goal of this programme is solely to support and enable organisations to improve their safety culture through embedding a continuous cycle of understanding the issue – developing a plan – delivering the plan – evaluating the outcome.

We have also updated the principles underpinning all the national safety improvement programmes to reflect our exploration of a cross-cutting ‘key enablers’ workstream.

What may not be apparent from the updated objectives and deliverables is the ongoing work to develop the networks of organisations and individuals who are working directly with us to achieve the strategy’s goals. We held our first online meeting with registered patient safety specialists in October 2020; their energy and enthusiasm will galvanise the formation of effective local networks over the next few months. Trusts had until the end of November to let us know who they had identified as their patient safety specialists and we look forward to involving them in our work to develop the role, notably that on the patient safety syllabus and patient safety education and training. We

have started the pilot phase of adoption of the Patient Safety Incident Response Framework and several early adopter organisations have managed to maintain their preparatory work throughout the pandemic.

## Technical updates

The tables below include all the updates to the original strategy and the new objectives. New items under 'What and by when' largely replace non-specific items, or they clarify milestones that in 2019 were insufficiently developed. Those that have been achieved have been removed ([as recorded in the strategy progress report published in September 2020](#)) as have others for which the learning from the last year has shown very limited potential for further alignment and value from their explicit inclusion in the strategy.

**Table 1: Safety culture objectives**

Objective	Who will deliver this	What and by when	Changes from the original deliverables (shown in grey)
<p><b>Monitor the development of a safety culture in the NHS</b></p>	<p>National patient safety team</p>	<p>Assess whether additional safety culture questions in the staff survey would have value by Q4 2020/21.</p> <p>Complete a discovery phase for a safety culture data ‘visualisation tool’ by Q2 2021/22, which includes identifying potential new metrics related to safety cultures in the scope.</p>	<p><b>Updated</b> to reflect the 2020 changes to the NHS staff survey and plans for its future development.</p> <p>Original:</p> <p>NHS staff survey q17 (fairness and effectiveness of reporting) and q18 (staff confidence and security in reporting), published annually every spring.</p> <p>Explore the introduction of further metrics related to safety cultures, e.g. monitoring levels of staff suspension and of anonymous incident reporting.</p>
		<p>Explore the safety culture characteristics of highly safe NHS trusts, and share insights by Q1 2021/22.</p> <p>The maternity and neonatal safety improvement programme will ascertain how insights from the initial safety culture survey are being used and what key interventions high scoring organisations are using during 2021/22, ahead of repeat culture surveys.</p>	<p><b>Updated</b> to make the deliverables more specific.</p> <p>Original:</p> <p>Monitoring progress in relation to the well-led framework via CQC inspection outcomes as published</p>
<p><b>Support the development of a safety culture in the NHS</b></p>	<p>National patient safety team</p>	<p>Establish the safety culture work programme to bring together data, research and practical support for safety culture improvement by Q1 2021/22.</p>	<p><b>New</b> deliverables added to specify national action to support safety culture development.</p>

		<p>Produce a safety culture guide to help organisations implement specific improvement activities by Q1 2021/22 (see key enablers objective under Safety system).</p> <p>Extend the exploration of safety culture processes and infrastructure to mental health, community and primary care settings by Q4 2021/22.</p> <p>Continue to establish and test safety culture interventions to support local systems, as part of the key enablers objective.</p>	
	Local systems	<p>Local systems to set out how they will embed the principles of a safety culture on an ongoing basis.</p> <p>These should include monitoring and response to NHS staff survey results and any other safety culture assessments, adoption of the NHS England and NHS Improvement '<a href="#">A Just Culture Guide</a>' or equivalent, adherence to the well-led framework and 100% compliance declared for National Patient Safety Alerts by their action complete deadlines.</p>	<p><b>Updated</b> to include compliance with National Patient Safety Alerts which was previously in a different section of the strategy.</p>

**Table 2: Safety system objectives**

Objective	Who will deliver this	What and by when	Changes from the original deliverables
<p><b>Clarify who does what in relation to patient safety</b></p>	<p>National patient safety team</p>	<p>Develop the National Patient Safety Committee (see specific deliverable under Insights).</p> <p>Explore the existing provision of information to patients about raising patient safety issues and concerns, and assess if there is a gap, by Q1 2021/22.</p>	<p><b>Updated</b> to reflect the fact that patient safety is an evolving landscape requiring the continual development of working relationships between organisations to respond to new challenges.</p> <p><b>Updated</b> to reflect patient feedback on information needs.</p> <p>Original: Publish a definitive guide to who does what in relation to patient safety</p>
<p><b>Support workforce development through the NHS People Plan</b></p>	<p>National patient safety team and the NHS England and NHS Improvement Workforce Policy and Strategy team</p>	<p>Identify by Q1 21/22 how we can contribute to <a href="#">We are the NHS: People Plan for 2020/2021</a>, specifically in relation to plans for:</p> <ul style="list-style-type: none"> <li>• bringing more people into the NHS to implement the Long Term Plan</li> <li>• addressing health inequalities, embedding health and wellbeing support and fostering a culture of trust</li> <li>• fostering a culture of belonging in trusts, STPs, ICSs and across directorates</li> <li>• facilitating new ways of working and delivering care</li> <li>• education and training for executives and leaders</li> <li>• increased places for undergraduates in nursing, allied health professions and medicine, including patient safety modules in the programmes.</li> </ul> <p>Co-develop a plan for collaboration by Q2 2021/22.</p>	<p><b>Updated</b> to align with the People Plan published in July 2020.</p>

<p><b>Support quality planning, surveillance, and improvement through NHS England and NHS Improvement quality governance processes</b></p>	<p>National patient safety team and the NHS England and NHS Improvement Quality Strategy team</p>	<p>Identify by Q1 2021/22 how we can ensure safety strategy alignment within quality strategy in local systems, with regard to:</p> <ul style="list-style-type: none"> <li>• promoting a shared view of quality</li> <li>• embedding quality (including safety) into ICS structures.</li> </ul> <p>Aligning with governance and reporting mechanisms. Co-develop a plan for collaboration by Q2 2021/22.</p>	<p><b>New</b> objective added to ensure the strategy translates to local system leadership structures and processes as they continue to develop.</p>
<p><b>Ensure understanding of patient safety is embedded across regulatory bodies</b></p>	<p>National patient safety team working with regulators</p>	<p>Enable within regulatory bodies:</p> <ul style="list-style-type: none"> <li>• uptake of the training in the essentials of patient safety by Q1 2023/24</li> <li>• identification of their regulatory body patient safety specialist by Q1 2021/22.</li> <li>• inclusion of two patient safety partners on their safety-related clinical governance committees (or equivalents) by Q1 2022/23.</li> </ul>	<p><b>Updated</b> to include dates. Original: Encourage:</p> <ul style="list-style-type: none"> <li>• uptake of the new patient safety curriculum and training</li> <li>• contribution to the patient safety specialist network</li> <li>• commitment to patient safety partners.</li> </ul>
<p><b>Reflect patient safety in the digitisation agenda</b></p>	<p>NHSX, working with the national patient safety team, clinical leaders and NHS Digital</p>	<p>Co-develop and implement a work programme with the leads of NHSX Mission 4 (patient safety) by Q2 2021/22.</p>	<p><b>Updated</b> to recognise the establishment of NHSX Mission 4 (Patient Safety). Original: Make the safety case for the initiatives in Chapter 5 of the NHS Long Term Plan including:</p> <ul style="list-style-type: none"> <li>• EPMA implementation</li> <li>• record digitisation and data linkage</li> <li>• patient access to their records</li> <li>• clinical decision support.</li> </ul>

<b>Enhance safety in primary care</b>	National patient safety team working with primary care leaders	Scope and produce a primary care patient safety plan by Q2 2021/22, to include: <ul style="list-style-type: none"> <li>• how primary care involvement can be expanded in the national patient safety improvement programmes (NatPatSIPs)</li> <li>• how the developing NHSX programme relates to primary care.</li> </ul>	<b>Removed</b> the following as the programme draws to a close: Support the Keeping General Practice Safe component of the 2019 to 2021 GP IT operating model.
		Expanding incident reporting in primary care by replacing the National Reporting and Learning System (NRLS) from Q1 2021/22.	<b>Updated</b> to include the planned roll-out schedule.
<b>Patient safety equality, diversity and inclusion</b>	National patient safety team	<p>Review and update the equality impact assessments for patient safety strategy initiatives by Q2 2021/22.</p> <p>Identify how to improve our equality data collection capability across the strategy (e.g. Patient Safety Incident Management System [PSIMS], medical examiners, specialists, patient safety partners) by Q1 2021/22.</p> <p>Review the evidence base on patient safety health inequalities in the NHS by Q4 2020/21.</p> <p>Develop a roadmap for addressing patient safety inequalities at a strategic level by Q3 2021/22.</p> <p>Include guidance for diverse representation in initiatives such as Patient Safety Partner recruitment by Q3 2021/22.</p> <p>Continue to establish and test interventions to address inequalities and co-design as part of the key enablers improvement work.</p>	<b>New</b> objective added to recognise that we do more to explicitly address health inequalities in patient safety.



<p><b>Deliver key enablers of patient safety improvement</b></p>	<p>Local systems supported by the national patient safety team and the patient safety collaboratives (PSCs)</p>	<p>Addressing Inequalities – support patient safety networks to undertake a mapping exercise by Q1 2021/22 to better understand their populations with respect to demography, ethnicity and social deprivation factors, and use the insights to prioritise local improvement approaches to ensure they are addressing inequalities.</p> <p>Patient and carer co-design – support patient safety networks to identify their current levels of patient and public voice (PPV) co-design around patient safety improvement by Q2 2021/22, to ensure it reflects the diversity of the population served.</p> <p>Safety culture – develop and publish a patient safety culture guide (see safety culture).</p> <p>Patient safety improvement networks – PSCs to set up and support the development of networks to provide the delivery architecture for each safety improvement programme: maternity and neonatal by Q1 2021/22 and deterioration, care homes and mental health by Q4 2021/22 or sooner.</p> <p>Improvement leadership – PSCs to identify aspiring local improvement leaders (including clinical leaders) by Q2 2021/22 and support their development, demonstrating diversity and equality of opportunity in all safety improvement work.</p> <p>Building safety improvement capacity and capability – patient safety networks to identify specific improvement capability needs of each national programme by Q2 2021/22 and build targeted safety improvement capacity and capability, using a dosing approach, where specific needs are identified.</p> <p>Local measurement for improvement – PSCs to support systems and organisations to adopt a measurement for improvement approach and local measurement plans by Q1 2021/22, to measure testing and the impact of interventions in line with the national strategy patient safety measurement principles.</p>	<p><b>New</b> objective replaces the following, which is business as usual: Enhance the impact of the national patient safety improvement programmes.</p>
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		<p>Improvement and innovation pipeline – develop and test an improvement and innovation pipeline by Q2 2021/22 and use this to inform and prioritise future improvement work.</p> <p>To build on links with local systems and regional teams in all safety improvement activity.</p>	
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**Table 3: Insight objectives**

Objective	Who will deliver this	What and by when	Changes from the original deliverables
<b>Embed the principles of patient safety measurement nationally and work with other organisations to spread adoption</b>	National patient safety team	<p>Formulate a measurement strategy for the NatPatSIPS by Q4 2020/21.</p> <p>Publish data request prioritisation framework for provision of data to external requestors by Q3 2020/21.</p> <p>Continue work with external organisations to encourage adoption of the national strategy patient safety measurement principles.</p> <p>Ongoing publication of regular incident reporting statistics, including official statistics.</p>	<p><b>Updated</b> to be more specific.</p> <p>Original:</p> <p>Embed the principles of patient safety measurement nationally and work with other organisations to spread adoption.</p>

