NHS Shropshire CCG
NHS Telford and Wrekin CCG

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

to be held on Wednesday 9 September 2020
at 9.00am

AGENDA

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

Item Number	Agenda Item	Presenter	Purpose	Paper	Time
GB-20-09.093	Apologies	Julian Povey	I	verbal	9.00
GB-20-09.094	Members' Declaration of Interests	Julian Povey	I	enclosure	9.00
GB-20-09.095	Introductory Comments from the Chair	Julian Povey	I	verbal	9.05
GB-20-09.096	Accountable Officer's Report	David Evans	I	verbal	9.10
GB-20-09.097	Minutes of Previous Meeting: • Shropshire CCG Governing Body – 8 July 2020	Julian Povey	A	enclosure	9.15
GB-20-09.098	Matters Arising: • Shropshire CCG Governing Body – 8 July 2020	Julian Povey	A	enclosure	
GB-20-09.097	Minutes of Previous Meeting: • Telford and Wrekin CCG Governance Board – 14 July 2020	David Evans	A	enclosure	9.20
GB-20-09.098	Matters Arising: • Telford and Wrekin CCG Governance Board – 14 July 2020	David Evans	A	enclosure	
GB-20-09.099	Questions from Members of the Public Guidelines on submitting questions can be found at: https://www.shropshireccg.nhs.uk/get-involved/meetings-and-events/governing-body-meetings/ and https://www.telfordccg.nhs.uk/who-we-are/our-governance-board	Julian Povey	I	verbal	9.25
ASSURANCE					
	Quality & Performance				
GB-20-09.100	NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report	Zena Young/ Julie Davies	S	*enclosure*	9.30
GB-20-09.101	SaTH SOAG (System Oversight and Assurance Group) Update report	Zena Young	S	*enclosure*	9.50

	Finance				
GB-20-09.102	NHS Shropshire CCG and NHS Telford and Wrekin CCG Finance and Contracting Report, including Quality, Innovation, Productivity & Prevention (QIPP) schemes	Claire Skidmore	S	*enclosure*	10.05
GB-20-09.103	COVID-19 Update	Sam Tilley	S	*verbal*	10.15
BREAK					10.30
GB-20-09.104	Update on Shropshire, Telford & Wrekin System Restoration from COVID-19	Steve Trenchard	S	*verbal*	10.45
GB-20-09.105	Board Assurance Framework (BAF):	Alison Smith			11.00
	• Shropshire CCG Board Assurance Framework		A	*enclosure*	
	• Telford and Wrekin CCG Board Assurance Framework (BAF)		A	*enclosure*	
GOVERNANCE					
GB-20-09.106	Proposed changes to the Constitutions and Governance Handbooks of NHS Shropshire CCG and NHS Telford and Wrekin CCG	Alison Smith	A	*enclosure*	11.05
GB-20-09.107	Appointments to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin	Alison Smith	A	*enclosure*	11.15
OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY (Issues or key points to be raised by exception with the Chairs of the Committees outside of the Governing Body meetings)					
	Shropshire CCG Reports Only:				
GB-20-09.108	Shropshire CCG Finance and Performance Committee – 29 July 2020		I	*enclosure*	
GB-20-09.109	Shropshire CCG Quality Committee – 29 July 2020		I	*enclosure*	
GB-20-09.110	Shropshire CCG Clinical Commissioning Committee – 20 May 2020		I	*enclosure*	
GB-20-09.111	Shropshire Locality Forum - North – 25 June, 23 July 2020		I	*enclosure*	
GB-20-09.112	Shropshire Locality Forum - South – 2 July 2020		I	*enclosure*	
GB-20-09.113	Shropshire Locality Forum - Shrewsbury & Atcham – 30 July 2020		I	*enclosure*	

	Telford and Wrekin CCG Reports Only:				
GB-20-09.108	Telford and Wrekin CCG Planning, Performance and Quality Committee (PPQ) – 28 July 2020		I	*enclosure*	
GB-20-09.109	Telford and Wrekin CCG Audit Committee – 21 July 2020		I	*enclosure*	
GB-20-09.110	Telford and Wrekin CCG Practice Forum – 21 July 2020		I	*enclosure*	
GB-20-09.114 / GB-20-09.111	Any Other Business	Julian Povey	I	*verbal*	11.30
	Date and Time of Next Meeting - Wednesday 11 November 2020, time and venue to be confirmed				
RESOLVE:	*To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960).*				

Dr Julian Povey
CCG Chair

Mr Dave Evans
Accountable Officer

NHS Shropshire CCG and NHS Telford and Wrekin CCG Governing Body
Register of Interests - 2 September 2020

Surname	Forename	Position/Job Title	Committee Attendance JCCC = Joint Strategic Commissioning Committee FCiC = Finance Committees in Common QCiC = Quality Committees in Common PCCC = Primary Care Commissioning Committee ACiC = Audit Committees in Common RCiC = Remuneration Committees in Common	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)	To	
Ahmed	Astakhar	Joint Lay Member - Patient and Public Involvement (PPI) for Equality, Diversity and Inclusion - **Attendee**	FCiC					None declared	1.8.20	ongoing	
Allen	Martin	Independent Joint Secondary Care Doctor Governing Body Member	QCiC, FCiC	✓			Direct	Employed as a Consultant Physician by University Hospital of North Staffordshire NHS Trust,	1.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					✓		Direct	Member of CRG (Respiratory Specialist Commissioning)	1.8.20	ongoing	Level 1 - Note on Register
					✓		Direct	Chair of the Expert Working Group on coding (respiratory) for the National Casemix Office	1.8.20	ongoing	Level 1 - Note on Register
					✓		Direct	Member of the Royal College of Physicians Expert Advisory Group on Commissioning	1.8.20	ongoing	Level 1 - Note on Register
						✓	Indirect	Wife is a part-time Health Visitor in Shrewsbury and employed by the Shropshire Community Health Trust	1.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					✓		Direct	Board Executive member of the British Thoracic Society	1.8.20	ongoing	Level 1 - Note on Register
					✓		Direct	Member of the National Public Health England (PHE) TB Programme Board	1.8.20	ongoing	Level 1 - Note on Register

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					✓		Direct	NHSD. Member of CAB (Casemix Advisory Board)	1.8.20	ongoing	Level 1 - Note on Register
					✓		Direct	National Clinical Respiratory Lead for GIRFT NHS Innovation (NHSI)	1.8.20	ongoing	Level 1 - Note on Register
					✓		Direct	Chair of Respiratory Expert Advisory Group Respiratory Network for the West Midlands	1.8.20	ongoing	Level 1 - Note on Register
					✓		Direct	Member of the Long Term Plan Delivery Board (respiratory) with responsibility for the pneumonia workstream	1.8.20	ongoing	Level 1 - Note on Register
Braden	Geoff	Lay Member - Governance & Audit, Telford & Wrekin CCG - **Attendee**	FCiC, RCiC, ACiC,	✓			Direct	Director in Royal Mail Group, which is not a contractor of T&W CCG	17.4.19	ongoing	Level 1 - Note on Register
Bryceland	Rachael	GP/Primary Care Health Professional Governing Body Member	QCiC	✓			Direct	Employee of Stirchley and Sutton Hill Medical Practice	1.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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				✓			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for	1.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				✓			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Dream	1.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						✓	Indirect	Husband is a provider of executive coaching and	1.8.20	ongoing	Level 1 - Note on Register
Cawley	Lynn	Observer - Healthwatch Shropshire - **Attendee**	PCCC					None declared	13.3.19	ongoing	
Davies	Julie	Director of Performance - **Attendee**	PCCC		✓		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	1.1.20	ongoing	Level 1 - Note on Register
Evans	David	Accountable Officer	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum, JSCC	✓			Direct	Accountable Officer of Telford and Wrekin CCG	21.10.19	ongoing	Level 1 - Note on Register
				✓			Direct	Member of the Telford and Wrekin Health and Wellbeing Board	21.10.19	ongoing	Level 1 - Note on Register
				✓	✓		Direct	Owner of PSPC, a private Health Care Consultancy which does contract with the NHS, but is not a contractor of the CCG	21.10.19	ongoing	Level 1 - Note on Register
				✓			Direct	Non-Executive National Skills Academy for Health	21.10.19	ongoing	Level 1 - Note on Register

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						✓	Indirect	Wife is a partner in Realising Solutions LLP, a Consultancy that contracts with the NHS, but is not a contractor of the CCG	21.10.19	ongoing	Level 1 - Note on Register
						✓	Indirect	Wife is an employee of Tribal Education Ltd, which contracts with the NHS, but is not a contractor of the CCG	21.10.19	ongoing	Level 1 - Note on Register
Matthee	Michael	GP/Primary Care Health Professional Governing Body Member	North Locality Board, FCiC	✓			Direct	GP Partner at Market Drayton Medical Practice	9.1.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				✓			Direct	GP Member of North Shropshire PCN	13.11.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				✓			Indirect	Wife is Practice Manager at Market Drayton Medical Practice	9.1.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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McCabe	Julie	Independent Joint Registered Nurse Clinical Governing Body Member	JSCC, QCiC					None declared	1.8.20	ongoing	
Noakes	Liz	Director of Public Health, Telford and Wrekin - **Attendee**		✓			Direct	Assistant Director, Telford and Wrekin Council	9.4.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					✓		Direct	Honorary Senior Lecturer, Chester University	9.4.19	ongoing	Level 1 - Note on Register
Parker	Claire	Director of Partnerships - **Attendee**	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum		✓		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	23.03.20	ongoing	Level 1 - Note on Register
Pepper	John	GP/Primary Care Health Professional Governing Body Member	JSCC	✓			Direct	Partner at Belvidere Medical Practice (part of Darwin Group)	11.9.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				✓			Direct	Belvidere Medical Practice is a member of Darwin Group of practices and Shrewsbury Primary Care Network	11.9.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					✓		Direct	NHS England GP Appraiser	11.9.19	ongoing	Level 1 - Note on Register

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Povey	Julian	Chair	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum	✓			Direct	GP Member at Pontesbury Medical Practice	22.6.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				✓			Direct	Practice Member of Shrewsbury & Atcham Primary Care Network	22.6.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						✓	Indirect	Wife Member of University College Shrewsbury - Advisory Board	22.6.20	ongoing	Level 1 - Note on Register
				✓			Indirect	Wife Medical Director at Shropshire Community Health NHS Trust	22.6.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						✓	Direct	Chair of Telford and Wrekin CCG	1.8.20	ongoing	Level 1 - Note on Register