<b>Deliver replacement for the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS)</b>	National patient safety team	<p>Start transition from NRLS to the Patient Safety Incident Management System in Q4 2020/21 (subject to agile system development processes and Government Digital Service approvals).</p> <p>Develop business support applications to enable analysis of reported information.</p> <p>Identify the best way to request equalities information in the data collection.</p>	<p><b>Removed</b> the following as the goal has been achieved:</p> <p>Incorporate learning from what goes well (Safety II) in the development of the NRLS replacement.</p> <p><b>Updated</b> to reflect clarified milestones.</p>
		Ongoing feedback to local systems to improve reporting.	No change.
	Local systems	Local systems, including current non-reporters, to connect to the new system by end Q4 2021/22 subject to local software compatibility.	<p><b>Updated</b> timeline.</p> <p><b>Removed</b> as repetition of the national goal to improve reporting: Continuous increase in effective incident reporting.</p>
<b>Implement the new Patient Safety Incident Response Framework (PSIRF)</b>	National patient safety team, NHS England and NHS Improvement national and regional teams, and early adopter organisations	<p>By Q4 2020/21 begin work with HSIB to support the testing and introduction of national patient safety incident investigation training.</p> <p>Develop investigation training supplier procurement framework by Q4 2020/21 as an interim measure before national training is made available.</p>	<p><b>Removed</b> the following as the goal has been achieved:</p> <p>Establish PSIRF national implementation group in Q2 2019/20.</p> <p><b>Updated</b> to reflect work to support HSIB ambition to develop patient safety incident investigation training.</p> <p>Original:</p> <p>Develop investigation training supplier procurement framework by Q4 2020/21.</p>
		Develop supporting resources for early adopters to support implementation up to Q4 2021/22.	<p><b>Updated</b> to be more specific about tasks and timeline.</p> <p>Original:</p> <p>Develop resources for boards to support implementation, including incorporating relevant content into existing board development programmes by Q4 2019/20.</p>

		<p>Conclude work with regional colleagues and early adopters across several local systems to gain insight into how best to implement the PSIRF by Q4 2021/22.</p> <p>Update the equality impact assessment for the national PSIRF programme and support early adopters to address health inequalities in their piloting of the framework in Q4 2020/21.</p> <p>Publish resources to support rollout after the early adopter pilot concludes in Q4 2021/22.</p> <p>Start national rollout by Q1 2022/23.</p>	<p><b>Updated</b> to reflect progress, addition of specific equality work and updated timelines.</p> <p>Original:</p> <p>Regional team oversight roles and responsibilities developed to support ambitions of the PSIRF.</p> <p>Work with early adopters across several local systems to gain insight into how best to implement the PSIRF.</p>
		<p>Local systems to plan how they will prepare for and support implementation of the PSIRF. This should be informed by nationally shared early adopter experience. Initially local systems should:</p> <ul style="list-style-type: none"> <li>• identify PSIRF implementation lead(s) by beginning Q3 2021/22</li> <li>• review current resource (in terms of skills, experience, knowledge and personnel) and subsequent action required from beginning Q4 2021/22, to ensure organisations across the local system are equipped to respond to patient safety incidents as described in the PSIRF, and to undertake patient safety incident investigation (PSII) as describe in the PSII standards: <ul style="list-style-type: none"> <li>– NB: leaders and staff must be appropriately trained in responding to patient safety incidents, including PSII, according to their roles,<sup>1</sup> with delivery of that training from Q4 2021/22 onwards</li> </ul> </li> </ul>	<p>Updated timeline.</p> <p>Original:</p> <p>Local systems set out in their LTP implementation plans how they will implement the new PSIRF. Full implementation is anticipated by July 2021, informed by early adopter experience. Initially plans should:</p> <ul style="list-style-type: none"> <li>• identify PSIRF leads in local systems by Q4 2019/20</li> <li>• anticipate development of organisational-level strategic plans for patient safety investigation and review by the end of Q2 2020/21</li> <li>• ensure that leaders and staff are appropriately trained in responding to patient safety incidents, including investigation, according to their roles,<sup>100</sup> with delivery of that training and development from end Q2 2020/21 onwards</li> <li>• eliminate inappropriate performance measures from all dashboards/performance frameworks by Q2 2020/21</li> <li>• as part of the organisation's quality governance arrangements, monitor on an annual basis the balance of resources for investigation versus improvement and whether actions</li> </ul>

<sup>1</sup> Note: This relates to currently available training in the specific skills required to effectively respond to patient safety incidents, particularly investigation skills. Wider work under Involvement to develop and deliver a national patient safety curriculum and training will also incorporate relevant aspects of incident response, including investigation, but local systems should not delay work to ensure their existing staff are skilled to perform the roles they are asked to while the wider curriculum work takes shape.

		<ul style="list-style-type: none"> <li>• develop quality governance arrangements (from Q4 2021/22) that: <ul style="list-style-type: none"> <li>– support implementation and oversight of PSIRF requirements</li> <li>– eliminate inappropriate PSI/SI/patient safety performance measures from all dashboards/performance frameworks</li> <li>– monitor on an annual basis the balance of resources for patient safety incident investigation versus improvement across the local system and whether actions completed in response to patient safety incidents measurably and sustainably reduce risk.</li> </ul> </li> </ul>	completed in response to patient safety incidents measurably and sustainably reduce risk.
<b>Implement the medical examiner system</b>	National patient safety team and regional teams	<p>Implement quarterly reporting for medical examiner offices by Q3 2020/21.</p> <p>Facilitate the extension of medical examiner scrutiny from deaths in acute trusts to deaths in non-acute settings, to start Q4 2020/21 and be completed by Q1 2022/23.</p> <p>Establish medical examiner offices in all acute trusts by Q4 2020/21.</p>	<p><b>Added</b> deliverables at national level.</p> <p><b>Removed</b> the following as the goal has been achieved:</p> <p>Recruitment of regional medical examiners</p>
	Acute trusts	Ensure deaths in all areas (in non-acute settings as well as acute trusts) are scrutinised by medical examiners by end Q1 2022/23.	<b>Updated</b> timeline.
<b>National clinical review and response, advice and guidance</b>	National patient safety team	<p>Clinical review of and response to reported patient safety incidents, including strategic review of sources, to focus where most new or under-recognised issues are found, and through the publication of NHS England and NHS Improvement National Patient Safety Alerts and activity summaries (Q3 2020/21 and Q1 2021/22).</p> <p>Complete a national patient safety response advisory panel membership review by Q1 2021/22.</p>	<p><b>Updated</b> objective to be more specific:</p> <p>Original:</p> <p>Ongoing clinical review of and response to patient safety incident reports – including through publishing NHS Improvement Patient Safety Alerts</p> <p><b>Moved</b> to the safety system section:</p>

		<p>Complete a review of all historical National Patient Safety Agency and NHS England and NHS Improvement alerts to identify any requirements which remain viable beyond their original action date, by Q4 2020/21.</p> <p>Care Quality Commission to begin assessing providers' approaches to ensuring their compliance with the national Patient Safety Alerts as part of its regulatory activity, by Q2 2021/22.</p>	<p>100% compliance declared for all Patient Safety Alerts from Q2 2019/20.</p> <p>Updated objective to replace the following goal which was achieved: Implement the National Patient Safety Alerts Committee (NapSAC).</p>
<b>Agree alignment across ALBs for key shared national patient safety processes</b>	National patient safety team, alert-issuing bodies and CQC	<p>Complete pilot systems for oversight of implementation of HSIB's investigation recommendations:</p> <ul style="list-style-type: none"> <li>• HSIB complete stage one of pilot (assessment of written responses) by Q3 2020/21</li> <li>• NHS England and NHS Improvement complete remainder of pilot by Q1 2021/22</li> <li>• Proposals for way forward for future oversight prepared by Q2 2021/22.</li> </ul> <p>All relevant ALBs/teams apply to become credentialled issuers of National Patient Safety Alerts by Q1 2021.</p> <p>Procedures for managing exceptional national safety issues that involve multiple ALBs:</p> <ul style="list-style-type: none"> <li>• strategic approach agreed by Q4 2020/21</li> <li>• operational approach agreed by Q1 2021/22.</li> </ul>	<p><b>Updated</b> to be more specific and updated timeline.</p> <p>Original: Oversight of implementation of HSIB's investigation recommendations so that 100% are responded to and implemented or alternatives are in place from Q4 2019/20.</p>
<b>Enhance the learning from claims</b>	NHS Resolution	<p>Ensure that development of the new claims management system throughout 2021/22 aligns where possible with PSIMS.</p> <p>Identify the potential for enabling data analysis across established databases (aligning with PSIMS).</p> <p>Deliver an aligned Faculty of Learning to share insight from claims, as part of a search tool to be implemented by Q1 2021/22.</p>	<p><b>Updated</b> to specify claims (rather than litigation) and add a timeline.</p> <p><b>Removed</b> as it is NHS Resolution business as usual: Supporting the reduction in maternity incidents via the early notification scheme, CNST incentives, thematic reviews, claims scorecards.</p>

	GIRFT	<p>Produce a litigation data pack for every acute and specialist trust in England by Q4 2020/21. These aim to encourage trusts to review their claims data and learn from claims to improve patient care at a local level. This will continue to include the triangulation with complaints, inquests and serious incidents to maximise learning and the development of interventions to improve patient care.</p> <p>Produce specific documentation best practice guidance in partnership with NHS Resolution, Royal Colleges and specialist societies for five general surgical procedures by Q2 2021/22 and a further five surgical specialties by Q4 2021/22.</p> <p>Publish the first best practice guidance on claims learning for clinicians and managers in collaboration with NHS Resolution by end Q4 2020/21. This will explain to clinicians and managers how to participate in learning from claims and share learning to drive focused improvement.</p>	<p><b>Updated tasks.</b></p> <p>Original:</p> <p>Continue programme to support improvements through claims learning including will publishing the first GIRFT best practice guidance on claims learning in orthopaedic surgery, focusing on the high-volume areas of hip and knee arthroplasty during 2019/20.</p>
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**Table 4: Involvement objectives**

Objective	Who will deliver this	What and by when	Changes from the original deliverables
Patient involvement in patient safety	National patient safety team and patient safety partners	<p>Conclude extended patient safety partners framework consultation and additional series of focus groups by Q3 2020/21.</p> <p>The final framework published in Q1 2021/22.</p>	<p><b>Updated task and timeline.</b></p> <p>Original:</p> <p>Patient safety partners framework published by Q4 2019/20.</p>
	Local systems	Local systems and regions aim to include two patient safety partners on their safety-related clinical governance committees	<p><b>Updated timeline.</b></p> <p>Original:</p>

		(or equivalents) by Q1 2022/23, and elsewhere as appropriate, and who will have received required training by Q1 2023/24.	Local systems and regions aim to include two patient safety partners on their safety-related clinical governance committees (or equivalents) by April 2021, and elsewhere as appropriate, who will have received required training by April 2022.
<b>Deliver a patient safety curriculum and syllabus that supports patient safety training and education for the whole NHS</b>	HEE, NHS England and NHS Improvement	Publish the final national patient safety syllabus in Q4 2020/21. Review the syllabus content regarding healthcare inequalities.	<b>Removed</b> the following as the goal has been achieved: Evaluate current education and training packages, for inclusion or not in the national patient safety syllabus and create the first national patient safety syllabus by April 2020 <b>Updated</b> timeline.
		Developing a set of quality standards for delivery of the patient safety syllabus by Q1 2021/22 Identification of an accreditation model by Q1 2021/22	<b>Updated</b> task. <b>Removed</b> the following as the goal has been achieved: Develop plans for implementing patient safety training in all relevant training and education
		Make training in the essentials of patient safety available to all staff by Q2 2021/22.	<b>Updated</b> timeline.
	Local systems	Support all staff to receive training in the essentials of patient safety by Q1 2023/24.	No change.