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Pringle	Adam	GP/Primary Care Health Professional Governing Body Member	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum	✓			Direct	GP Partner, Teldoc (Lawley Medical Practice)			Level 1 - Note on Register
				✓			Direct	Member of Shropshire Doctors Co-Operative Ltd (Shropdoc) an out of hours			Level 2 - Restrict involvement in any relevant commissioning decisions
				✓			Direct	Owner of the premises of Lawley Medical Practice (joint owner with wife)			Level 2 - Restrict involvement in any relevant commissioning decisions
Robinson	Rachel	Director of Public Health, Shropshire - **Attendee**		✓			Direct	Director of Public Health for Shropshire	22.7.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Shepherd	Deborah	Medical Director	PCCC,					None declared	15.8.19	ongoing	
Shirley	Paul	Observer - Healthwatch Telford and Wrekin - **Attendee**	PCCC, JSCC					(To be confirmed)			
Skidmore	Claire	Executive Director of Finance	FCiC, ACiC, PCCC			✓	Direct	Shared post across Shropshire and Telford & Wrekin CCGs	1.1.20	ongoing	Level 1 - Note on Register
Smith	Alison	Director of Corporate Affairs - **Attendee**	AC		✓		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	1.1.20	ongoing	Level 1 - Note on Register

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						✓	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.	2.1.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Smith	Fiona	GP/Primary Care Health Professional Governing Body Member	JSCC	✓			Direct	Advanced Nurse Practitioner at Shawbirch Medical Practice	1.8.20	ongoing	
Tilley	Samantha	Director of Planning - **Attendee**			✓		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	1.1.20	ongoing	Level 1 - Note on Register
						✓	Indirect	Brother in Law holds a position in Urgent Care Directorate at SATH	23.8.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Timmis	Keith	Lay Member - Governance & Audit, Shropshire CCG	FCiC, ACiC, QCiC, RCiC			✓	Indirect	Wife is a Archivist for Shropshire Council	25.4.19	ongoing	Level 1 - Note on Register
Trenchard	Steve	Interim Executive Director of Transformation	JSCC, PCCC		✓		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	16.3.20	ongoing	Level 1 - Note on Register

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Turner	Gary	Joint Lay Member - Primary Care	PCCC, RCiC, ACiC, JSCC			✓	Indirect	Wife is employed by the CCG as PA to Chair, AO, Medical Director and Interim Executive Director of Transformation	1.8.20	ongoing	Level 1 - Note on Register
						✓	Direct	Chair of The Priory School Trust (Education)	1.8.20	ongoing	Level 1 - Note on Register
Vivian	Meredith	Joint Lay Member - Patient & Public Involvement	QCiC, RCiC, AC, PCCC			✓	Indirect	Wife is a part-time staff nurse at Shrewsbury & Telford Hospital NHS Trust (SATH)	9.1.20	ongoing	Level 1 - Note on Register
						✓	Direct	Trustee of the Strettons Mayfair Trust (voluntary sector organisation that	9.1.20	ongoing	Level 1 - Note on Register
Young	Zena	Executive Director of Quality	JSCC, F&P, PCCC		✓		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	14.4.20	ongoing	Level 1 - Note on Register
MEMBERS WHOSE BOARD ROLE HAS CEASED OR WHO HAVE LEFT THE CCGs WITHIN THE LAST 6 MONTHS											
Bayley	Maggie	Interim Executive Director of Quality	CCC, QC, F&P, PCCC					None declared	24.02.20		Left the CCG on 14.4.20
Beck	Fran	Interim Director of Partnerships			✓		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	1.1.20		Left the CCG on 31.3.20
						✓	Indirect	Son is a Patient Adviser working in TRAQs at Telford & Wrekin CCG	1.1.20		

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Bird	Matthew	Locality Chair - South Locality	South Locality Board. CCC	✓			Direct	GP Partner at Albrighton Medical Practice	9.1.19		Board role ceased on 31.7.20 continues as Locality Chair - South Locality
				✓			Direct	NHS England GP Appraiser	9.1.19		
				✓			Direct	Member of South East Shropshire PCN	13.11.19		
Fortes-Mayer	Gail	Director of Contracting & Planning	CCC, F&P					None declared	18.1.19		Board role ceased on 31.7.20 continues as Programmes Director
George	Priya	General Practice Governing Body Member	CCC	✓			Direct	GP Member of North Shropshire PCN	13.11.19		Board role ceased on 31.7.20 New role of Clinical Lead wef 1.8.20
					✓		Direct	NHS England GP Appraiser	13.3.19		
						✓	Indirect	Husband - Consultant (Radiologist) at University Hospitals North Midlands NHS Trust	13.3.19		
James	Stephen	General Practice Governing Body Member	PCCC, CCC	✓				None declared	10.9.19	ongoing	Board role ceased on 31.07.20
Leaman	Alan	Secondary Care Clinical Member	QC, CCC					None declared	21.1.19		Left the CCG on 31.7.20
Lewis	Katy	Locality Chair - North Locality	North Localty Board	✓			Direct	GP Principle at Westbury Medical Centre	24.1.19		Board role ceased on 31.7.20 continues as Locality Chair - North Locality. New role also as Clinical Lead wef 1.8.20

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Lynch	Finola	Deputy Clinical Chair	PCCC, QC, CCC			✓	Indirect	Husband works as a locum GP for Shropdoc and is involved in writing contract for Urgent Treatment Centre	08.1.20		Left the CCG on 30.4.20
					✓		Direct	Salaried GP at Bishops Castle Surgery, which is also part of SW PCN	08.1.20		
				✓			Direct	Director of Sabre Medical Solutions (previous locum income)	08.01.20		
				✓			Direct	Clinical Director for the South West Primary Care Network	23.03.20		
Morris	Chris	Chief Nurse	CCC, QC, F&P, PCCC		✓		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	12.6.19		Left the CCG on 31.3.20
				✓			Indirect	Husband is a Governing Body Member at Shropshire CCG	12.6.19		

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Morris	Kevin	General Practice Governing Body Member	CCC, F&P, PCCC	✓			Direct	Managing Partner at Cambrian Surgery	9.9.19		Left the CCG on 31.7.20
				✓			Direct	Cambrian Surgery is a member of North Primary Care Network (PCN)	26.6.19		
				✓			Indirect	Wife was Chief Nurse for Shropshire CCG and Telford & Wrekin CCG	26.6.19		
				✓			Indirect	Wife is Acting Chief Nurse at Robert Jones and Agnes Hunt Orthopaedic Hospital	20.04.20		
Porter	Sarah	Lay Member - Transformation	RC, AC, PCCC, CCC, QC, F&P					None declared	15.8.19		Left the CCG on 31.7.20
Sokolov	Jessica	Executive Director of Transformation and Shropshire CCG Medical Director	CCC, F&P, QC	✓			Direct	Executive Director post shared across Shropshire and Telford & Wrekin CCGs	1.1.20		Left the CCG on 30.4.20
						✓	Indirect	Father elected to Shropshire Council	10.9.19		
						✓	Indirect	Father Governor of West Midlands Ambulance Service (WMAS) Board	10.9.19		

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Stanford	Colin	Lay Member	PCCC		✓		Direct	Clinical Champion for Osteoarthritis - part time position at Keele University	13.5.20		Board role ceased on 31.7.20 continues as Independent GP Member on Primary Care Commissioning Committee
						✓	Direct	Trustee - Bell Educational Trust (Concord College)	13.5.20		
						✓	Direct	Director - Concord College International Ltd	13.5.20		
				✓			Direct	Director - Apostle Coffee Ltd	13.5.20		
				✓			Indirect	Wife is Nurse Manager for Jubilee Care Ltd - Churchill House (Ludlow) and The Sandford (Church Stretton) Nursing Homes	13.5.20		
				✓			Direct	Returning GP employed by the South Central Ambulance NHS Foundation Trust undertaking COVID-19 assessment work	17.4.20		
Wilde	Nicky	Director of Primary Care	PCCC, CCC			✓	Indirect	Husband's family members are nursing staff (general and midwife) at Shrewsbury & Telford Hospital NHS Trust (SATH)	25.4.19		Board Role ceased on 31.7.20 continues as Interim PCN Programme Director

Shropshire Clinical Commissioning Group

MINUTES OF THE SHROPSHIRE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING

VIA TELECONFERENCE USING ZOOM

AT 1.00 PM ON WEDNESDAY 8 JULY 2020

Present

Dr Julian Povey	CCG Chair
Mr David Evans	Accountable Officer for Shropshire and Telford & Wrekin CCGs
Mrs Claire Skidmore	Executive Director of Finance for Shropshire and Telford & Wrekin CCGs
Dr Stephen James	GP Governing Body Member & Clinical Director
Dr John Pepper	GP Governing Body Member & Clinical Director
Mr Kevin Morris	GP Practice Governing Body Member
Dr Matthew Bird	Locality Chair, South Locality Board
Dr Michael Matthee	Joint Locality Chair, North Locality Board
Dr Deborah Shepherd	Interim Medical Director & Locality Chair, Shrewsbury & Atcham Locality Board
Dr Alan Leaman	Secondary Care Member
Mr Steve Trenchard	Interim Executive Director of Transformation for Shropshire and Telford & Wrekin CCGs
Mrs Zena Young	Executive Director of Quality for Shropshire and Telford & Wrekin CCGs
Dr Julie Davies	Director of Performance for Shropshire and Telford & Wrekin CCGs
Miss Alison Smith	Director of Corporate Affairs for Shropshire and Telford & Wrekin CCGs
Mrs Sam Tilley	Director of Planning for Shropshire and Telford & Wrekin CCGs
Ms Claire Parker	Director of Partnerships for Shropshire and Telford & Wrekin CCGs
Mrs Nicky Wilde	Director of Primary Care
Mrs Gail Fortes-Mayer	Programmes Director
Mr Keith Timmis	Lay Member – Governance and Audit
Mrs Sarah Porter	Lay Member – Transformation
Mr Meredith Vivian	Lay Member – Patient and Public Involvement

In Attendance

Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire
Ms Rachel Robinson	Director of Public Health, Shropshire Council
Ms Frances Sutherland	Head of Commissioning Mental Health and Learning Disabilities [For Item GB-2020-07.083]
Mrs Helen Bayley	Associate Director of Quality & Nursing [For Item GB-2020-07.083]
Mrs Andrea Harper	Head of Communications and Engagement
Mrs Sandra Stackhouse	Corporate Services Officer – Minute Taker

1.1 Dr Povey welcomed members and observers to the Shropshire Clinical Commissioning Group (CCG) Governing Body meeting.

Minute No. GB-2020-07.070 - Apologies

2.1 Apologies were noted from:

Dr Priya George	GP Governing Body Member & Clinical Director
Dr Colin Stanford	Lay Member

Minute No. GB-2020-07.071 - Declarations of Interests

3.1 Members had previously declared their interests, which were listed on the Governing Body Register of Interests and was available to view on the CCG's website at: http://www.shropshireccg.nhs.uk/about-us/conflicts-of-interest/ However, Members were asked to confirm any additional conflicts of interest that they had relating to the agenda items.