<b>Develop a network of patient safety specialists</b>	National patient safety team	<p>Establish patient safety specialist (PSS) networks at system level by Q4 2020/21.</p> <p>Start distribution of the patient safety update by Q4 2020/21.</p> <p>Identify demographic data for first cohort of PSS and identify if there are equality challenges by Q1 2021/22.</p> <p>Plan for ongoing recruitment and development of a diverse PSS workforce, including support for effective local recruitment practices by Q2 2021/22.</p>	<p><b>Removed</b> the following as the goal has been achieved:</p> <p>Initial role description available by Q3 2019/20</p> <p>Hold the inaugural patient safety specialist network meeting in Q2 2020/21 (took place in Q3 20/21).</p> <p><b>Added</b> deliverables.</p>
	Local systems, regional and national healthcare organisations	Identify to the national patient safety team at least one patient safety specialist per organisation by end Q3 2020/21	<p><b>Updated</b> timeline from:</p> <p>Q4 2019/20.</p>
		Release some patient safety specialists for learning sets as required to inform the development of training by Q1 2021/22.	<p><b>Updated</b> task.</p> <p>Original:</p> <p>Release patient safety specialists for identified training by Q4 2021/22.</p>
	Deliver training for 750 PSS by Q1 2023/24.	<p><b>Updated</b> timeline</p>	

**Table 5: Improvement objectives**

Objective	Who will deliver this	What and by when	Changes from the original deliverables
<p><b>Deliver the Managing Deterioration Safety Improvement Programme (ManDetSIP)</b></p>	<p>Local systems supported by the national patient safety team and the PSCs</p>	<p>Support the adoption of the COVID-19 oximetry@home and COVID Virtual Ward models across England by Q1 2021/22.</p> <p>Undertake small scale testing of the paediatric early warning score (PEWS) in acute in-patient and ED settings by Q3 2021/22 ahead of scale-up across England.</p> <p>Scale up adoption of deterioration management tools (e.g. NEWS2, RESTORE2, etc.) and reliable personalised care and support planning (PCSP) in non-acute settings across health and social care from Q3 2020/21.</p>	<p><b>Updated</b> as a distinct national patient safety improvement programme.</p> <p>Original: Deliver NPSIP priorities.</p>
<p><b>Deliver the Adoption and Spread Safety Improvement Programme (A&amp;S-SIP)</b></p>	<p>Local systems supported by the national patient safety team and the PSCs</p>	<p>Support the increase in the proportion of patients in acute hospitals receiving every element of the British Thoracic Society chronic obstructive pulmonary disease discharge care bundle for which they are eligible by Q1 2022/23.</p> <p>Support the increase in the proportion of eligible sites (ie acute hospitals in England that care for patients with tracheostomies) adopting three evidence-based tracheostomy safety interventions (bedhead signs, availability of emergency equipment, daily care bundle) by Q1 2021/22.</p> <p>Support organisations to consider designated safe cohort wards for patients with tracheostomies that have trained staff to competently care for these patients by Q1 2021/22.</p> <p>Support the increase in the proportion of patients in acute hospitals receiving every element of the asthma discharge care bundle for which they are eligible, to start Q1 2021/22.</p>	<p><b>Updated</b> as a distinct national patient safety improvement programme.</p> <p>Original: Deliver NPSIP priorities.</p>

<p><b>Deliver the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)</b></p>	<p>Local maternity systems supported by the MatNeoSIP team</p>	<p>Contribute to the national ambition to increase the proportion of smoke-free pregnancies to 94% or greater by Q1 2023/24.</p> <p>Nationally reduce the rate of stillbirths, neonatal deaths and brain injury by 50% by 2025.</p> <p>Continue to support the spread and adoption of the preterm <a href="#">perinatal optimisation care pathway</a> across England from Q3 2020/21:</p> <p>Improve the early recognition and management of deterioration of women and babies from Q3 2020/21:</p> <ul style="list-style-type: none"> <li>• develop a national pathway approach for the effective management of maternal and neonatal deterioration using the plan/prevention, identification, escalation and response (PIER) framework</li> <li>• work with national stakeholders to develop a national maternal early warning score (MEWS) by Q1 2021/22 ahead of testing and scale-up</li> <li>• support the adoption and spread of the neonatal early warning 'trigger and track' score (NEWTT).</li> </ul>	<p><b>Updated</b> tasks to include more detail and revised goals.</p>
<p><b>Deliver the Medication Safety Improvement Programme (MedSIP)</b></p>	<p>MedSIP national programme team, PSCs and local systems</p>	<p>Reduce medicine administration errors in care homes by completing intervention testing by Q1 2022/23 ahead of scale-up in:</p> <ul style="list-style-type: none"> <li>• safety huddles</li> <li>• learning from errors</li> <li>• managing interruptions</li> <li>• three-way communication.</li> </ul> <p>Reduce harm from opioid medicines by reducing high dose prescribing of opioids through scoping and intervention identification by Q1 2022/23, ahead of testing and scale up.</p>	<p><b>Updated</b> tasks to include more detail and revised goals.</p> <p>Original:</p> <p>The programme will reduce avoidable, medication-related harm in the NHS, focusing on high risk drugs, situations and vulnerable patients. Details to be confirmed.</p>

		<p>Reduce harm by reducing the prescription and supply of oral methotrexate 10mg by Q3 2021/22.</p> <p>Develop a programme to reduce severe harms associated with anticoagulants, which can be delivered from Q1 2022/23.</p> <p>Develop a programme to reduce problematic polypharmacy for the most at-risk populations, which can be delivered from Q1 2023/24.</p>	
<p><b>Deliver the Mental Health Safety Improvement Programme (MHSIP)</b></p>	<p>Local systems supported by the MHSIP national programme team</p>	<p>Reduce suicide and deliberate self-harm in inpatient mental health services, healthcare settings and in the healthcare workforce by:</p> <ul style="list-style-type: none"> <li>identifying the interventions that reduce absence without leave (AWOL) and scoping interventions to reduce suicide and deliberate self-harm while on agreed leave by Q1 2021/22 ahead of testing and scale-up</li> <li>scoping the incidence and understanding of suicide and deliberate self-harm in non-mental health acute settings by Q1 2021/22 ahead of testing</li> <li>from Q1 2021/22, support the assessment of ligature anchor points and other environmental self-harm risks for inpatient mental health services.</li> </ul> <p>Reduce the incidence of restrictive practice in inpatient mental health and learning disability services by:</p> <ul style="list-style-type: none"> <li>reviewing the interventions and outcomes from the first phase of work by Q1 2021/22</li> <li>from Q1 2021/22, undertake further testing of the interventions ahead of scale-up across England.</li> </ul> <p>Improve the sexual safety of patients and staff on inpatient mental health and learning disability units by developing the change package by Q3 2021/22, ahead of testing and scale-up.</p>	<p><b>Updated</b> tasks to include more detail and revised goals.</p> <p>Original:</p> <p>MHSIP engagement programme – local systems should develop safety improvement plans post their engagement meeting (unless agreed not needed)’</p> <p>National programme to deliver 33% reduction in restrictive practice in pilot wards by Q4 2019/20.</p> <p>All mental health inpatient providers nominate a ward to participate in the improving sexual safety collaborative. Data collection to be confirmed.</p>

<p><b>Address safety issues that affect older people</b></p>	<p>National patient safety team</p>	<p>Align and bring together patient safety improvement initiatives in care homes, including links to the enhanced health in care homes framework and the learning disability improvement standards.</p> <p>Scope the potential for a distinct care homes national patient safety improvement programme (to include work underway on managing deterioration and medicines safety in care homes).</p>	<p><b>Updated</b> task consolidating initiatives for the national patient safety team. Expanding the breadth and ambition of work in this area.</p> <p><b>Removed</b> the following goal as it has been achieved in the medicines safety dashboard:</p> <p>Link data on medications and falls.</p>
	<p>NHS England and NHS Improvement Ageing Well team</p>	<p>Produce an anticipatory care framework encompassing the identification of people living with frailty and complex needs, holistic needs assessment and personalised care and support planning by Q1 2021/22.</p> <p>Align work on deterioration of older patients with the managing deterioration safety improvement programme.</p>	<p><b>Removed</b> the following as the work has concluded:</p> <p>Continue to facilitate the Falls Collaborative Programme and improve falls prevention in hospital through the 2019/20 NHS Commissioning for Quality and Innovation (CQUIN) scheme.</p> <p><b>Replaced</b> the following by the broader anticipatory care framework:</p> <p>Spread uptake of the electronic frailty index and routine frailty identification and assessment.</p>
	<p>NHS England and NHS Improvement Nursing team</p>	<p>Continue the Stop the Pressure Programme including focus on:</p> <ul style="list-style-type: none"> <li>• reducing health inequalities, understanding the specific issues that relate to pressure ulcers and planning appropriate action by Q2 2022/23</li> <li>• further development of the evidence base on pressure ulcers</li> <li>• safety improvement in community settings, including an audit on prevalence and clinical care by Q4 2021/22</li> <li>• improving risk assessment of pressure ulcers by Q4 2021/22.</li> </ul> <p>Align work on enhanced health in care homes with the national patient safety team safety improvement work.</p>	<p><b>Updated</b> to be more specific.</p> <p>Original:</p> <p>Continue the Stop the Pressure Programme.</p>

<p><b>Address safety issues that affect autistic people and people with a learning disability</b></p>	<p>NHS England and NHS Improvement supporting local systems</p>	<p><b>Reduce restrictive Interventions:</b></p> <ul style="list-style-type: none"> <li>Expand <a href="#">STOMP</a> and <a href="#">STAMP</a> programme to ensure accessible, quality information, regular improved quality medication reviews (at least annually) and access to correct level of monitoring and support to improve quality of life.</li> <li>Publication of segregation and seclusion guidance for CAMHs inpatient care by the Quality Taskforce in 2021</li> <li>Improvements in data quality of reporting on restrictive practices in 2021.</li> </ul> <p><b>Reduced use and improved quality of inpatient care:</b></p> <ul style="list-style-type: none"> <li>Ensure implementation and delivery of <a href="#">care, education and treatment (C(E)TR) reviews</a> in line with current C(E) TR policy, and review and refresh current policy by end Q3 2021/22</li> </ul> <p><b>Reducing health inequalities across the healthcare system:</b></p> <ul style="list-style-type: none"> <li>Collaborative working with NHS England and NHS Improvement programmes to ensure fair access to mainstream healthcare through Identification of opportunities to collaborate; agreement of joint work plans during 2021</li> <li><a href="#">Learning Disability Improvement Standards</a> will be applied to all NHS-commissioned care by 2023/24</li> <li>Continue to deliver the <a href="#">LeDeR</a> (learning disabilities mortality review) programme including delivery of Restore2 mini project in 2021 to support management of deterioration in health and publication of national LeDeR policy in 2021</li> <li>Ensure health care services makes reasonable adjustments for people with a learning disability and, or</li> </ul>	<p><b>Updated</b> to add detail to the original tasks; to better align to Long Term Plan commitments and the work of the Children and Young People Quality Taskforce; and to focus on initiatives that can be aligned with the NatPatSIPS.</p> <p>Original:</p> <p>Accelerate LeDeR and align with the medical examiners system.</p> <p>Expand STOMP and STAMP.</p> <p>Further spread use of care and treatment reviews.</p> <p>All NHS-Commissioned care to meet the learning disability improvement standards by 2023/24.</p>
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		autistic people (in line with Equality Act and Accessible Information Standard) including further development of the <a href="#">Reasonable Adjustments Digital Flag</a> (technical updates to SCRa and piloting of system integration) by end Q3 2021/22	
<b>Deliver the UK National Action Plan for AMR</b>	Local systems, supported by national and regional teams	Local systems should develop plans to: <ul style="list-style-type: none"> <li>• reduce community antibiotic use by 25% (from 2013/14 baseline) by 2024</li> <li>• reduce use of 'reserve' and 'watch' antibiotics by 10% (from 2017 baseline) by 2024.</li> </ul>	<b>Updated</b> task to focus on targets that remain active. <b>Removed</b> the following: <ul style="list-style-type: none"> <li>• improve the management of lower UTI in older people in all care settings by Q4 2019/20 (supported by CQUIN)</li> <li>• improve antibiotic prophylaxis for colorectal surgery by Q4 2019/20 (supported by CQUIN).</li> </ul>
<b>Support patient safety research and innovation</b>	PSTRCs, AHSNs, NIHR, DHSC and the national patient safety team	Publish a summary of patient safety research needs related to the national patient safety strategy, including need for new technical solutions to Never Events and needs related to patient safety health inequalities, by Q4 2020/21.  Submit any identified needs that are appropriate for policy research to the Department of Health and Social Care policy research stream, by Q1 2021/22.  Identify opportunities to incorporate patient safety research needs in existing centres and funding streams.	<b>Updated</b> task and timelines.  Original:  Develop new technical solutions to Never Events Support the safety innovation pipeline more widely.