3.2 There were no further conflicts of interest declared.

Minute No. GB-2020-07.072 - Introductory Comments from the Chair

4.1 Dr Povey referred to the use of Zoom for this meeting and confirmed the process for using the feature of the raised hand at the point when Members would like to ask a question or make a comment. Members were also asked to mute their microphones when not intending to speak.

4.2 This was the last meeting for the Governing Body in its present form. Dr Povey referred to when Shropshire CCG was established in 2012, and all the work and change that had occurred since then and that from 1 August there would be a big positive change with the first step of holding Committees in Common with Telford and Wrekin CCG, followed in April 2021, subject to NHSEI approval, a new single CCG.

4.3 For Members who would be leaving at the end of July, Dr Povey thanked them for all their hard work, energy and support during their tenure as a Governing Body Member and extended his best wishes to them for the future.

4.3 The Audit Chairs of both CCGs had been asked to continue in their current roles until 31 March 2021, after which date there would be one Audit Chair appointed for the new CCG. The CCG was currently going through the process of conducting interviews for the Governing Body roles of the Lay Members, Secondary Care Consultant, and for the Registered Nurse.

Minute No. GB-2020-07.073 – Minutes of the Previous Meeting – 13 May 2020

5.1 The minutes of the previous meeting held on 13 May 2020 were presented and approved as a true and accurate record of the meeting subject to the following two amendments:

Page 10, paragraph 9.21, line 3: insert 'to be' before 'sustained'.
Page 12, paragraph 10.7, lines 5-6: delete: 'not' and 'any' to read: 'Whilst the budgets had been grounded in operational delivery ..'

RESOLVE: MEMBERS FORMALLY RECEIVED AND APPROVED the minutes presented as an accurate record of the meeting of Shropshire Clinical Commissioning Group (CCG) held on 13 May 2020.

ACTION: Mrs Stackhouse to action the agreed amendments to the minutes as noted in paragraph 5.1 above.

Minute No. GB-2020-07.074 – Matters Arising from the Minutes of the Previous Meeting

6.1 It was noted that the actions from the previous meeting had been completed or included on the agenda. The following updates on the matters arising were noted as follows:

a) GB-2020-05.052 – Matters Arising GB-2020-01.010 – Shropshire CCG Strategic Priorities – It was noted that the item on the Alliance Agreement with the providers for the new model of care for the integrated provision of Musculoskeletal (MSK) services had been removed from this formal agenda. Mr Trenchard gave a brief verbal update reporting that as a result of the response to COVID-19, the MSK Alliance Board had continued to meet predominantly to continue to look at the risk share agreement; to refresh the terms of reference; and this week to consider the MSK service in relation to the restoration and recovery process.

ACTION: Mr Trenchard to bring back a progress report on the MSK Alliance Agreement to the next formal meeting.

b) GB-2020-05.052 – Matters Arising GB-2020-03.034 – Update on Transforming Midwifery Care – Mr Evans referred to the Governing Body Part 2 Confidential meeting held earlier that day. In light of the police investigation into Maternity Services and whether or not criminal charges would be pursued, it had been considered that it would be likely that the investigation would take some considerable time to complete. It had, therefore, been agreed that Dr Povey and Mr Evans would write to NHS England/Innovation (NHSE/I) conveying the Governing Body's frustration that the CCG had not received further information on the proposals submitted for consideration by the national panel on transforming maternity care because clearly this was in the best interests of the population and for women who are to give birth.

ACTION: Dr Povey and Mr Evans to write to NHSE/I conveying the Governing Body's frustration that the CCG had not received further information on the proposals submitted for consideration by the national panel.

c) **GB-2020-05.055 – Performance and Quality Report including integrated, secondary and primary care** – Mrs Young reported that a meeting had been arranged with Ms Cawley to discuss further the cases that had been previously raised by Ms Cawley. Mrs Young understood that Ms Cawley had had separate communications with the Director of Nursing at Shrewsbury and Telford Hospital NHS Trust (SaTH) about the information received by Healthwatch regarding concerns in relation to patient care. Mrs Young would also escalate those complaints to SaTH with the request to urgently address the concerns raised.

ACTION: Mrs Young to escalate the concerns raised by Healthwatch on behalf of patients to SaTH with the request to urgently address the concerns raised.

d) **GB-2020-05.058 – Single Strategic Commissioner Update** – Dr Povey reported that following consultation with NHSE/I about the transitional arrangements between the two CCGs' Governing Bodies, it had been agreed to extend the current Governing Body roles to 31 July 2020. The new Governing Body roles would, therefore, commence on 1 August 2020.

Minute No. GB-2020-07.075 – Public Questions

7.1 Dr Povey advised the meeting that a number of questions had been received from the public with one question that had been received subsequent to the deadline and the CCG would respond accordingly to that individual. As previously agreed, the questions and the CCG's responses would be attached to the draft minutes that would be published on the CCG's website two weeks following the meeting.

7.2 Dr Povey noted that a number of questions that had been received were very detailed and focussed on the same areas that had been previously submitted for past Board meetings. Reference was made to when the CCG conducted the last review of the process for questions from the public. Following discussion, it was agreed that Miss Smith would conduct a review of the current process for receiving and responding to questions from the public.

7.3 Mr Vivian advised that whatever process was to be followed in the future, the CCG needed to ensure that there was transparency around what the public asked and the answers that they were given. It was agreed that Mrs Stackhouse would also circulate copies of the questions received from the public and the CCG's responses to Members when they were published with the draft minutes on the CCG's website.

ACTIONS: Miss Smith to review the process for receiving and responding to questions received from the public, particularly with regard to the regularity of similar questions received covering the same areas.

Mrs Stackhouse to circulate copies of the questions received from the public and the CCG's responses to Members when they are published with the draft minutes on the CCG's website.

Minute No. GB-2020-07.076 – COVID-19 Update

8.1 Mrs Tilley presented the COVID-19 Update using PowerPoint slides, which focussed on the main headlines of the current situation of the system's response to COVID-19.

8.2 Shropshire was in a Level 4 incident and therefore its response was commensurate with the requirements of that level, however, it had moved from the pandemic phase into an outbreak phase. Shropshire was therefore seeing prevalence rates locally declining, and outbreaks, although they were occurring at levels that the CCG might anticipate at this point. The county had seen a slightly different trajectory than other areas with not such a significant peak and a little later than other areas but with a longer plateau. The number of Shropshire cases was decreasing now with a small number of outbreaks which were being managed through the local authority as the lead agency with Public Health England (PHE) but within the parameters that was expected at this stage.

8.3 In terms of the CCG's response, the critical care community capacity has remained sufficient to meet the demand that has been experienced and activity continues to decline and these settings are no different from the wider picture.

8.4 The system partners have worked incredibly closely together to respond to a whole range of government and NHSE/I requirements around implementation of arrangements to respond to the pandemic and this

had been very fast and furious, particularly in the early part of the pandemic with new guidance being issued hourly. This is not received so rapidly now but circumstances continue to evolve.

8.5 Personal Protection Equipment (PPE) has been a significant issue nationally as well as locally. The situation has now stabilised although the CCG was monitoring closely because occasionally there were still some issues raised about this.

8.6 Swab testing had been a central part of the response and capacity was continuing to increase. The CCG was utilising a combination of local, regional and national options to meet local need. Also in line with national requirements, the CCG had implemented antibody testing for NHS staff, the uptake of which had been exceptionally good locally and it was understood that there were plans to extend this testing to a wider staff group.

8.7 One of the themes that had emerged from COVID-19 was that it did present a higher risk to people within the Black Asian and Minority Ethnic group (BAME). The CCGs had utilised the NHSE risk assessment tool to ensure that they were assessing the needs of this particular staff group and supporting them in any way they could. The assurance framework that had been provided by NHSE had been used for the assessment of risks for not only the BAME group but also for other protected characteristics and this would continue to be a piece of work that would continue beyond the response to COVID-19.

8.8 Miss Smith shared that the CCG had completed the demographic risk assessment for those staff that were currently on-site currently full time or part time. Assessments had been completed for those staff who had self-declared as falling into a BAME group and of the 68 people who were currently working at William Farr House, none of them fell into the BAME category. Those staff who were part of this group were all working from home and therefore the risk to this group had been reduced. Out of the 68 members of staff who were working on-site, one person had been identified as having an underlying health condition and was now working from home. Those staff who returned to site for business need would complete the demographic risk assessment before they would be allowed on site.

8.9 Mrs Young informed Members that the risk assessment process was a dynamic piece of work as staff were asked to provide mutual aid, for example, some CCG staff were contributing towards the phlebotomy pool as part of the antibody testing work.

8.10 Restoration was a key phase now in terms of the on-going legacy of COVID-19. Reference was made to a letter received from NHSE/I which set out stringent expectations around restoring services that were paused in response to the COVID-19 pandemic, which was proving complex.

8.11 There was a significant piece of work being undertaken around demand and capacity modelling to understand what capacity was required, where and how that could be brought together at the same time as preparing for the winter pressures. This work would continue to draw in resource across the system to assist with this.

8.12 The system was very much considering what the new normal will be as it moved forward from COVID-19 and the many opportunities that have been presented in how the system has worked together, which it was keen to continue to benefit from as it moved forward.

8.13 As Shropshire moved out of the pandemic phase into the outbreak phase, the local authorities would be taking a lead on the work through their Directors of Public Health to set up health protection boards and outbreak control plans to manage this phase.

8.14 Ms Robinson reported that the Local Outbreak Plan would be formally launched at the Health and Wellbeing Board meeting the following day. Although the plan was required to be signed off by the local authority, it was very much a system-wide plan, which all system partners would be contributing to as work continued through the outbreaks on a daily basis.