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**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.048	Interim Joint NHS Shropshire CCG and NHS Telford and Wrekin CCG Board Assurance Framework (BAF)

<b>Executive Lead (s):</b>	<b>Author(s):</b>
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<b>Action Required (please select):</b>					
A=Approval	R=Ratification	S=Assurance	X	D=Discussion	I=Information

<b>History of the Report (where has the paper been presented:</b>		
<b>Committee</b>	<b>Date</b>	<b>Purpose (A,R,S,D,I)</b>
BAF Report for both CCGs to Audit Committees meeting in common	20 <sup>th</sup> January 2021	S

**Executive Summary (key points in the report):**

1.1 The purpose of this report is to present the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG with an update on the strategic risks on the Joint Interim 2020/2021 Board Assurance Framework and provide assurance that the risks are effectively identified and mitigated.

1.2 The interim joint BAF is attached as appendix A which has been updated by Directors and AO and presented to the Audit Committees meeting in common in January.

1.3 The following changes have been made since the interim BAF was presented to the Governing Bodies for both CCGs in November 2020 and highlighted in red/bold text:

- Risk 1 – Underlying financial position
- Risk 2 – Quality and Safety
- Risk 6 – Patient and Public Involvement
- Risk 9 – ICS Development – risk ratings changed in bold
- Risk 10 – Sustainable Services

1.4 The Governing Bodies also asked at the meetings held in November to allocate each BAF risk to a committee where possible, to ensure that the risks and mitigations are being scrutinised in detail. The following is a recommended allocation which has been supported by both Audit Committees:

- BAF 1 – Finance – Finance Committee
- BAF 2 – Quality and Safety – Quality and Performance Committee
- BAF 3 – Performance targets – Quality and Performance Committee
- BAF 4 – EPRR Response – Audit Committee
- BAF 5 – Restoration of Health Services during Covid – Joint Strategic Commissioning Committee (Strategic Commissioning Committee post 1<sup>st</sup> April 2021)
- BAF 6 – Patient and Public Involvement – Assuring Involvement Committee (post 1<sup>st</sup> April 2021)
- BAF 7 – Leadership as Single Strategic Commissioner – reserved to Governing Body
- BAF 8 – Population needs – Joint Strategic Commissioning Committee (Strategic Commissioning Committee post 1<sup>st</sup> April 2021)
- BAF 9 – ICS development – reserve to Governing Body

BAF 10 – Sustainable services – Joint Strategic Commissioning Committee (Strategic Commissioning Committee post 1<sup>st</sup> April 2021)

BAF 11 – EU Exit – Governing Bodies agreed in November to have regular reporting on this issue for next 6 months and to review at that point.

1.5 Governing Body members are asked to consider the joint Interim BAF attached and provide feedback on its content and the level of assurance it provides.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability? Financial risk is outlined in detail on both BAFs	Yes
4.	Is there a legal impact to the organisation?	No
5.	Are there human rights, equality and diversity requirements? Health inequality risks are highlighted on the BAFs where applicable.	Yes
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

**Recommendations/Actions Required:**




**NHS Shropshire CCG Governing Body is recommended to:**

- accept and note the content of this report and supporting appendix A for assurance purposes;
- review the updated strategic risk position and confirm that the current level of risk is acceptable in line with actions outlined; and
- discuss and approve the suggested allocation of BAF risks to Committees outlined in section 1.4 above.

**NHS Telford and Wrekin CCG Governing Body is recommended to:**

- accept and note the content of this report and supporting appendix A for assurance purposes;
- review the updated strategic risk position and confirm that the current level of risk is acceptable in line with actions outlined; and
- discuss and approve the suggested allocation of BAF risks to Committees outlined in section 1.4 above.


1	2	3	4	5	6	7	8	9	10	11	12	13	14
Risk ID	O b j e c t	Opened / added by	Risk and description	Opportunity	Existing key controls	Existing sources of assurance	Gaps in controls or assurances	Risk score (consequences x likelihood)	Risk score trend	Action plan / cost / action lead / (target date) / sufficient mitigation	Target risk score for end of financial year	Executive Lead and Risk Owner	Amendments : name and date
1	SCCG - 3 TWCCG - 5	Claire Skidmore	Underlying Financial Position is <b>currently a 9.8% deficit (compared to recurrent allocation)</b>  There is a risk that the CCGs fail to deliver their financial plans for 2020/21 and that the underlying position going forward significantly deteriorates	This offers the opportunity to fully assess commissioned services to ensure best clinical value as well as financial efficiencies. The COVID19 situation also presents opportunity to reset to a 'new normal' which may assist in driving out inefficiency in the cost base of the system	Detailed 20-21 financial YTD and forecast reporting in place QIPP Programme Board meeting monthly to monitor delivery of savings and action plans Constitution/Prime Financial policies etc in place and communicated across organisation Regular budget meetings with budget holders and both budget manager handbook and regular training programme in place	Regular reporting to Finance Committee and Governing Body Internal audit reporting to audit committee on assessment of financial processes/systems Longer term financial plan and strategy in place	1. Development/refresh of financial strategy/recovery plan aligned to system financial plan including programme board implementation plans for key priorities. 2. Absence of formal signed off 2020/21 plan with NHSEI due to financial arrangements in place due to COVID-19 3. CHC process issues remain - <b>action plan progression delayed due to impact of COVID-19 pandemic</b>	20 (almost certain x major)		1. CCG financial strategy to be updated for submission to NHSEI by <b>11th January in line with system plan - LC</b> System long term financial <b>sustainability plan to be updated by 31st March 2021</b> , to include implementation plans from programme boards to address priorities and inclusion of COVID-19 recovery trajectories. - (CS/System DOFS) 2. CCG financial plan for M7-12 2020/21 submitted on 22nd Oct 2020, awaiting NHSEI feedback, <b>budgets for second part of year to be aligned to plan. Awaiting detailed planning guidance for 2021/22 and plans and budgets to be developed in line with this for reporting to Board in March 2021. (LC)</b> 3. CHC action plan in place and discussed with CFO and AO. Action plan is progressing and CHC teams are reviewing QIPP plans for 2021/22 although the COVID-19 pandemic is still posing a risk. The recent Internal audit report notes progress and evaluation scheduled for April 2021. - CP/BTP	16 (likely x major)	C Skidmore	Laura Clare 12.01.21
2	SCCG - 1 TWCCG - 1	Zena Young	Quality and Safety  If the CCGs fail to commission safe, quality, services for their populations then there is a risk that patients will come to harm, that regulatory action <b>or commissioning decisions</b> will result in closure of services, <b>with our population having to access services out of county</b> , and a risk of adverse publicity	System service improvement plan  System wide Quality Surveillance, Patient Safety, Medicines Safety Groups  Agreed system quality metrics, <b>with agreed areas for quality improvement focus and action</b>  <del>Maternity - LMNS</del> <b>exploring</b> opportunity to benchmark data across region/similar maternity systems	1. CCG attendance at all providers quality and contract monthly meetings RAP in key areas of concern inc; ED, Maternity, Ophthalmology, Diagnostics, neurology, cancer waits, RTT, mental health, LAC 2. Monthly SIRG's (serious incident review group) for each provider. 3. Monthly internal CCG SIRG 4. Quality visit schedules for all providers, primary care and care homes 5. IP&C health economy meetings and attendance at IPC committees and outbreak meetings 6. NHS England/Improvement Oversight and Assurance process in place with agreed support 7. Regular monitoring re workforce inc; mandatory training, supervision, sickness, absence and vacancy rates for all providers 8. <b>CCG Quality Strategy and associated delivery programme.</b>	1. Monthly Quality & Performance Committee <b>with business reporting cycle</b> 2. Board reporting and scrutiny processes of SI's following the NHSE SI framework. Number of overdue SI reports is reducing <b>and quality of investigatory reports and action plans improving</b> for acute provider 4. Patient Safety Group - system group to review themes from SI's and share learning 5. Quality Surveillance Group is in the process of being established to provide system quality oversight. Providing opportunity to share, drive and monitor quality priorities. 6. Care Homes and Dom Care information sharing meetings with LA: 7. Quality monitoring of providers in place based on concerns escalation 8. Regular information sharing CQC/LA for all providers 9. Information sharing and benchmarking via LMNS and MatNeo Clinical Network. <b>10. Maternity &amp;</b>	Gaps in Control: 1. Provider workforce vacancy and staff turnover for skilled workers. Necessary workforce is not in place/do not have capacity/capability, or achieved with temporary staffing solutions 2. Patients are not seen within national guidelines/evidence base which has consequences re: patient outcomes 3. Backlog in key performance areas leading to poor outcomes, patient experience 4. Time lag of 2 years for MBRRACE-UK nationally validated and published comparative perinatal mortality data 5. <b>New system Quality and Safety governance arrangements yet to be fully implemented and embedded.</b>  Gaps in assurance: 6. <b>Triangulated information indicates areas of concern within providers.</b> Specific performance and quality concerns with Culture and Leadership, aspects of clinical care 7. Provider failing to meet required performance and quality standards <b>and progress at pace</b> 8. Providers <b>rated by CQC as inadequate for 'well-led' domain</b> 9. <b>Quality governance processes in acute provider not fully formed and embedded.</b> 10. Unvalidated provider metrics/data quality - maternity services	4x5 = 20 (likely x catastrophic)		1. <b>Continue to monitor workforce plans and risks at provider CQRM's.</b>  2, 3, 6, 7, 8, 9 - <b>Undertake themed reviews for both individual providers and system quality concerns and issues.</b> - <b>Maintain a schedule of quality assurance visits, with triangulation of data from a variety of sources, including increased inclusion of patient experience elements.</b> - CCG attendance at relevant provider internal governance meetings. <b>By June 2021 - ZY</b>  4. Develop and implement a maternity metrics dashboard. <b>By March 2021 - ZY.</b> Evidence to support maternity CNST submission to be reviewed and validated by CCG. <b>By July 2021 - ZY</b>  5, 10. Implement /embed a System Wide approach to quality improvements - Quality Surveillance Group; Patient Safety Group; Medicines Safety Group, which aligns to NHSE requirements (when published) to allow shared view of quality and appropriate escalation both within and external to system. <b>By February 2021 - ZY.</b>	3x5 = 15 (possible x catastrophic)	Z Young	Zena Young 02.11.20 13.01.21