8.15 Dr Povey sought further information about the testing arrangements available in Shropshire including the capacity at the different sites.

8.16 Ms Robinson explained that the crucial pillar categories for coronavirus testing were pillars 1 and 2. Pillar 1 covered the NHS testing and the local capacity and lab testing. It was understood that the current lab capacity was 400 and Mrs Tilley added that there were options being considered to increase capacity continuously to now also cover antibody testing. The capacity was being bolstered with the regional and national routes for testing, which utilised local labs.

8.17 The Pillar 2 testing was the regional testing that had a mobile site, which was linked to the regional unit. The regional unit was now based at Telford, which had satellite sites at military sites. There was one

mobile site presently in Shropshire and Telford was also being given a mobile site. There were also back-up sites to cover in the event of an outbreak, which had significant capacity. The responsibility for agreeing where the various sites would be on rotation would be passed to the Directors of Public Health over the next few weeks. In addition, a range of testing options was being explored around demand and capacity, ie the use of postal capacity, and hyper-local sites.

8.18 Shropshire Community Health Trust (SCHT) had agreed to support up to 30 cases if these were required to be managed locally. If there was a larger scale outbreak, PHE labs or the mobile sites could be used and so there was flexibility in the system to respond to the increasing need and this was being monitored.

8.19 Dr Povey referred to the Pillar 3, which was the antibody testing and asked if it was known when this would be available to Shropshire patients.

8.20 Ms Robinson and Mrs Tilley confirmed that they had not received any further information about when the antibody testing would be available to Shropshire patients. Ms Robinson offered to take this action to find out if there was any further information on this but understood that it would not be imminently available. Dr Povey thanked both Mrs Tilley and Ms Robinson for all the hard work they had been undertaking locally and for presenting the update.

RESOLVE: The Governing Body DISCUSSED and NOTED the contents of the verbal report.

ACTION: Ms Robinson to come back to the CCG to confirm if there was any further up-to-date information on the antibody testing for Shropshire patients.

Minute No. GB-2020-07.077 – Shropshire Telford and Wrekin (STW) CCGs' Response to COVID-19

9.1 Mr Trenchard presented the paper on the STW CCGs' response to COVID19 and assumed the paper as read. Some high level issues were highlighted from the paper as follows:

- The paper described the restoration of services following the announcement to close services down that were not a priority at the time. A system set of pathways had been set up underneath an overarching pathways group, led by Dr Julie Davies. As the system moved into the restoration phase, Mr Trenchard had taken over as chair of that group, which had begun to reorganise the care pathways group.
- Also set out was the process in which the three-tier method works, which was a clinically-led system with the commissioner and operational managers who were working together on the services to be restored. The senior clinicians make recommendations to the restore group, which are then taken to Silver Command and then to Gold Command for final approval.
- Gold Command consisted of the Chief Executives for the system plan across health and the local authority with some Sustainability Transformation Partnership (STP) support. Gold Command had been very clear that all services that had been stood down would go through the process of restoration and as part of that process each service was required to complete a rigorous template.
- As highlighted in section 7, when services were stood down, new guidance received had stated that all services needed to be reported through to the regulators, NHSE/I, and those services were submitted on a platform on a monthly basis.
- As part of the process highlighted under section 9, the learning from this was being captured through working with clinical leaders, frontline workers, the service users, hard metrics on quality, finance and performance, to understand both the impact of services that were stood down but also to capture, in line with the regional approach, the services that would be due for transformation to ensure work was carried out differently in the future to ensure better health outcomes for patients.
- The paper also outlined a number of key risks that the system faced.

9.2 Dr Pepper asked how the system as a whole was assured that those services that were currently stood down and had not been raised for restoration were being monitored.

9.3 Mr Trenchard clarified that there had been very clear guidance received from NHSE/I on the priority 1 services, which included cancer and emergency and trauma services. Elective care services had been stood down and they were being monitored and benchmarked against the wider services regionally and nationally. Conversations in the restore group had shared Dr Pepper's concern and part of the process was to ensure that services could be stood down quickly if there was a need due to changes in the COVID-19 position. It was highlighted that the services which were being restored and had had minor changes would be reviewed to understand whether the changes resulted in better patient outcomes.

9.4 Dr Pepper referred to the table on page 8, point 9, which showed the key risks to care homes and asked if the process in Shropshire was right in currently discharging patients to care homes. The question was

asked if the CCG was looking to have specific nursing homes and care homes that were dedicated purely to the discharge of patients from hospital.

9.5 Mr Trenchard explained that there was very clear guidance for discharging patients into care homes with a wait for 14 days to ensure patients are COVID-free. There had been some concerns raised, for example, regarding individuals with dementia, which had been addressed with a solution. Mrs Young and the Infection Prevention Control Team (IPC) had also provided IPC support and training to care homes, which had achieved the 100% target but not all care homes had taken up the offer, which the CCG continued to offer to them.

9.6 Regarding those care homes that had not accepted the offer of support for training, Dr Pepper asked if the system was then reliant on trust for those care homes to undertake their own training. Dr Pepper also asked if the care homes were able to solve the difficulties experienced with the dementia patients and whether the patients were still vulnerable to COVID-19 following discharge from hospital.

9.7 Mr Evans explained that part of the challenge with the care homes was that most care homes across STW were individual businesses, which created difficulties in ensuring that they were COVID-free sites. Some of the larger care homes had agreed to dedicate wings in their homes for patients who were either COVID-free or COVID-positive, which had been the approach taken, but the CCG was not in a position to enforce measures in care homes.

9.8 In terms of the issue around discharge arrangements and testing, the CCG had followed the national guidance and any patient that was to be discharged would have to be tested before being discharged and isolated if necessary. Work was on-going with IPC training, which was not a unique problem locally, and the CCGs were following up cases and offering further support and training, if required.

9.9 Ms Robinson reminded Members that a care sector support group had been established earlier during the COVID-19 period and there was a large package of support to care homes. Weekly calls were made with every care home of the 120 care homes in Shropshire. For those homes considered more at risk either because of their IPC measures or because of some further concerns, additional support was provided.

9.10 Mrs Young added that some of the decisions taken about the care homes not taking up the IPC offer had been taken by the parent companies in that they undertook their own IPC training. The CCG was asked to deliver to all those care homes that had accepted, which it had done and it was following this up and was continuing to provide the SitRep reports to NHSE/I.

9.11 Mrs Tilley clarified that the CCG was required to follow national guidance on discharge arrangements but the local pathway had been developed with clinicians from primary care, SCHT and from SaTH. Swabs were taken 48-24 hours prior to discharge within SaTH so that the discharge can be developed around the test results. If the test result was negative, the patient would be discharged into the care home with isolation arrangements in place. If the individual received a positive result, there was an option to place them into a community hospital for that isolation period. However, there were a small number of beds within the care homes sector where they were able to accommodate positive patients appropriately and so these care home beds were utilised as required.

9.12 Dr Matthee referred to the long-standing issues within the local providers around waiting list management, which they had been unable to resolve for five years. The question was asked why the CCG was anticipating that during the restore and recovery phase, which was complicated enough, would the providers be able to solve the historical problems as well. Dr Matthee also highlighted the need for conversations between the hospital and primary care if services were going to be moved to primary care.

9.13 Mr Trenchard outlined some of the work that had been taking place by multi-professionals across the system to ensure that there was a strong clinical voice in the process of restoration and recovery. It was known which areas that needed to be addressed in terms of gaps with some having got larger, ie in the mental health service. There was a recognition that work needed to be carried out differently but this could not be done straightaway and services needed to be reinstated. Those services that were ripe for change for transformation would be included on the Long Term Plan for work over the next two years. There would still be the three clusters of out of hospital community primary care; acute specialist care; and mental health but a focus on what those services would offer was likely to be different in light of the learning from the period during the response to COVID-19.

9.14 Mr Timmis voiced concern that the point regarding the cancer service had sounded overly positive because there had been awareness that during the COVID period that GPs had seen far fewer patients presenting with potential cancer risks. It had been reported that at one stage, SaTH had seen approximately 15%-20% of the normal cancer referrals. There was, therefore, an unidentified backlog of referrals in addition to the diagnostic problems. As reported in the national media, there was a risk that

there would be excess cancer deaths. Mr Timmis was conscious that the Governing Body needed to be aware of the unidentified need as well as dealing with the need that was already known.

9.15 Mr Trenchard thanked Mr Timmis for raising this and explained that there had been no intention made to put a positive slant on cancer services. There was more work to be done, which would include the work of Dr Davies and colleagues looking at the backlog in relation to the full impact of COVID-19 and the services that have had been stood down. When that work was completed, the CCG would be in a better position to understand the situation across the system.

9.16 Mr Vivian raised the following points, which he sought the CCG's comments on:

(1) Re. mental health, there had been reference to a mitigating action to strengthen the voluntary sector. What was meant by this and how would that be funded?
(2) Re. communications with the population of Shropshire, Telford and Wrekin. Mr Vivian pointed out that there were a lot of changes taking place and so how was the CCG planning to communicate the changes to the public and what would the changes mean for them?
(3) The CCG was required to make very fast and sensible changes which may affect compliance with consultation requirements. Mr Vivian's advice was that the CCG needed to be careful and ensure that it consulted appropriately.

9.17 In response to Mr Vivian's question, Mr Trenchard reported that the mental health service, the voluntary sector in Shropshire, and colleagues in PHE had co-ordinated an excellent response to working at community level, with the social prescribing support, and had co-ordinated additional resource through for example, MIND, using virtual outreach Zoom meetings to focus on support for those most anxious through the COVID phase. This process had demonstrated a real proactive response that had come through the third sector that it was hoped would continue.

9.18 Regarding the changes and communications with the public, there was a system communications plan. It had been recognised in regular conversations with the Joint Health Overview and Scrutiny Committee (JHOSC) Chairs and with Healthwatch that there was more work to be done. It was considered that as a clearer plan emerged about the impact of the changes, there would be an opportunity to ensure that the public not only were properly informed but also involved and consulted about the service changes.

9.19 Mrs Tilley added that there was a dedicated communications person linked into the restoration work, which would mean that as services went through the approval process, that person would be ready to pick up the communications output and would ensure that that area was addressed.

9.20 In summing up the discussion, Mr Evans highlighted that the restoration and recovery work was very complex. Despite NHSE/I's aspiration, the reality was that it would take some time for the local health system and probably any other systems to be able to return to full activity, in terms of pre-COVID levels of activity and clearing the backlog created by the COVID pandemic. Certainly for elective care particularly, it would be surprising if the pre-COVID levels could be achieved next year and it was probably much more likely to be in 2022. This was going to be a difficult message to convey to the public although the CCG had been consistently saying to the JHOSC Chairs and Healthwatch that the recovery to reinstate services was going to be a slow process. The system was doing as much as it could but was trying to balance the various risks, particularly considering the winter pressures; the potential for a further COVID spike; and the unknown flu pressures this year. For these reasons, the CCG had been unable to articulate for some time what a clear picture of recovery resembled because of the inherent challenges the system faced.

RESOLVE: The Governing Body DISCUSSED and NOTED the contents of the verbal report.

CORPORATE PERFORMANCE REPORTS

Minute No. GB-2020-07.078 – Performance and Quality Report including integrated, secondary and primary care

10.1 Performance - Dr Davies presented the CCG's integrated Performance and Quality Report, which was taken as read. This report contained the CCG's performance against all of its key performance and quality indicators for Months 1 and 2 where available for 2020-21. The key standards that were not met year to date for the CCG were in the following areas:

62 day and 14 day Referral to Treatment (RTT)
A&E 4hr target
Ambulance handovers >30mins and >1hr
RTT

Diagnostic waits

10.2 Highlights from the report were focussed upon and further information was provided that had arisen since the report had been produced.

Cancer – Prior to the COVID-19 response, SaTH had been in a fairly strong position with the exception of some pathways that have regional and national challenges. Performance had broadly been maintained and the latest position would be known following the Planned Care Working Group meeting, which was scheduled to take place the following day. Dr Davies reported that she had been informed that the two week performance was being maintained and the backlog was reducing. As a result of the decrease in demand during the response to COVID-19, this had meant that SaTH had been working through its backlog of referrals but this had impacted on the 62 day Referral to Treatment (RTT) performance.

10.3 Diagnostic services had been considerably affected following the impact of the COVID-19 pandemic. A submission had been made regionally and nationally for extra resource for diagnostic equipment and work continued with the Regional Cancer Alliance and to develop the links to optimise the pathways to try and make the best possible use of the limited diagnostic capacity that was available. Work was being undertaken to see what steps could be taken to expand the current Endoscopy service to operate 7 days per week because of the limitations and the time lost as a result of social distancing and new infection control procedures.

10.4 Referral to Treatment (RTT) – The performance for RTT was linked to the fact that all routine surgery had been placed on hold, which had resulted in a substantial backlog of referrals, the full detail of which would be shared by SaTH at tomorrow's meeting. Once this information was received and a view of the available capacity, options would be considered to maintain the capacity at the Nuffield Hospital and also looking to use their third theatre, which had not been used so far to bring the performance back to target. It was anticipated that the over-52 week wait position would continue to deteriorate for some time. There was also a balance to be achieved between how long patients have waited with their clinical urgency.

10.5 The normal 18 week Patient Tracking List (PTL) reporting that was suspended as a result of the response to COVID-19 was being reintroduced from Qtr 2. Whilst this was being done at a provider level, it was being encouraged at a system level to try and look at combining the PTL again so that this could be managed as equitably as possible. This would maximise the use with the capacity that was available in order to achieve the best possible outcomes for patients.

10.6 A&E performance – Dr Davies drew attention to A&E performance and the frustration expressed at the last meeting with regard to the continued low performance even though activity had decreased at the local hospitals. Dr Davies was pleased to report that there had been a subsequent improvement in the performance of the Emergency Departments (EDs) with levels back up to the mid-range of 80%. This improvement had been as a result of new work that, although had been inspired by the Emergency Care Intensive Support Team (ECIST), had been carried out by the staff and clinicians themselves hence why there was optimism that this work would be more sustainable. The challenge would be to maintain the level of performance as activity and demand returns.

10.7 12 hour breaches – Mrs Young updated the Governing Body on the 12 hour breach position at SaTH, the data of which was included in the Performance and Quality Report. The CCG was working with the Trust to reconcile what they are reporting as 12 hour breach data and what the CCG's understanding might be. Mrs Young had asked SaTH to strengthen their escalation processes, which was work underway. The CCG had been informed by NHSE/I that they were due to launch a new process/template around the 12 hour breach process and reporting, which was awaited.

10.8 Work with the ED continued and ECIST had been very complimentary about the changes that have been made and were confident on the sustainability of those changes. The CCG did have a line of sight through the System Oversight and Assurance Group (SOAG) and the recently reconvened A&E Delivery Board, which would continue to be monitored.

10.9 Throughout the COVID-19 period, the CCG had maintained quality performance management meetings with SaTH monthly for the main services and specifically for Maternity. The Quality Team then report back on progress through the reporting mechanisms to the Quality Committee which then reports to the Governing Body.

10.10 The CCG remained not assured of the quality of services in SaTH given not least the findings of the Care Quality Commission (CQC) but also from the CCG's line of sight of the clear gaps over time. The nature of the many issues that had been raised by the CQC had also been detected on quality visits made by the CCG and those issues had been fed back to SaTH as requiring improvements. It was felt that only now,

with the CQC issuing regulatory action against the Trust, that they were really looking to address the issues in a really consistent and considered way.

10.11 In terms of having confidence in the Trust's ability to turn some of the issues around, many were internal issues that were in the Trust's gift to resolve. One of the areas was around culture and leadership, which was difficult to influence from the outside other than to bring to the attention of the executives that this was a theme that had been highlighted.

10.12 On a recent quality visit to Wards 9 and 10 at PRH improvements in completion of falls risk assessments had been found, however, there were gaps in other clinical assessments noted, particularly on ward 9 and a feeling of apathy had been experienced around leadership, which had been disappointing. This had been discussed with the Trust and they were refreshing and re-energising their ward quality assurance processes and will be launching a frontline leadership programme for Ward Managers. The key point was that it would take some time for the changes to impact materially on a different patient experience.

10.13 The CQC had asked SaTH to make changes by the end of August and the organisation quite clearly needed to demonstrate significant and clear progress with all of the schemes that it had been asked to improve upon.

10.14 Quality – Mrs Young referred to the other areas covered in the Quality Report. Work had been carried out looking at suicide prevention and deaths by suicide and a report would be presented to the next Quality Committee meeting. The CCG was working with the Midlands Partnership Trust (MPFT) around the associated learning from that harm review process. This was seen as a positive move and demonstrated that the Trust was allowing the CCG to work with them to improve their processes.

10.15 A Deep Dive in to Serious Incident management processes had been conducted recently with NHSE/I in attendance, which had afforded the opportunity to go through the current position to how serious incidents (SIs) are managed and to reconcile the CCG's information sources so that there was a clear and shared view of where the issues are and where improvements needed to be made. SaTH had changed their leadership of the Patient Safety Team, which the CCG was encouraged by and was working closely with that new leadership to help them improve their processes.

10.16 Dr Leaman noted from the ED data that as the workload fell during the height of the COVID-19 pandemic the throughput times had improved, which was what would be expected. If the CCG wished to see those throughput times maintained, Dr Leaman asked if the CCG would be looking to find ways of permanently removing workload from the EDs.

10.17 Mrs Young acknowledged that this question had been raised and had been responded to previously. Clearly this also involved work around the system improvement and was not all within SaTH's gift to resolve. The point had been well made at the SOAG meeting and there was a requirement to develop a system improvement plan, which was in development and would require all partners to work together to help achieve demand management at the front door.

10.18 Dr Leaman explained that the Royal College for Emergency Medicine took a very similar position in that it was felt that the acute trust should not return to a pre-COVID position where the EDs were inundated with the numbers of patients and the throughput times and the patient experience was not good. In order to avoid that situation, the heavy workload needed to be removed from the EDs and patients needed to be seen in some other assessment area.

10.19 Dr Davies agreed with Dr Leaman and explained that this was part of the work and the agenda of the Urgent Care Working Group. Unfortunately, with regard to the data, there had been a significant lag in the improvement and performance, which had only reached the level of mid-80% consistently at the end of May and the beginning of June. This was compared to the reduction of activity, which had happened much sooner and so there was a lag in performance. Dr Davies was pleased to report that the two departments had worked really hard and were now seeing the benefit of that work in performance. The challenge would be to maintain the performance because some of the reduced activity would need to return but not all. Dr Davies agreed with Dr Leaman that the system did need to work differently and this was part of the ultimate work around the re-design of the urgent care service and the urgent care centres that were described within the Future Fit concept.

10.20 Mr Evans clarified that the whole reason for the NHS 111 first proposal in which Shropshire would be the second system in the Midlands region to take a part in, was to take some of the demand away from the front doors of the EDs,. Mr Evans was confident that in theory the system would work, however, following discussions with colleagues across the systems, Mr Evans was unsure whether sufficient activity would be diverted away from the EDs and this would need to be checked. There was a need for strong

messaging to the public around this stating clearly the alternatives to the EDs that were in place over the next few months.

10.21 Mr Evans reported that for the system, David Stout, Chief Executive of SCHT, had been asked to look at the Out of Hospital Community Services Board to be established and operating quickly so that the right services could be in place to enable people to be cared for closer to home.

10.22 Whilst agreeing with the comments made to avoid people presenting at the front door, Dr James referred to Dr Davies' comment that he had also noted that it had taken a long time for the performance to improve. Dr James highlighted that there also appeared to be long waits within the department where there were lots of free beds and so it was not just the demand at the front door but the processes within the hospital department that also needed to be reviewed to sustain the improvement going forward.

10.23 Mrs Young thanked Dr James for this comment and confirmed that ECIST had been looking at some of the measures that the Trust needed to implement around patient flow within the department.

10.24 In relation to ambulance response times, Dr Leaman asked if it was possible for the CCG to find out how long the local ambulance crews were spending on-scene.

10.25 Dr Davies advised that the CCG did not receive this data automatically but did request that information periodically. The CCG did wish to avoid unnecessary conveyances but equally it was having the crews who are on-scene having access to those alternatives so that they can make those decisions quickly and then they can respond to the next call. There was no real variation across the region in terms of times on-scene. Shropshire's response times tended to be because of its rurality and the distances to it. Dr Davies would ensure the latest data on the ambulance crew on-scene timings was shared with Dr Leaman as soon as it was received.