3	SCCG - 1 TWCCG - 1	J Davies	NHS Constitution Performance Targets  There is a risk that the CCGs fail to meet the NHS Constitution performance targets consistently	To improve the delivery of key performance targets for the services our patients received which are designed to improve the quality of care and outcomes and patient experience	CCG attendance at :- Monthly Planned Care Working Groups Fortnightly UEC Delivery Group Fortnightly SaTH Cancer Performance meeting Monthly provider contract meetings	Monthly Quality & Performance Committee Monthly ICS Shadow Board	1) Lack of staff resource to develop improvement plans and oversee delivery 2) Lack of overarching improvement plan for A&E performance 3) Multiple sources of performance information 4) Impact of COVID pandemic preventing recovery work on elective care and RTT	5 x 4 = 20 (Almost Certain x Major)		1) MOC for staff due to complete in December, possible recruitment to new performance posts in January 2) Agree key elements of A&E improvement plan at UEC Delivery Group by end of November 3) Working across system to get single performance framework and single reporting through system PMO by the end of March 21 (Pandemic permitting) 4) Maximising use of all available system capacity for cancer and urgent elective care through to the end of March 21 and beyond as required. Minimal improvement in Referral to Treatment Times this year due to COVID so mitigation is not sufficient to improve overall risk score this financial year- listed mitigation should improve A&E performance and help maintain cancer performance.	5 x 4 = 20 (Almost Certain x Major)	J Davies	J Davies 04.11.20
4	SCCG - 1 & 4 TWCCG - 1 & 4	Sam Tilley	Covid 19 EPRR Response  There is a risk that the CCGs fail to manage with partner organisations the local health system response to Covid 19 second wave pandemic	Opportunity to develop innovative and more effective approaches to patient care  Opportunity to develop a system approaches to patient pathways and care	Gold Command Silver Command CV19 work stream Task & Finish Groups	Weekly System CV19 Gold and Silver SitReps System CV19 Risk Register Regional PHE intelligence briefings Weekly regional and National NHSE/I briefings Weekly Demand and Capacity reporting Weekly Outbreak reporting	Business Intelligence capacity and capability to adequately address data needs lack of workforce capacity to assign adequate SRO and PM to support all programmes of work lack of capacity in system to address competing demands of delivery of CV19 response, winter pressures, restoration and recovery requirements and system improvement as a result of social distancing PPE, swabbing and wider IPC issues Lack of workforce to deliver the above Staff resilience	25 Almost certain x catastrophic		Full programme in place to address all elements of CV19 response. System incident response structure in place and operational. Continued system approach to managing the incident as it evolves. Ongoing demand and capacity work to track impact in real time and inform decision making. Continued evaluation of winter and surge planning. Ongoing discussions across region regarding mutual aid as well as with the Independent sector. MoU in place to support re-deployment of staff	15 Almost Certain X moderate	S Tilley	S Tilley 30.10.20
5	SCCG - 1 TWCCG - 1	Sam Tilley	Restoration of health services during Covid 19 second wave  There is a risk that the CCGs fail to take account of best practice and learning during Covid 19 response in the planning for future health needs	Opportunity to develop innovative and more effective approaches to patient care  Opportunity to develop a system approaches to patient pathways and care	Gold Command Silver Command CV19 work stream Task & Finish Groups System Transformation Delivery Group System Planning & Performance Group <b>Use of Teams platform as repository for all CV19 related information</b>	Weekly System CV19 Gold and Silver SitReps System CV19 Risk Register Regional PHE intelligence briefings Weekly regional and National NHSE/I briefings Weekly Demand and Capacity reporting Weekly Outbreak reporting Winter Plan Phase 3 Plan System Improvement Plan Range of learning exercises	Gaps in Controls: 1) Lack of staff resource to adequately manage the oversight and implementation of learning 2) Lack of staff resilience to embrace change 3) Lack of time to step outside of the immediate CV19 response requirements to implement change <b>Gaps in Assurance:</b> Nil	20 Major x almost certain		1) <b>Commitment via Gold and Silver Command to embrace new ways of working and where possible encourage the implementation of innovative ideas and solutions. Learning outputs presented to Silver and Gold as and when appropriate. Full debrief will be carried out following stepping down of incident response as part of usual EPRR process. System Improvement Plan developed and in implementation stage</b> 2) <b>To be addressed as part of Single Strategic Commissioner Organisational Development work as well as thorough programme to develop the ICS</b> 3) <b>Prioritisation of critical tasks at height of pandemic will inevitably mean that change will focus on the immediate and necessary tasks to manage patient care and learning will be captured as a reflective piece at a later date</b>	12 Possible x Major	S Tilley	S Tilley 14/01/21

6	SCCG - 1 & 2 TWCCG - 1	A Smith	<p>Patient and Public Involvement</p> <p>There is a risk that the CCGs fail to involve patients and the public in planning commissioning arrangements, in development and consideration of proposals to change existing services or to cease existing services.</p>	<p>To ensure that service redesign is informed by consistent and robust involvement of patients and the public</p>	<p>Communications and Engagement Strategies</p> <p>Communications and Engagement teams working jointly across both CCGs providing expertise in planning and delivery</p> <p>Reports to Governing bodies/Committees require section completing on Patient involvement Decisions at STP level on restore of services require equality and engagement plans to be completed</p> <p>Presence of Health watch for both areas at Governing body meetings/JSCC and Quality Committees</p> <p>Joint Lay Member for PPI and Joint Associate Lay Member for PPI - EDI in place on Governing Bodies to act as specific check and balance</p> <p>Patient engagement events delivered January 2020 and December 2020 as per single strategic commissioner Comms and Eng Plan.</p>	<p>IAF Engagement Rating of Outstanding for T&amp;W and Good for Shropshire retained for 2019/20</p> <p>Reporting to Assuring Involvement Committee</p> <p>Reporting on Engagement as part of wider reporting and decision making at JSCC</p>	<p>Gaps in controls:</p> <p>1) Final Communications and Engagement Strategy for single CCG continuing to be agreed with a supporting action plan against which progress can be reported.</p> <p>2) Final Patient engagement events planned but yet to be delivered to input into the development of the Strategy above</p> <p>3) Staff MOC creating new roles in existing Comms and Eng team which will need to be recruited to which will mean a leadtime of having full team</p> <p>Gaps in assurance:</p> <p>None</p>	<p>possible x major = High 12</p>	<p>1) Draft communications strategy will be submitted to NHSE/I by 25/01/21 deadline. AS</p> <p>2) Final Patient Engagement events are planned for March as part of the programme to create a single CCG. AS</p> <p>3) MOC for staff due to complete in December, with possible recruitment to senior positions and other vacant positions taking place January - March 2021. AS</p>	<p>Unlikely x major = Moderate 8</p>	A Smith	A Smith 04/01/21
7	SCCG - 4 TWCCG - 1	S Trenchard	<p>Single Strategic Commissioner</p> <p>There is a risk that the CCGs fail to provide system leadership and the delivery of system transformation.</p>	<p>To ensure the system works together to achieve improvements for the population health within available resources</p>	<p>ICS Shadow Board</p> <p>Chief Executives Group</p> <p>STP Programme Boards</p> <p>CCG Directors weekly meeting</p> <p>Commissioning Strategy</p> <p>Operating Model</p> <p>Project plans for delivering required changes</p> <p>Agreement from system to have single leadership model for ICS and CCG</p>	<p>STP Programme Board Reporting</p>	<p>Gaps in control:</p> <ul style="list-style-type: none"> <li>- Comprehensive plans for all STP priorities</li> <li>- Single management structure for ICS and CCG</li> <li>- Full ICS development plan</li> <li>- Accountability framework for whole system and place based commissioning and delivery</li> <li>- Outcomes framework</li> <li>- Operating model in development</li> </ul> <p>Gaps in assurance:</p> <ul style="list-style-type: none"> <li>- Full cluster board reporting due to gaps in project plans</li> <li>- Monitoring of impact of accountability framework</li> <li>- Monitoring of impact of outcomes framework</li> <li>- Monitoring of improvements using accurate data</li> </ul>	<p>Likely x Major = High 16</p>	<p>Recruitment of a single Accountable Officer for CCG and STP by March 2021 (Owner: CCG Board)</p> <p>PMO programme management website to be updated with comprehensive project plans for all STP priorities by November 2020 (Owner: STP programme board SRO's)</p> <p>Full ICS Development Plan finalised and approved by &lt;date&gt; (Owner: CCG ACO)</p> <p>Development of appropriate accountability framework that accommodate whole system and place based commissioning and delivery by &lt;date&gt; (Owner: STr)</p>	<p>Possible x Major = High 12</p>	S Trenchard	S Trenchard 30/10/2020

8	SCCG - 1 TWCCG - 2 & 3	Sam Tilley	<p>Population Needs</p> <p>There is a risk that the CCGs fail to understand their populations needs that contribute to health inequalities across the County</p>	<p>To develop stronger partnerships with Local Authorities, public health and other stakeholders to develop a system strategy for health inequalities and population needs</p> <p>To tailor health and wellbeing services more accurately to population need ensuring they have a greater impact</p>	<p>Population Health management portfolio priority for Director of Planning.. Partnerships and relationships developing with key stakeholders. JSNA for STW. Health Inequalities system strategy overseen by Director of Partnerships and feeds into governance of Care Closer to Home Programme Board. Links with Patient, parent and carer groups to embed specific groups i.e. SEND, Childrens, Mental health into strategies</p>	<p>Health Inequalities outline strategy and bid. Personalisation agenda to meet population needs supported by regional funding and bid. New partnership arrangements for SEND with both local authority groups. Shropshire CCtH board and TWIPP working towards a place based delivery model on the needs of the populations.</p>	<p>Gaps in Controls:</p> <p>1) lack of specific PHM expertise within the CCGs</p> <p>2) lack of system position regarding the approach to BI within which PHM needs to sit</p> <p>3) Need to co-ordinate system BI platforms to enable and support the development of a system approach to BI and PHM</p> <p>4) Comprehensive engagement and communication strategy required for the public patient engagement exercise (SCCtH &amp; TWIPP)</p> <p>Gaps in Assurance:</p> <p>1) Lack of infrastructure and agreed reporting lines to support impact assessments, BI outputs and resultant plans.</p> <p>2) Lack of recurrent funding to ensure capacity in workforce to deliver needs of populations both internally and with providers.</p>	16 Major x Likely	<p>Controls</p> <p>1) CSU Strategy Unit undertaking system review of BI capacity &amp; capability to provide recommendations on future system model for BI including PHM. 2 x PMH posts in new CCG structure, each to be a joint post with our two LAs</p> <p>2) as for 1</p> <p>3) as for 1</p> <p>4) Engagement strategies being developed with the SCCtH and TWIPP boards. Joint posts with Local Authority to develop partnership and place based working to deliver the needs of the population (November 2020)</p> <p>Assurance</p> <p>1) PHM SRO within ICS structure but reporting lines and working group arrangements to be developed</p> <p>2) Funding requirement linked to output of the SCU Strategy Unit review</p>	12 Major x possible	S Tilley	<p>Claire Parker 30.10.20</p> <p>S Tilley 14/01/21</p>
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11	SCCG 1 TWCCG 1	Exec	EU Exit  There is a risk that the CCGs fail to manage the impact of EU Exit on the adequacy of patient care.		<ul style="list-style-type: none"> <li>1. CCG attendance at all regional and national pharmacy leads briefings</li> <li>2. National planning and stockpile of medicines to ensure supply over first stages of Brexit</li> <li>3. National shortage supply protocols implemented</li> <li>4. Medicines team will support practices with information and to respond to shortages</li> <li>5. POD can be utilised to shorten prescribing duration to ensure stock is equitable distributed</li> <li>6. Financial impact on NCSO and Cat M price changes are monitored monthly</li> <li>7. System EU Exit Lead identified</li> <li>8. Engagement with NHSE/I on EU Exit planning</li> <li>9. System procurement and supply chain Task &amp; Finish Group in place</li> </ul>	<ul style="list-style-type: none"> <li>1. Monthly Quality &amp; Performance Committee</li> <li>2. Board reporting and scrutiny</li> <li>3. Monthly finance meetings</li> <li>4. Area Prescribing Committee to agree system response and amendments to formulary</li> <li>5. An STP Medicines Safety Group is proposed to be established to provide system medicines safety oversight.</li> <li>6. Silver Command</li> <li>7. Gold Command</li> </ul>	<ul style="list-style-type: none"> <li>1. This is largely outside of CCG control and is dependant on national planning and procurement</li> <li>2. Negative impacts on patient care may be unavoidable if there is not an equally effective alternative</li> <li>3. Potential financial impacts are unclear and difficult to plan for with any degree of accuracy.</li> <li>4. This is likely to be managed responsively rather than have ability to plan proactively in advance</li> <li>5. Likely to have negative impact on patient experience and confidence and lead to a rise in complaints and concerns</li> </ul>	16 Major x Likely		<p>System EU Exit Lead in place and organisation ICC's in place to receive communications and directives from NHSE/I</p> <p>System Procurement and Supply chain Task &amp; Finish Group meeting regularly and providing updated to Silver Command twice a week as well as a weekly SitRep.</p> <p>System will continue to monitor the position as it develops and request input/ flag issues as required</p>	9 possible x moderate	S Tilley	Elizabeth Walker 26.10.20 S Tilley 30.10.20
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RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1 Negligible	1 VERY LOW	2 VERY LOW	3 VERY LOW	4 LOW	5 LOW
2 Minor	2 VERY LOW	4 LOW	6 LOW	8 MODERATE	10 MODERATE
3 Moderate	3 VERY LOW	6 LOW	9 MODERATE	12 HIGH	15 HIGH
4 Major	4 LOW	8 MODERATE	12 HIGH	16 HIGH	20 EXTREME
5 Catastrophic	5 LOW	10 MODERATE	15 HIGH	20 EXTREME	25 EXTREME