10.26 Dr Matthee sought clarification on the data shown on page 10, section 6 of the report for Urgent and Emergency Care – A&E Performance and Ambulance Handover Delay. Dr Davies advised Members that this was national comparative data which showed emergency admissions for chronic conditions that should not be going into hospital. Following a further query raised by Dr Pepper regarding the meaning of the numbers 845 and 965 included in the table, Dr Davies would double-check the data for Qtr 2 quoted in the report because it was understood that this information should not yet be available.

10.27 Mr Vivian raised three points, upon which he sought the CCG's comments:

(1) The Governing Body previously had held lengthy discussions about 12 hour breaches and the assessment of harm processes. It was noted that in the shared paper that there was a reference to on-going monitoring of harm processes that have been agreed. Mr Vivian asked if Mrs Young felt confident that the current measurements were sufficiently appropriate and comprehensive, specifically for the psychological effects of a patient waiting on a trolley.
(2) Clarification was sought on where the new role of Patient Safety Lead sat within the organisation.
(3) It was noted that the Governing Body received very little information about quality and performance on services in the community. Mr Vivian acknowledged that the performance was not measured in the same way but felt there was a large gap of information and sought Mrs Young's comments on this.

10.28 In answer to the first question, Mrs Young explained that it was difficult to evaluate SaTH's psychological harm review information. Mrs Young believed that any harm review process should not just be a snapshot of a service that has been delivered in the ED. It was the consequence of the service received for that patient. The CCG did try to take a longitudinal view where it could by triangulating the information with other information, such as mortality information, but it was quite difficult to work through that in the same way it would for physical harm. The Friends and Family Test and the Patient Survey would be other measures that would normally be used.

10.29 It was accepted that it was not good patient experience. Whether there was any psychological harm was really difficult to assess unless there was an individual complaint, or issue or incident raised as a result of that, there was no clear way or knowing whether there had been any psychological impact. A more valid point would be to consider the effect of long waits for patients awaiting mental health assessments when it can be seen there might be a clearer link or a more pressing need to shorten those waits. This was a piece of work that was being worked through within the system, not just at the acute trust.

10.30 Mr Vivian understood that it was difficult but it felt as though the CCG might be accepting that it was too difficult also. Mr Vivian asked if it was possible to investigate whether an experience has been harmful to a person's emotional as well as physical well-being rather than to wait for a complaint.

10.31 Dr Povey agreed with Mr Vivian's view and considered it was surprising that there had been a number of 12 hour breaches and not a single person had come to harm and considered that that there was work that the CCG needed to be doing on this.

10.32 Mrs Young said that she was not aware of any particular tools that could be applied to test whether a patient experience had been harmful to their emotional well-being but offered to seek a professional view on this point.

10.33 Ms Cawley explained that Healthwatch had discussed for some time about receiving feedback from patients and families and referred to a conversation with the previous Chief Nurse when it had been agreed for some Healthwatch leaflets to be handed to patients who were experiencing long waits in the ED and inviting them to share their feedback on their experience. To date, Ms Cawley understood that no feedback had been received from that leaflet but confirmed that Healthwatch was certainly interested in supporting the CCG in this area.

10.34 Mrs Young said she was unable to comment on why feedback had not been received by Healthwatch and what had previously agreed before she had joined the CCG but was happy to discuss further in Ms Cawley's and Mrs Young's forthcoming meeting.

10.35 Dr Povey raised that there had been approximately 150-250 empty beds in SaTH and yet there had been 2 x 12 hour trolley waits and 2 breaches in June and could not understand the reason for this. Mrs Young agreed that in each case that had been brought to the CCG's attention, there had been clear gaps in internal processes to manage those patients better. The Trust was being asked to provide assurance that they had the processes in place and that they were following them. Mrs Young added, however, that the numbers of empty beds included those wards and bays that had been segregated into COVID and non-COVID and awaiting test results. Therefore, not all of the beds were necessarily open to the right patient at the right time and some of those would be in specialty areas.

10.36 In answer to Mr Vivian's second question, the Patient Safety Lead was an internal appointment and the postholder reported directly to the Interim Chief Nurse, whose portfolio included patient safety.

10.37 Regarding Mr Vivian's third question, Dr Davies agreed that one of the areas identified as a gap in terms of the development of performance monitoring as a system was that it needed to be expanded more for community. Dr Davies was working with SCHT on this which would link in with the work of reinstating services. .

10.38 Dr Povey expressed a view that the new format of the Performance and Quality Report worked well for the performance elements but did not think it presented the Quality information very well and could be improved upon. It was discussed that perhaps the report would benefit from being broken down into separate sections for the providers. It was agreed that Dr Davies and Mrs Young would review the structure of the report for presentation to future meetings.

10.39 Maternity Services – Mrs Young reported that further information had been received after the Performance and Quality Report had been prepared. The CCG and other partners had been informed the week before that the police were launching a formal investigation into some matters that had come to their attention by way of information received around maternity services. There was still the Secretary of State's review that was being undertaken by Donna Ockenden and that the CCG was led to believe was going to continue alongside a formal investigation into some of those circumstances.

10.40 No further information was available at this time other than it was known that the acute trust had published a statement stating that it was working co-operatively with all parties. The CCG was not in a position to comment directly. In the meantime, the CCG was working to provide information to the Ockenden Report.

10.41 Dr Pepper referred to page 4 and the cancer breach reports and noted that one patient had been classified that harm had been caused due to a long wait, which was believed to be irretrievable. Dr Pepper asked if the CCG was sighted on the whole process for that particular individual, including the Duty of Candour and the patient involvement in the learning process.

10.42 Mrs Young confirmed that the CCG would be sighted on the detail of this case. The CCG was working with the Trust to understand their process for extracting learning from harm reviews so that that is applied to all patients rather and not just for an individual patient. There was some NHSE/I guidance expected that suggested individual harm review processes were only part of what was needed to be reviewed. The systems needed to have risk stratified approaches for dealing with, for example, backlogs. The patient and family would be sighted on a pathway which would come through the SI reporting process and there would be a full root cause analysis (RCA) that would include the Duty of Candour.

10.43 Dr Pepper referred to page 7 and the data on Maternity, for neonatal mortality, and voiced concern that the figures compared to a baseline from 2015. It was pointed out that it was very difficult for the majority of Board Members to deliver assurance as the majority of Board Members' terms were for three years.

10.44 Mrs Young was in agreement with this comment and reported that internal discussions had taken place and concerns had been raised with NHSE/I's Regional Chief Midwife and the National Chief Midwife in that there was a delay in the validated moderated data. By way of some assurance, the maternity metrics data was to be presented to this month's Quality Committee meeting. It was hoped that an output from that report to that committee would then be presented to the Governing Body. In the meantime, Mrs Young said she was happy to share any further data if individuals considered that would be helpful.

10.45 Mrs Young confirmed that the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK) report did cohort the trust with trusts with a similar number of annual deliveries. Mrs Young advised that it was also important to benchmark with trusts with similar rurality and NHSE/I had been asked to look at producing regional data set reports that would allow like-for-like reporting. In addition, the Local Maternity System (LMS), subject to final confirmation of funding, would be looking to employ a new Data Systems Analyst, who would assist in developing comparative reporting.

10.46 Dr Pepper referred to page 8 of the report and asked if the waiting list numbers and timescales for the development of the pathways were available for Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

10.47 Ms Parker confirmed that she had planned to pick up this point later on in the agenda under the item on SEND. Ms Parker did not have the waiting lists data to hand but would request these and would include in the report.

10.48 Mr Trenchard explained that there had been a delay in funding received for the development of the new pathway but it had been previously recognised and also in the CCG's prioritisation of the budget for this year that that was an urgent piece of work. The performance of the CCG and more broadly the system had been escalated to NHSE/I. The history was that the focus on this area of work had moved a few years ago from Shropshire Council to the Transforming Care partnership (TCP). Mr Trenchard had just taken over the role of Senior Responsible Officer (SRO) and Tanya Miles, from Shropshire Council, was the Deputy SRO. It was known that there was more work to do. It was agreed Mr Trenchard would provide more detail to the next Governing Body meeting.

RESOLVE: The Governing Body NOTED the contents of the report and SOUGHT assurance from the CCG actions contained within it to ensure patients' safety and compliance with quality care.

ACTIONS: Dr Davies to share the data on the ambulance crew on-scene timings with Members when received.

Dr Davies to double-check the data quoted for Qtr 2 on page 10, section 6, of the Performance and Quality Report and to email clarification of the information to Members.

Mrs Young to seek a professional view on whether there are any to tools that can be applied to test whether a patient experience has been harmful to their well-being as well as their physical well-being.

Dr Davies and Mrs Young to review the structure of the Performance and Quality Report for presentation to future meetings.

Ms Parker to include the waiting list numbers and timescales for the ASD and ADHD pathways in the SEND report.

Mr Trenchard to provide an update on the new ASD and ADHD pathways to the next meeting

CLINICAL AND FINANCE REPORTS

Minute No. GB-2020-07.079 – Finance, Contracting Report including Quality, Innovation, Productivity & Prevention (QIPP) schemes

11.1 Mrs Skidmore presented the report that set out the 2020/21 Month 2 (M2) financial position of the CCG. Members would recall that at the last meeting it had been reported that very little guidance had been received and the CCG had not received any allocations. It was reported that soon after that meeting,

guidance had been published. The CCG had been given a 4-month allocation, like all CCGs, and therefore over Q1 and for July, the CCG had only reported on an in-year basis and up to the end of M4.

11.2 Guidance was still awaited for the M5-12 position. It was known that the CCG would be given an allocation through to the end of the year and at that point it would need to reassess the guidance and consider what that means in terms of its position and how it will report for the remainder of the year.

11.3 Mrs Skidmore explained that the CCG was in a strange position and would usually report on a position that was relative to its budget but because it did not have that control total target at present it did not have that relative position to consider. The Finance Department had therefore at M2 spent a lot of time looking at the run-rate, to review the month on month spend, which helped the CCG to see whether its costs were as expected or whether there was an increase. There was therefore a focus around grip and control at the present time in the absence of the particular control total to aim for.

11.4 Reference was made to the data included in the report which showed that at M2, Shropshire CCG was reporting within £5.7m over the budget that it had been given. It was pointed out, however, that the budgets that the CCG was given excluded any contributions to assist with any COVID-19 related spend; and the £5.7m overspend included £4m COVID-19 costs.

11.5 The CCG's M1-M4 position was going to be allocated in a similar way to the Trust in that it had been given its allocation for the four months but would also receive a retrospective allocation adjustment to enable the CCG to break even. Work had been undertaken to consider what the M4 position would be based on and what was known at M2. In M2 there was £4m of COVID expenditure included in this position and forecast COVID related spend for the 4 month forecast was £6.3m. With the exception of COVID costs, the CCG was looking at spending £3.7m more than it had been allocated.

11.6 Further NHSE/I guidance was expected but this had been delayed nationally. Mr Trenchard's frustration was shared in that the CCG could not move forward to invest in some of the real priority areas, such as mental health, but it was understood that when the guidance was available it would be given due priority. Mrs Skidmore considered that the work undertaken by Mr Trenchard would place the CCG in a good position to be ready to act upon the guidance as soon as it was published.

11.7 Mr Morris referred to the fact that most of CCG's contracts with the providers were block contracts and so QIPP was very difficult. Following Mr Morris' meeting with Mrs Skidmore and Ms Clare, he had been relatively assured the CCG was doing the right things with the information that it had. After 4 months into these unprecedented times, it was still very surprising that further guidance had not been received. The Finance and Performance would be holding their last meeting of this Board in two weeks' time and hopefully some guidance would be received in order to settle the accounts in readiness for the new Board going forward. In Mr Morris' view, it was really important that the CCG continued with the QIPP schemes as there were still some programmes that the CCG could consider further, ie in continuing healthcare.

11.8 Dr Pepper referred to the providers having a similar arrangement whereby they received a top-up payment from NHSE/I in addition to their monthly budget payments. Dr Pepper asked how did the CCG know that the acute spend had increased by 2% and why was the CCG seeing growth above what it had been planning for.

11.9 Mrs Skidmore explained the method in which NHSE/I constructed the block payment from CCGs to Trusts. NHSE/I reviewed the Trusts' spend at a point in time and applied an arbitrary price uplift and growth uplift to the amount. The CCG's core contract with the acute trust, the mental health trust and SCHT therefore would break even because the providers would be paid the same amount as what the CCG was given from NHSE/I.

11.10 It was explained that there was a big variance on spend for primary care because there had been a number of new initiatives that had been introduced into the primary care contract from 1 April. Whilst the CCG honoured the payments to primary care, it had not had the allocation adjusted for that, which was one of the queries asked of NHSE/I. It was noted that other regional areas had also highlighted this area as an overspend at the present time.

11.11 Dr Pepper requested an explanation of the variance in costs that related to primary care contained in the tables of the report and in appendix A, particularly the differences between what the COVID-19 costs were in primary care and the £4.2m total costs represented.

11.12 Mrs Skidmore explained that the general practice COVID costs covered a wide range of claims, including the additional Bank Holiday cover, IT support to ensure practices can operate remotely and other areas such as PPE. The broader piece around the budget was complicated because there was an underlying issue with the CCG's delegated primary care budget relating to a backlog from last year and the CCG had

been subsidising the balance of spend to its programme budgets. Allocations for some of the new DESs and aspects of the primary care contract that had been introduced from 1 April were expected and guidance on how balance the budgets was expected from M5 onwards.

RESOLVE: The Governing Body NOTED the information contained in the report.

GOVERNANCE & ENGAGEMENT

Minute No. GB-2020-07.080 – Governing Body Assurance Framework (GBAF)

12.1 Miss Smith presented the GBAF, which had been updated following the last Audit Committee meeting, and was taken as read.

12.2 Dr Leaman asked if the CCG accepted that it had been slow to pick up on a problem in maternity, how was it going to do things differently to avoid similar problems happening in the future.

12.3 Mr Evans said that he was not sure that the CCG had been slow to identify a problem in maternity and reported that none of the data available at the time suggested that there was anything to be concerned about which had been outlined in a letter to Dr Leaman.

12.4 Dr Leaman explained that perhaps the information that had been presented did not properly represent the full facts of the situation.

12.5 Miss Smith referred to Risk 2/20 No 2: Quality and Safety logged on the GBAF, which stated that 'there is a risk that the CCG fails to commission safe, quality services for its population'. In the key controls column there was a list of controls that the CCG believed were in place at the present time to mitigate that risk. Miss Smith asked Dr Leaman where he thought there was a potential gap in terms of mitigation and whether there was an additional action that could be taken on the controls and assurances.

12.6 Dr Leaman reported that he had a list of suggestions but considered that the current oversight performance framework was not fit for purpose.

12.7 During discussion it was highlighted that the whole purpose of the risk register was to highlight the current risks. Mr Evans acknowledged that there had clearly been concerns around maternity care for a number of years, which had been highlighted. It was considered the CCG had recognised this and had tried to work with the acute trust to change this but nonetheless there remained risks, which the CCGs were aware of and were trying to mitigate.

12.8 Mrs Young confirmed that the assurance framework used in this system was not unusual to the standard approach used in other systems that were doing well and those that were more challenged. Mrs Young was unsure of Dr Leaman's comment that the framework the CCG used was not working. It worked to the extent to which accurate data is populated and the information shared is accurate. It had been heard that in the past that the SaTH Board itself had perhaps taken assurance from its internal data but that had not been as accurate as it should have been and the acute trust was taking steps to correct this. The CCG was always going to be reliant on the information that was shared with it because the provider was the statutory owner of that information and therefore the data sets were not the CCG's.

12.9 Dr Povey suggested that it would be helpful if the GBAF was re-columned to show an assessment of: the original risk; the current level of risk; and an assessment at the end point that the CCG aimed to achieve.

12.10 It was considered that at this point of the meeting, the Governing Body was reviewing the assurance framework, which was felt to have the right components. Whether it showed the right rating or whether the CCG achieved all the mitigations was a separate question. However, it was considered that there was nothing missed and nothing to suggest that the CCG was slow to respond. There were timelines showing a lot of interventions. It could be argued that the interventions were not effective but that was not necessarily about slowness to respond and slowness to recognise a problem. Dr Leaman thanked Members for making the position clear.

RESOLVE: The Governing Body

- ***REVIEWED the detail of the GBAF risks and highlighted any updates required.***
- ***CONSIDERED the risks highlighted in the GBAF as it conducts its business.***

ACTION: The Executive Team to review the current GBAF to see whether further improvements can be made including looking at the inclusion of the levels of the original risk, present risk and the risk aimed for.

Minute No. GB-2020-07.081 – Review of Governance Arrangements in Response to COVID-19

13.1 Miss Smith presented the paper on the Review of Governance Arrangements in Response to COVID-19, which was taken as read. Governing Body Members had previously agreed to step down a number of committees to a different regularity and to move to virtual meetings in response to COVID-19. There was now a requirement for the Governing Body to review the governance arrangements that had been adopted and to approve a timescale of reverting back to normal governance arrangements from September.

13.2 Miss Smith explained that due to the joint arrangements with Telford and Wrekin CCG meeting as committees in common from August, the proposal as set out in the paper was to reinstate committee meetings from September. Clearly there needed to be a discussion about whether the meetings would need at that point to be virtual and how face-to-face meetings would be held if there was a requirement to hold these. It had been recognised that the situation around COVID-19 could change at any given time and the paper proposed that the Chair and the Accountable Officer would review the situation in August.

13.3 Dr Povey drew attention to the letter received from Amanda Pritchard, Chief Operating Officer, NHSE/I of 6 July regarding the stepping back up of key reporting and management functions and asked if there were any further points from that letter that needed to be highlighted to Members.

13.4 Miss Smith explained her interpretation of the guidance was that NHSE/I would like NHS organisations to start standing their governance structures back up with local determination, but to avoid face-to-face meetings and to continue with virtual meetings in the immediate future and move to face-to-face meetings at a later date. If the Governing Body wished to continue with the virtual meetings in the interim period for the meetings in common, the CCG would need to consider how it could re-establish public involvement. Miss Smith would investigate the option for live-streaming a virtual meeting or a face-to-face meeting with social distancing in place.

13.5 Dr Matthee and Dr Bird reported that both the North Locality and South Locality Boards had recently held successful virtual meetings, which had been well received by the Members. It had been suggested by the South Locality Board that perhaps it could hold virtual meetings in the future with just two face-to-face meetings held per year. Dr Bird highlighted that the virtual meetings were not the best to chair but if it was a choice between not holding a meeting and a virtual meeting then conducting the meeting virtually was perfectly acceptable.

13.6 Mrs Tilley expressed her view that she was not supportive of reverting back to the previous governance arrangements. Mrs Tilley highlighted some of the learning and processes that had been implemented in the system during the pandemic phase and suggested that, whilst the CCG would want to move into its governance structure going forward, as it moved towards creating a new organisation, it should consider some of the learning from the COVID work that could be factored into improvements to the structure. Mrs Tilley felt that there was a balance to be struck from where the CCG was before and where it had been recently that required serious consideration. Mrs Tilley's concern was that once the CCG reverted back to its previous governance structures, it would be difficult to move out of those again and so it should not lose the opportunity to make some of those changes going forward. Furthermore, Mrs Tilley clarified that it was the phraseology of returning back to normal that was setting the tone and the CCG needed to be clearer about what normal was because it could not necessarily be what it was before.

13.7 Dr Povey agreed with the comments made but considered that the governance arrangements agreed should be reinstated and then reviewed. At this current point, Dr Povey suggested that it was right to move the Board meetings back as proposed in September to the meeting schedule notwithstanding there will be virtual meetings.

13.8 Mr Timmis reported that at its last meeting, the Audit Committee had raised concern that the current arrangements could not continue much longer than was necessary and in September the CCG should revert back to its normal governance arrangements. Mr Timmis understood Mrs Tilley's view but was opposed to any further delay. The CCG did have a constitution that it should follow and whilst there was a Level 4 position nationally, it was felt that the situation was beyond the pandemic stage now and the CCG should revert to its existing governance processes.

13.9 Mr Vivian commented that he was in agreement with both Mr Timmis' and Mrs Tilley's viewpoints. However, whether or not the processes and procedures for the CCG's governance was helpful, he suspected that it had been tied up in bureaucracy and had not successfully delivered much output and outcomes. Mr Vivian suggested that the CCG should revert back to good governance but making it as streamlined and efficient as it could possibly be and not to revert back to its previous governance method.

13.10 Dr Povey referred to the caveat that the Chair and the Accountable Officer would review the situation in August. Dr Povey highlighted that the present position was that the UK was not out of the COVID pandemic and that the definition of a pandemic was about whether an illness was spreading across multiple places around the globe at the same time at a high level, which was still happening. Shropshire was getting the situation under control but there were still outbreaks and the situation could change at any given point.