1 – 3	Very Low risk
4 – 6	Low risk
8 – 10	Moderate risk
12 – 16	High risk
20 – 25	Extreme risk

	Consequence score (severity levels) and examples of descriptions				
Domains	1. Negligible	2. Minor	3. Moderate	4. Major	5. Extreme
Impact on the safety of patients, staff or public (physical/psychological harm).	Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/complaints/audit	Peripheral element of treatment or service suboptimal. Informal complain/injury.	Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.	totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.
Human resources/organisational development/staffing/competence	Short term low staffing that temporarily reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspections	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Risk in relation to CCGs <b>THIS ROW HAS BEEN UPDATED</b>	Insignificant cost increase	1-2% over plan/target	2-5% over plan/target	5-10% over plan/target	>10% over plan/target
	On assessing impact, consideration will also be given to other key financial objectives including but not limited to cash management and receivables/payables control				
Service/business interruption/environmental impact	Loss/interruption of >1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common Held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.049	CCG Wellbeing Guardian

<b>Executive Lead (s):</b>	<b>Author(s):</b>
David Evans Accountable Officer David.evans2@nhs.net	Alison Smith Director of Corporate Affairs <a href="mailto:alison.smith112@nhs.net">alison.smith112@nhs.net</a>

<b>Action Required (please select):</b>					
A=Approval	<input checked="" type="checkbox"/>	R=Ratification	<input type="checkbox"/>	S=Assurance	<input type="checkbox"/>
D=Discussion	<input type="checkbox"/>	I=Information	<input type="checkbox"/>		<input type="checkbox"/>

<b>History of the Report (where has the paper been presented):</b>		
<b>Committee</b>	<b>Date</b>	<b>Purpose (A,R,S,D,I)</b>
Not applicable		

**Executive Summary (key points in the report):**

The NHS People Plan 2020-21 sets out national health and wellbeing policy ambitions to enable system stakeholders to create a culture of wellbeing, where NHS staff are well looked after and cared for. One of these policy areas is the introduction of a Wellbeing Guardian.

**Background:**

The NHS Staff and Learners' Mental Wellbeing Commission (2019), launched by the Secretary of State for Health and Social Care, identified a lack of uniformity in board-level leadership around the wellbeing of our NHS people.

The review recommended improving the consistency across NHS boards through the introduction of a board-level Wellbeing Guardian role, which has more recently been referenced in the NHS People Plan (2020).

**Vision for the role**

The Wellbeing Guardian is recommended to be a board-level role that provides oversight, assurance and support to the NHS board (or equivalent senior leadership team in non-trust settings) to fulfil their legal responsibility in ensuring the health and wellbeing of our NHS people.

The expectation is for this role to be introduced in every local, regional and national NHS organisation (for example at NHS Trusts, within a Primary Care Network, at CCG level and at national NHS E&I level).

The role of the Wellbeing Guardian is to:

- Challenge the GB to have measures in place to support and promote the wellbeing of our staff
- Request evidence that steps are being taken in that respect
- Seek evidence that the wellbeing of our staff is being assessed and actions are taken to address concerns.

It is proposed that the Lay Member PPI and Deputy Chair, Mr Meredith Vivian is appointed as the existing CCGs' and the new CCG Wellbeing Guardian until the end of his tenure as a Governing Body member.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation?	No
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

**Recommendations/Actions Required:**

**NHS Shropshire CCG Governing Body is recommended to:**

Appoint Mr Meredith Vivian, Lay Member PPI and Deputy Chair, as the existing CCGs and new CCG Wellbeing Guardian until the end of his tenure as a Governing Body member.

**NHS Telford and Wrekin CCG Governing Body is recommended to:**

Appoint Mr Meredith Vivian, Lay Member PPI and Deputy Chair, as the existing CCGs and new CCG Wellbeing Guardian until the end of his tenure as a Governing Body member.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common Held in Public on 10 March 2021**

Item Number:	Agenda Item:
GB-21-03.050	Audit Committee

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs <a href="mailto:alison.smith112@nhs.net">alison.smith112@nhs.net</a>	Keith Timmis Lay Member - Governance

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

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

Executive Summary (key points in the report):
<ul style="list-style-type: none"> <li>We reviewed the Board Assurance Framework. Members noted areas that needed updating, although they accepted the difficulties of keeping this up to date while dealing with covid issues.</li> <li>Due diligence progress was summarised for the creation of the new CCG from April. Internal audit were positive about the progress made to date. There are still some gaps in the actions needed. Weekly meetings are taking place and the Director of Corporate Affairs is satisfied the CCG has a robust process.</li> <li>The Executive Director of Finance provided an update on the information governance toolkit. We are on track to deliver the requirements by the end of the operational year.</li> <li>The Committee considered the annual accounts timetable and plan. This is detailed for the finance elements, but we asked for more details covering the production of the annual report to be included.</li> <li>Internal audit reported they are on track to complete their Head of Internal Audit Opinion. We discussed their recent review of the arrangements for committees at the CCG. They noted good practice but that arrangements are still bedding in, with a particular need to focus on the Joint Strategic Commissioning Committee.</li> <li>The CCG is currently completing a procurement exercise for internal audit and counter fraud contracts.</li> <li>External audit were not able to present their plan as they are revising their audit approach to take account of the new NAO requirements for the VFM Conclusion and to assess the impact of revised international audit standards. This will come to the next Audit Committee meeting.</li> <li>Counter Fraud work continues, both for awareness-raising exercises and investigations. There are no risk issues to raise with the Governing Body at present.</li> <li>The Committee also received papers on: use of the seal; registers for conflicts of interest, gifts, hospitality; financial management update; losses, special payments and waivers; a cyber security survey.</li> <li>The Audit Committee Handbook recommends that Committee members meet privately with internal and external auditors once a year. We completed this process after the January Committee. There were no issues from this to raise with the Governing Body.</li> </ul>

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

1.	Is there a potential/actual conflict of interest? <i>(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).</i>	No
2.	Is there a financial or additional staffing resource implication? <i>(If yes, please provide details of additional resources required).</i> External audit costs will probably rise to meet the new requirements for the VFM Conclusion. The rise will not be significant to the CCG.	Yes
3.	Is there a risk to financial and clinical sustainability? <i>(If yes, how will this be mitigated).</i>	No
4.	Is there a legal impact to the organisation? <i>(If yes, how will this be mitigated).</i>	No
5.	Are there human rights, equality and diversity requirements? <i>(If yes, please provide details of the effect upon these requirements).</i>	No
6.	Is there a clinical engagement requirement? <i>(If yes, please provide details of the clinical engagement).</i>	No
7.	Is there a patient and public engagement requirement? <i>(If yes, please provide details of the patient and public engagement).</i>	No

**Recommendations/Actions Required:**

The Governing Body is asked to note this report.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

Item Number:	Agenda Item:
GB-21-03.051	JSCC Chair's Report

Executive Lead (s):	Author(s):
Steve Trenchard, Interim Executive Director of Transformation	Ash Ahmed, Lay Member

Action Required (please select):					
A=Approval	R=Ratification	S=Assurance	<input checked="" type="checkbox"/>	D=Discussion	I=Information

History of the Report (where has the paper been presented):		
Committee	Date	Purpose (A,R,S,D,I)
First presentation at Governing Body	10/03/2021	S

**Executive Summary (key points in the report):**

**Phase 3 Covid Recovery**

The committee received updates on Covid recovery across the system. A&E activity and emergency admissions remain below pre-Covid levels with some decline in A&E 4 hour performance although this has improved in recent weeks. Urgent referrals through RAS and TRACS are largely as expected but routine referrals remain below previous levels. SaTH outpatient and elective activity has reduced following the decision to pause non-critical services in response to third wave of Covid but radiology diagnostics have been maintained. RJAH have also seen a reduction in outpatient activity but continue to treat priority 2 and orthopaedic cancer patients on behalf of the system; diagnostics remain stable with signs of recovery in ultrasound. Cancer two week waits have recovered to levels seen at the end of last year with some areas such as lung recovering to pre-Covid levels. Some cancer activity continues to take place at Nuffield where possible. The committee heard that the waiting list position remains a concern and will remain so due to the cessation of elective activity.

The committee asked what steps were being taken to keep patients informed about the waiting list position and were assured that individual providers were communicating with patients and the system was close to agreeing a standard process for this. The committee also queried whether Primary Care colleagues were being kept informed about the waiting list position for other services such as those delivered in the community and agreed that updates on these services should be provided going forward.

**Updates from ICS Transformation Boards**

The committee received and noted updates on the following areas:

- Acute & Specialist – a number of work streams feed into the board and it was agreed that committee members would see a live stream of the STW Together website where the schemes of work are held.
- MSK Alliance – workshops have taken place to develop the clinical model and service specifications.
- Cancer – it is understood from NHSE that there will be significant investment in the next 12 months and a refreshed cancer strategy will be shared with the committee once complete.
- Midwifery – the LMNS board are now meeting monthly to ensure pace around areas of action and work is ongoing to provide dual reporting assurance around the Ockenden Report to the Shadow ICS Board and the CCG Board.
- Elective & Outpatients – at a regional event three high-volume specialities have been identified for recovery; ENT, Ophthalmology and Orthopaedics. The committee will be kept informed of progress

going forward.

- Urgent & Emergency Care – the board now has an activity dashboard allowing them to view recent performance and identify any improvements that need to be undertaken.
- Mental Health, LD and Autism - external help has been agreed to complete a system diagnostic to support the development of strategies for learning disabilities and for people with autism. A significant piece of transformation work around redesign of community mental health is also underway to address continuity of care for people with serious mental illness and close existing gaps in the system.
- Community & Place Based - the board priorities have been agreed and include case management, rapid response, a community services review and an end of life review. The committee noted that Shropshire Care Closer to Home has undergone some proposed changes to the terms of reference and has evolved into the Shropshire Integrated Place Partnership (ShIPP) in line with the partnership way of working in Telford and Wrekin. The committee was assured that models of care developed would provide equity of access to services across the system.
- Children, Young People and Families – this new board was board has been developed to bring together SEND, mental health and wellbeing and physical health across the system and will work at a strategic level to identify gaps in services.

### **Addendum to SaTH Access Policy**

The committee noted changes to the access policy following national guidance. Two further priority levels have been identified, levels 5 and 6. The committee noted that the addendum will be in place for as long as the pandemic continues and that these are the levels against which the waiting list will be managed. The committee were advised that P5 patients who are discharged to the care of their GP will remain on an active waiting list unless a clinician decides otherwise. P6 patients who have declined two possible dates for treatment are paused on the waiting list through their own choices to decline treatment options.

### **Procurement Strategy**

The committee received a procurement strategy developed as part of the move to a single strategic commissioning organisation and which had been reviewed by NHSEI and the CSU Procurement Team. The committee requested that the document be revised to reflect the legislative requirements around public engagement in procurement and approved the strategy subject to these revisions.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

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

**Recommendations/Actions Required:**

Governing Body Members are asked to note the contents of the report.



**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

Item Number:	Agenda Item:
GB-21-03.052	Finance Committee meetings in common 27 <sup>th</sup> January 2021

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs <a href="mailto:alison.smith112@nhs.net">alison.smith112@nhs.net</a>	Geoff Braden Lay Member – Governance <a href="mailto:g.braden@nhs.net">g.braden@nhs.net</a>

Action Required (please select):									
A=Approval	<input type="checkbox"/>	R=Ratification	<input type="checkbox"/>	S=Assurance	<input checked="" type="checkbox"/>	D=Discussion	<input type="checkbox"/>	I=Information	<input checked="" type="checkbox"/>

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

Executive Summary (key points in the report):
<ul style="list-style-type: none"> <li>• An improving financial position is improving from the original forecast of £23million to a deficit of £17 million, with all partners showing improvements. SATH still working through their position and are offset with COVID19 expenditure.</li> <li>• The underlying deficit is clearly a very significant concern and additional governance and plans are being initiated by ICS. This would be worked through a Financial recovery and sustainability committee.</li> <li>• Transformational work discussed with potential savings and areas of opportunity and how that fits with regional work and links with NHSE&amp;I</li> <li>• Workforce issues and the lack of stability because of the high level of temporary staff is still a significant concern and is recognised as one of the five opportunities for the ICS.</li> <li>• Updates for Value for Money and QIPP were received. It was agreed that QIPP programme board would be stood down for February and March to allow further work to be completed in other areas.</li> <li>• A number of key areas were highlighted to stand out for Governing body to consider:             <ul style="list-style-type: none"> <li>• Feedback from System audit chairs discussion considered the huge challenge of taking £30 million savings per annum.</li> <li>• Acute backlog and dialogue with clinicians, requiring strong leadership and involvement going forward post pandemic.</li> <li>• Primary Care allocation and the unlikely additional monies being available</li> <li>• QIPP – recognition of the savings identified and delivered this year with all the additional challenges and how we approach this in 2021/22.</li> </ul> </li> </ul>

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

<b>Recommendations/Actions Required:</b>
The Governing Bodies to note for information.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

Item Number:	Agenda Item:
GB-21-03.053	Summary Report of the Shropshire CCG and Telford and Wrekin CCG Quality and Performance Committees in Common meeting dated 27 January 2021.

Executive Lead (s):	Author(s):
Mrs Zena Young Executive Director of Nursing and Quality NHS Shropshire and NHS Telford & Wrekin CCGs <a href="mailto:zena.young@nhs.net">zena.young@nhs.net</a>	Mr Meredith Vivian Chair Shropshire and Telford and Wrekin Quality and Performance Committees in Common

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

History of the Report (where has the paper been presented):		
Committee	Date	Purpose (A,R,S,D,I)
Full minutes were approved at the NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Committees in Common on 24 February 2021.	27 January 2021	See below
Purpose		
<p>To provide assurance to the Governing Bodies' Committees in Common that the safety and clinical effectiveness of services commissioned by NHS Shropshire Clinical Commissioning Group and NHS Telford and Wrekin Clinical Commissioning Group, and the experience of patients receiving those services, have been reviewed in accordance with the Quality and Performance Committees' Terms of Reference.</p> <p>To provide a summary of the main items reviewed at the 27 January 2021 meeting.</p>		

Executive Summary (key points in the report):
<ul style="list-style-type: none"> <li>During the on-going pandemic, the scope and detail of the report on performance are limited due to suspension of many of the data flows. Performance against certain indicators is expected to deteriorate in this period (for example, RTT waiting lists).</li> <li>Recovery planning and achievement has been impacted by the current COVID cases surge and is likely to take longer than anticipated to recover.</li> <li>Performance measures related to the Urgent and Emergency Care environment locally remain challenging in particular in relation to the 4 hour treatment standard for A&amp;E though overall numbers of A&amp;E attendances and emergency admissions are lower than last winter. Ambulance handover delays in excess of 1 hour remain a challenge and increasingly so at PRH.</li> <li>Elective activity at local providers has been recovering steadily up to Christmas since the first COVID wave but has now been impacted by the current COVID surge with routine elective activity paused at RJAH and severe restrictions on capacity at SaTH.</li> </ul>

- In general, cancer performance has held up reasonably well up to present but the current COVID surge is likely to present problems in maintaining this position.
- There has been a specific issue related to the breast symptoms pathway related to the impact of COVID complaint IPC arrangements on the capacity of SaTH's one stop clinics. This has dramatically impacted the delivery of the 2 week target.
- SaTH reported 77 breaches of the 12 hour standard in December. The CCG continues to work with the Trust on reviewing assurance of care received by patients waiting extended periods for admission.
- Diabetic Eye Screening: Delays to allocating appointments and the pathway for these patients have been raised as a concern and the Trust has been asked to urgently respond to the issues raised.
- Bee-U Services Shropshire: Waiting Times for Assessment continues to be a PALS theme.
- CHEC (Community Eye Care Service) - a number of issues have been raised in relation to the Optometrist patient pathway resulting in the potential for delays in treatment. Collaborative working with SaTH and CHEC and the respective CCG referral management centres is on-going to refine and streamline the pathway ensuring universal clarity and adherence to documentation and defined terminology.
- Annual Health Checks (AHCs): The CCG and partners are continuing to work to improve the uptake and quality of Annual Health Checks for people with Learning Disabilities (LDs). There is significant variation in uptake of AHCs across the system.
- First Ockenden Report: the Committees heard that the LMNS requirements giving oversight of the baseline assessment undertaken by the Trust have been confirmed. The LMNS Board is to take place on 4 February where Mrs Young will be presenting information on quality governance and oversight of perinatal safety and mortality.
- The Committees received a quarterly report on Safeguarding of Adult, Children and Looked-after Children. It was noted that all three populations were exposed to the potential of higher risk as a result of the pandemic and the teams were working closely with all partners to ensure systems and processes are alert to this.
- The Committees received an update report on The Learning Disabilities Mortality Review (LeDeR) programme. Shropshire, Telford & Wrekin remain one of the best performing CCG's nationally, having a low number of unallocated cases, and a high number of completed cases.
- The Committees received an update on Learning Disability and heard that: LD&A board has new leadership and improved governance framework.
- In-patient target remains a challenge and COVID restrictions put more pressure on discharges; COVID restrictions are having a negative impact on the mental health of those with LDs and/or Autism.
- Annual health checks are continuing during pandemic restrictions and the CCGs are on target to meet trajectory.
- Autism pathways: Both Child and Adult Pathways are under significant pressures with long waiting lists. A plan is in place for the Children and Young People pathway and one is in preparation for the Adult pathway.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

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

**Recommendations/Actions Required:**

- The Governing Bodies were asked to note for assurance and information.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common Held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.054	South Shropshire Locality Forum – 6 January 2021

<b>Executive Lead (s):</b>	<b>Author(s):</b>
Claire Parker Director of Partnerships <a href="mailto:claire.parker2@nhs.net">claire.parker2@nhs.net</a>	Dr Matthew Bird South Shropshire Locality Forum Chair <a href="mailto:matthew.bird@nhs.net">matthew.bird@nhs.net</a>

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

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

<b>Executive Summary (key points in the report):</b>
<p>Key areas of discussion at the meeting:</p> <p>Dr Julian Povey, CCG Chair, gave an update about:</p> <ul style="list-style-type: none"> <li>The process that was still ongoing to recruit a new joint role for CCG Accountable Officer and Lead Director of the Integrated Care System.</li> <li>The consultation on the Integrating Care Proposal that had been developed by NHS England and Improvement.</li> <li>The process of creating a single CCG in Shropshire, Telford and Wrekin was still ongoing. Members had been sent an email about changes to the proposed constitution.</li> <li>Covid-19 rates in the county had risen dramatically over the previous few weeks. It was thought a knock on effect would be seen in the following couple of weeks in terms of hospital admissions and numbers locally.</li> <li>Covid vaccination programme, the sites that were up and running and plan in place to have all care homes vaccinated by the end of January 2021.</li> </ul> <p>Claire Parker, Director of Partnerships, advised that a daily communication about the covid vaccination programme was being arranged to go out to practices. Things were changing on sometimes an hourly basis but the CCG would try to communicate this.</p> <p>Sarah Pezzaoli, Team Leader for Shropshire Respiratory Service, attended the meeting to talk through the COPD and Oxygen services. She provided information to Members about the services provided, referral criteria and what GPs and patients could expect from the service. Sarah was aware that spirometry was not currently being done in primary care and mentioned a position statement from the ARTP (Association for Respiratory Technology and Physiology) that she would circulate for information. She advised that peak flow diaries could be used instead of spirometry for patients with suspected COPD.</p> <p>Julie Kenny, Service Manager from Shropshire Recovery Partnership, attended the meeting to give an update about the service. Discussion took place about building links with practices and issues that Members and the service had come across. Information was shared with Members about the service, what is offered and how to refer. A question was asked about whether the service could provide support to patients prescribed high dose opiates by their GP; Julie agreed she would discuss this further in the service clinical meeting.</p>

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

<b>Recommendations/Actions Required:</b>
<p>This report is provided for information only about the discussions that took place during the locality meeting. No further action is required by the CCG Governing Bodies.</p>

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.055	Shrewsbury and Atcham Locality Forum – 21 January 2021

<b>Executive Lead (s):</b>	<b>Author(s):</b>
Claire Parker Director of Partnerships <a href="mailto:claire.parker2@nhs.net">claire.parker2@nhs.net</a>	Dr Ella Baines Shrewsbury and Atcham Locality Forum Chair <a href="mailto:ellabaines@nhs.net">ellabaines@nhs.net</a>

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

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

<b>Executive Summary (key points in the report):</b>
<p>Key areas of discussion at the meeting:</p> <p>Julie Kenny, Service Manager from Shropshire Recovery Partnership, attended the meeting to give an update about the service. Discussion took place about building links with practices and issues that Members and the service had come across. Information was shared with Members about the service, what is offered and how to refer.</p> <p>Dr Julian Povey, CCG Chair, gave an update about:</p> <ul style="list-style-type: none"> <li>• Covid-19 rates in the county which had risen dramatically over the previous few weeks. The hospitals were under significant pressure with numbers of covid positive patients increasing. Most elective care had been paused and operations had been graded by priority.</li> <li>• The covid vaccination programme, the numbers of vaccinations that had been administered and sites that were now open.</li> <li>• The Integrating Care Proposal that had been development by NHS England and Improvement.</li> <li>• Dr Povey’s resignation from his CCG Chair role. Information about the vacancy on the Governing Body would be circulated to Members soon.</li> </ul> <p>Claire Parker, Director of Partnerships, gave an update about the Children’s and Young People’s Partnership Board that would be set up soon bringing a number of organisations together in the system to look at gaps in the system, priorities, focus on prevention and bring physical, mental health and wellbeing together.</p> <p>Dr Stephen James, Chief Clinical Information Officer, attended the meeting to give an update about the Integrated Care Record which would soon be implemented. Members talked about the huge variation in how people code and record information but agreed that information would still be valuable. Members had concerns about how they would know who was accessing data; Dr James advised that tried and trusted IG principles were being used for the system and the governance processes would be sound to protect practices as data controllers.</p> <p>Bir-inder Ironmonger and Dr Angus McGregor from the Pathology Team at SaTH attended the meeting to talk about the service. The Pathology Team currently had an annual user survey out and asked Members to complete this in order for the team to receive feedback about the service. Members gave some feedback and suggestions in the meeting such as flexibility on timings of collections, a live feedback</p>



system and some issues Members had with electronic referrals.

A couple of issues were raised about Cardiology Services – it seemed the echo service was repeating echos when not needed, it was explained that they used a RAG rating system and followed closely the national guidelines on how echos should be graded and repeated. There was also an issue raised about the Cardiology Service not always informing patients of their results causing patients to call their practice to chase them. The CCG agreed to look into these issues.

Members raised concerns about outpatient appointments and patients that had not yet been seen. It was thought that a joined up communication plan was needed for the system with a single point of access for patient queries. The CCG agreed to discuss this further and address the issue.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

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

**Recommendations/Actions Required:**

This report is provided for information only about the discussions that took place during the locality meeting. No further action is required by the CCG Governing Bodies.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common Held in Public on 10 March 2021**

<b>Item Number:</b>	<b>Agenda Item:</b>
GB-21-03.056	North Shropshire Locality Forum – 28 January 2021

<b>Executive Lead (s):</b>	<b>Author(s):</b>
Claire Parker Director of Partnerships <a href="mailto:claire.parker2@nhs.net">claire.parker2@nhs.net</a>	Dr Katy Lewis North Shropshire Locality Forum Chair <a href="mailto:katylewis@nhs.net">katylewis@nhs.net</a>

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

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

<b>Executive Summary (key points in the report):</b>
<p>Key areas of discussion at the meeting:</p> <p>Julie Kenny, Service Manager from Shropshire Recovery Partnership, attended the meeting to give an update about the service. Discussion took place about building links with practices and issues that Members and the service had come across. Information was shared with Members about the service, what is offered and how to refer.</p> <p>David Evans, CCG Accountable Officer, gave an update to Members about changes to the CCG Governing Body. He explained that Dr Povey had resigned as Chair of the CCGs and that a process would be starting to elect a new Governing Body Member and a new Chair. An update was also given about the situation locally in regards to Covid-19 and how the system was addressing this. It was explained that there was significant pressure across all sectors, though there appeared to be a flattening off in prevalence rates locally. An update about the covid vaccination programme was given by David Evans and a discussion took place about this and the issues and concerns that Members had.</p> <p>Dr Katy Lewis, Locality Chair, gave an update about the work being done by the Cancer Strategy Group around new proformas and also gave an update about the virtual covid step down ward which would soon be commencing. Claire Parker, Director of Partnerships, explained that the Long Covid pathway had started and was for any type of problem that caused an issue that was related to a previous diagnosis of covid.</p> <p>Dr Stephen James, Chief Clinical Information Officer, attended the meeting to give an update about the Integrated Care Record which would soon be implemented. Discussion took place about problems other areas had faced such as organisations deciding not to be part of the record. Questions were also asked about requests for data and what practices would need to provide to patients; Dr James agreed to look into this.</p> <p>Bir-inder Ironmonger and Dr Angus McGregor from the Pathology Team at SaTH attended the meeting to talk about the service. The Pathology Team currently had an annual user survey out and asked Members to complete this in order for the team to receive feedback about the service. Bir-inder reported concerns around children coming into the service for blood tests that were not being provided with numbing cream and asked for clinicians to prescribe this if they thought it was needed.</p>

Members discussed an issue regarding an increase in requests from Secondary Care for expedite letters. It was agreed these were not appropriate and were generating more workload for primary care at an already busy time. Claire Parker advised that the system was trying to set up a single point of contact for patients to phone and find out about their position in the waiting list.

There was discussion about pressures in the system and how Secondary Care was able to stand services down. It was felt that pressures in Primary Care were not recognised and that more communications were needed about this and the positive work being done in Primary Care. The CCG recognised that Primary Care was under a lot of pressure and this had been communicated in interviews and on the radio. It was agreed that the CCG would arrange further local communications.

An issue was raised about the Ophthalmology Service and why the service could not refer on for surgery after the cataract refinement process; GPs had to refer patients twice. The CCG agreed to look into this issue.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

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

**Recommendations/Actions Required:**

This report is provided for information only about the discussions that took place during the locality meeting. No further action is required by the CCG Governing Bodies.

**REPORT TO: NHS Shropshire and NHS Telford and Wrekin CCGs Governing Body Meetings in Common Held in Public on 10 March 2021**

Item Number:	Agenda Item:
GB-21-03.057	TWCCG CCG Practice Forum – 19 January 2021

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs <a href="mailto:alison.smith112@nhs.net">alison.smith112@nhs.net</a>	Ian Chan T&W CCG Forum Chair <a href="mailto:ian.chan@nhs.net">ian.chan@nhs.net</a>

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

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

Executive Summary (key points in the report):
<p><b>CCG Update</b></p> <p>Mr Evans informed members that the CCGs' application to become a Single Strategic Commissioning Organisation had been submitted. Good progress had been made against most of the conditions set out by NHSE/I.</p> <p>The Integrated Care System (ICS) application was submitted and was being reviewed by NHSE/I and will go to the national team later in the month.</p> <p>Dr Julian Povey has resigned as Joint CCG Clinical Chair of the Governing Body as of the end of March 2021. The process would begin shortly to appoint a new Chair from the GP/Healthcare Professional Governing Body members.</p> <p>Mr Evans has returned to his full-time role of Accountable Officer for both CCGs. Mr Mark Brandreth is leading on the ICS development work.</p> <p>As members were aware there are a rising number of COVID cases within both Shropshire and Telford and Wrekin, which is putting significant pressure on the healthcare system. The acute trust is under intense pressure, and a lot of work was being undertaken around the discharge of patients.</p> <p>Mr Evans thanked GP Practices for the huge efforts they were making at what was an incredibly difficult time in relation to COVID and acknowledge the additional pressures within primary care and the CCG really appreciated the effort everyone was making.</p>

## **Decisions Reserved to Practice Forum Under the Constitution**

### **GP Practice Forum Meeting Structure**

The decision had recently been made to include items relating to provider issues within the GP Practice Forum meeting, however there had been some concerns that this could result in a conflict of interest. Miss Smith, Director of Corporate Affairs attended the meeting and informed members that when the GP Practice Forum was formed, with the inception of the CCG, there were two areas the Forum needed to cover; decision making in relation to the governance of the CCG and engagement in relation to the commissioning of services. If the Forum discussed provider issues; issues that GP Practices had as providers of primary care this would be a conflict of interest. The solution was to have two separate commissioning and provider meetings.

Under the new Constitution for the single commissioning organisation arrangements were slightly different and Telford, as it had a smaller number of GP Practices, would retain their Forum, which could continue to be a commissioning and engagement meeting. In Shropshire their membership is made up of three localities. In the new organisation there will be an engagement mechanism if decisions need to be made, which will be via a ballot.

It was noted that around two years ago internal audit had undertaken an audit of the GP Practice Forum and they had been impressed by the level of debate and questioning at the meeting they attended. They also noted that there was a provider meeting following the GP Practice Forum, which had worked well. Dr Chan had said that the two separate meetings had worked well and therefore members should consider holding the separate meetings, with the provider meeting first followed by the commissioning meeting.

Following discussion GP Practice Forum Members agreed to having two separate meetings and a Chair for the provider meeting would be identified.

## **Clinical Commissioning Developments / Proposals**

### **Mental Health Service Update**

Mrs Parker informed members that she was taking a report to the Gold Group in relation to children's and young people's health, which discusses the setting up of a Partnership Board to look at physical mental health and wellbeing across the system. Due to the ongoing developmental needs within mental health services, it was decided adult and children mental health will become a recurrent agenda item for the forum meeting.

## **COVID Update / Vaccinations**

Mrs Parker indicated that putting a hold on the administering the second COVID vaccination had proved to be quite challenging. It was recognised, from the Primary Care point of view, that there was a need to share more regular updates on the COVID vaccination programme. It was felt that it would be helpful for the partnership managers to share information on the vaccination programme with GP Practices particularly in relation to when the PCNs and vaccination hubs were coming on stream.

Mr Ellis, Associate Director for Primary Care, had been seconded to the Vaccination Programme. Mrs Ralph had moved away from primary care and is supporting the finance and performance directorates and Mrs Parker formally thanked Mrs Ralph for all the work she had done, whilst working for the Primary Care Team in Telford and Wrekin.

There had been a slight decrease in the number of COVID cases; with around 400 per 100k in Shropshire and around 550 per 100k in Telford. This was slightly lower than the rest of the West Midlands. Mr Evans said that for both Shropshire and Telford and Wrekin there were still a significant number of care home residents and over 80s to be vaccinated and Mr Evans had asked if the focus could be on these patients. The target for getting all care home patients vaccinated was by 22<sup>nd</sup> January and for the over 80s it was by 29<sup>th</sup> January. It was therefore not possible, at this stage, to widen the cohort of patients being vaccinated.

It was noted that a lot of information GP Practices received was from the media and politician's Facebook pages, which was disappointing. Mrs Parker noted that it was the same for commissioners, which they found to be extremely frustrating. Mrs Parker went on to say that the announcement in relation to the delaying of the second vaccination had been received via the media. Mr Evans said that policy changes are being made extremely quickly and notification of them is only received at the last minute, which was again extremely frustrating. Mr Evans also said that it was frustrating that the messaging around the vaccination programme was being controlled centrally; CCGs are not allowed to disclose the number of vaccinations that had taken place or the sites coming on stream and given the level of anxiety amongst the population, both nationally and local, it was not clear why this information was being so tightly controlled.

The number of people being vaccination would increase significantly over the next week to ten days with the inception of the vaccine hub at the Telford International Centre (TIC) and the other PCNs coming on board. Dr Chan was concerned; in relation to the mass vaccinate sites that they would start vaccinating the cohorts that PCNs etc. are not currently allowed to vaccinate. Mr Evans responded that it was a concern that the mass vaccination sites would shortly start sending letters to the over 75s as they had not completed the programme for vaccinating the over 80s. The Midlands, in terms of vaccination rates, is in the middle in relation to the number of over 80s and care home residents and workers being vaccinated.

Dr Chan questioned whether the mass vaccination sites would have precedence over the PCNs in relation to deliveries of the vaccine. Mr Evans had responded that the supply of vaccine was still an issue and the local health system was not being notified until late in the day with regards to confirmed delivery dates; however the mass vaccination sites do not have precedence of supply.

There is a local COVID vaccination team in place led by Angie Wallace with Steve Ellis as her deputy. There are a number of personnel from within the healthcare system who are seconded to the vaccination team.

Members were informed that the vaccination hub at the Telford International Centre would be managed under the local health system and the main contract is with SaTH who would subcontract various elements but it will be help to account in the same way as primary care vaccination centres.

Mrs Parker informed members that in relation to the vaccination programme the feedback received from patients is how well it was being run, whether via a hospital hub or a PCN, which is testament to the clinicians and staff who are supporting the programme.

## **Home Pulse Oximetry Service**

Members were informed that Mr Tom Brettell, Primary Care Partnership Manager, who gave the presentation, had taken the role of project leader for the service. Delivery and development of the service is overseen by a Clinical Management Group. Demand on the service rose steeply in parallel with the increase in COVID cases early in the new year. Activity is now showing signs of reaching a steady rate of between 15–20 new referrals per day. As of 14<sup>th</sup> January there were 40 patients being managed by the service.

Work is underway to develop a COVID virtual ward model aligned to secondary care. The Clinical Management Group is working to design an appropriate model that will be complementarity to the existing Oximetry at home service. Engagement with secondary care consultants had been extremely positive.

Over 65s can be referred to the service or those who are in the extremely clinically vulnerable category. There is also a need to be flexible and if primary care had patients who they thought might benefit from the service they can contact the service.

### **SaTH Outpatients Restoration Update**

It was reported that parking charges had been reinstated at SaTH. The CCG had not been informed of exactly when the decision had been taken to do this.

### **Any Other Business**

Mr Evans informed members that Ms Kathy Lewis would be looking at this non-descript cancer pathway along with a number of pathways and Mr Evans would update members at the February meeting.

**Implications – does this report and its recommendations have implications and impact with regard to the following:**

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

**Recommendations/Actions Required:**

CCG Governing Body members are asked to note the content of the report.