13.11 In summary, Mr Evans agreed with the comments made in that the CCG did need to revert back to its governance arrangements of holding meetings that provide the assurance to committees and the Board on what the CCG was doing and how it was operating regarding its finance, performance, quality, etc. However, the CCG would need to ensure that it did not go back to the old normal but a new normal. There was no issue with the CCG returning in September to the schedule of meetings it previously followed before the COVID-19 response but it needed to ensure that in setting the Terms of Reference, etc, given that these would be new committees because of moving to new Board arrangements, it had got those right in terms of the expectations.

RESOLVE: The Governing Body:

- ***REVIEWED the current temporary governance arrangements adopted during the COVID-19 management response; and***
- ***APPROVED the timescale of reverting back to normal governance arrangements from September 2020, with the caveat that this is reviewed in August by the Chair and the Accountable Officer.***

Minute No. GB-2020-07.082 – Strategic Priorities Update

14.1 Mr Evans referred to the paper previously circulated, which was taken as read. It was explained that the paper contained updates on the CCG's priorities that had been previously agreed and the actions that had been taken since those priorities had last been reviewed. There were no questions raised.

RESOLVE: The Governing Body:

- ***NOTED the progress against the CCG's strategic priorities including the inclusion of a single high level KPI for each priority; and***
- ***SUPPORTED the development of a new set of Strategic Priorities as part of the process of preparing to become a single strategic commissioner.***

Minute No. GB-2020-07.083 – Learning Disabilities and Autism Update LeDeR Annual Report

15.1 On behalf of the Governing Body, Dr Povey welcomed Ms Sutherland and Mrs Bayley to the meeting. Ms Sutherland presented an update on the Learning Disabilities and Autism programme, which is overseen by the Learning Disabilities and Autism Board. The programme originated from the Transforming Care Partnership (TCP) which focussed on reducing the number of individuals with learning disabilities (LDs) and Autism with challenging behaviour. Over the last 18 months, the programme also now included all individuals in this cohort and not just those with challenging behaviours. The LD&A Board is a sub group of the Mental Health, Learning Disabilities and Children's STP work stream, which a number of sub groups report to.

15.2 Performance – It was explained that there had been an issue with the performance around in-patient beds. Over the past two years, the system had failed to meet its agreed trajectories for the number of patients in a mental health or learning disability hospital bed. At the end of 2019/20, system performance was rated 44th out of 48 TCPs across England, which was measured as a distance from target. The target that Shropshire was measured against at the time was 37 beds per million. The system was actually at 56 beds per million and so it was 8 patients over and above the target. As a result, there have been some issues that the CCG has been working on, which included: lack of capacity and commissioned services in the community in both adult and children's services; lack of suitable housing in the community; and the length of time it takes to actually develop very bespoke properties; lack of skills and capacity in the care market; and also some issues around consistent leadership in the system.

15.3 The team had continued work to address these issues, which had resulted in three discharges in the last four weeks, which was pleasing. The system was now on track to meet the required target of 37 beds per million by the end of Qtr 3 which equates to 14 beds. The CCG would need to do further work to meet the 2023/24 target, which was 30 beds per million. There were, however, some individuals with significant lengths of stay in hospitals and there was a focus on those patients to ensure that they received effective treatments so that they can live in a less restrictive environment in the community in the future.

15.4 Annual health checks - There is a requirement under the Quality Outcomes Framework (QOF) that 75% of individuals with an LD over the age of 14 received an annual health check. The numbers have increased since 2015/16 but unfortunately in Shropshire the numbers did decrease in 2018/19. The data for 2019/20 was not available until the autumn.

15.5 Work has been undertaken with GP practices and the Midland Partnership Foundation Trust (MPFT), who are the providers for the Community Learning Disabilities Team. An action plan is in place to ensure that the correct individuals are on the registers and the CCG aims to undertake 100% of the health checks.

15.6 Stopping Over Medication of People (STOMP) – is a national programme that focuses on reducing inappropriate over prescribing of medication to people with an LD, Autism or both with psychotropic medicines, and the CCG was due to review its system-wide action plan.

15.7 Learning Disability Mortality Review (LeDeR) Programme – Mrs Young presented the update on the LeDeR programme, which was taken as read. The LeDeR programme ensures that all the deaths of individuals who have a LD are reviewed and that any learning is put into place. STW remain one of the best performing CCGs nationally having a low number of unallocated cases and a high number of completed cases. There has been a lot of focus on ensuring that all deaths have had a systematic review. Carrying out the themed information learning reviews has allowed those learning points to be fed back to providers and services that that they can be taken account of moving forward.

15.8 There are six cases that have yet to be assigned. The CCG does try to assign those cases within a few weeks of being notified. It was considered that the CCG's achievements should be applauded given the COVID-19 situation having staff redeployed into different roles but still managing to keep a focus on the programme. However, Mrs Young expressed concern about keeping the momentum going during the next phase of management of change.

15.9 Mr Vivian reported that the Quality Committee was scheduled to review this report in detail at its next meeting at the end of July and would raise his questions at that meeting. .

15.10 Mrs Young explained the reason that the report was being received out of sequence was because of the timeline dictated by NHSE/I which required the report to be published on the CCGs' websites by the end of July. Therefore there was no opportunity to seek approval by the Governing Body at a later date. The report would be presented to the Telford and Wrekin Governance Board in the same manner. If the Quality Committee did not raise any concerns then the report would be published on the CCG's website.

15.11 Dr Povey thanked the team for the work that had been undertaken and said that it would be good if the CCG could look at the cases that have been unallocated.

15.12 Mr Trenchard said that the CCG was challenged by NHSE/I as a system about its ambition to raise the standards of care of those most vulnerable in society and any help that colleagues could provide to ensure that the health checks were carried would be welcomed. These comments were echoed by Dr Pepper who said that this view would also be shared by the vast proportion of primary care. Although this work was an aspirational achievement for primary care, it was agreed that the work was important.

15.13 Dr Povey pointed out that the other area that was shown in QOF which was not shown in the data presented was the patients who were shown as exclusions. It was discussed that the QOF data was based on different measures, which had been seen in a number of cases where the CCG had been seeking information that was not actually on the QOF performance. Dr Povey suggested that if the QOF achievement for practices was reviewed it was considered the percentage would be much higher than the 52% stated because of the exceptions they have applied.

15.14 Mrs Young asked if the numbers behind the percentages were available and whether there were themes around particular barriers to achieving health assessments for this vulnerable group. Ms Sutherland confirmed there were numbers for a very specific target and believed the number across the two CCGs was approximately 1200. The joint working of the LD Team and MPFT with general practice since COVID-19 had been considered much better.

15.15 Mrs Young saw this very positively as impacting on safeguarding as well because this was a vulnerable group and by having access to health checks was a means of assuring the CCGs around the line of sight.

RESOLVE: The Governing Body:

- ***NOTED the update report from the LD&A Board; and***
- ***APPROVED the LeDeR annual report prior to its publication on the CCGs' websites subject to sign-off by the Quality Committee.***

Minute No. GB-2020-07.084 – Update on the SEND Inspection Report

16.1 Ms Parker presented the update on the Special Educational Needs and Disability (SEND) Local Area Inspection Report and assumed the paper as read. Reference was made to the last meeting when Ms Parker had committed to update the Board regularly around the SEND inspection that had been carried out earlier in the year, the outcome of which had been published in May and was available in the public domain.

16.2 A meeting had been arranged to develop the written statement of action. Ms Parker proposed to present the final draft of the written statement of action with the next update report to the formal Governing Body meeting, scheduled to take place on 9 September, in readiness for publication on 25 September.

16.3 Ms Parker was pleased to report that a face-to-face workshop had recently taken place, which had been attended by representatives from patient and carers committees; providers and partners. A really good discussion had taken place on work to be taken forward. It was highlighted that one of the bigger risks identified was the funding stream for the Autism pathways.

16.4 Dr Povey pointed out that there was a difference in the actions listed in the covering sheet and the report itself. It was considered that the action contained in the report was more correct in that a clinical champion would be identified. Whilst the Governing Body supported the need for a suitable champion, in the new governance structure, it was felt inappropriate for a Governing Body Member to be identified as a champion for SEND for the reason that the Governing Members were providing officer functions to the CCG; they were appointed as representatives for Members around the perspectives of assurance, strategic matters, and setting the culture and were not clinical leads in their areas.

16.5 Ms Parker explained that the request for a Governing Body Champion had come out of the workshop attended by parents and carers.

16.6 Dr Shepherd suggested that the champion role was one that could be covered by one of the new clinical leads that she was hoping to appoint very soon, who could also be responsible for providing the clinical oversight of that work

16.7 Mr Evans added that there was probably a slight lack of understanding on the part of parents and service users particularly in that identifying a Governing Body Member with responsibility would give the programme more authority. Mr Evans' considered that the champion role required someone with the clinical expertise to provide the oversight. It was, however, important that the Governing Body was assured about the SEND programme and Mr Evans proposed that a conversation was required to discuss how that assurance would be provided at Governing Body level.

16.8 Mr Vivian agreed with the comments made but highlighted that there was a distinction between providing oversight and championing, which was very different. Mr Vivian considered that this particular group of patients did require an assigned champion, not a Governing Body Member, because of the vulnerability of the group and often the lack of access to services.

16.9 Mr Trenchard added that the discussion had been interesting because the STP had discussed the broad notion of clinical being any professional with the right sets of skills, not just a medical professional. It was suggested that perhaps in the new world, the champion might be affiliated or linked into the CCG but have a broader system role linking to the transformation so they would still be a strong professional voice but would not necessarily be a Member of the Governing Body.

RESOLVE: The Governing Body:

- ***NOTED the actions identified;***
- ***AGREED the CCG would continue to monitor the implementation of SEND within Shropshire;***
- ***APPROVED that a clinical champion for SEND would be identified.***

ACTION: Ms Parker to present to the next meeting an update report on SEND together with the final draft of the written statement of action in readiness for publication on 25 September.

The Executive Team to agree a process for providing the Governing Body with assurance around SEND.

Minute No. GB-2020-07.085 – Audit Committee – 24 June (summary)

17.1 Mr Timmis presented the Audit Committee summary report, which was taken as read, and focussed on the following key points:

- There had been very positive news in that the CCG had been given an 'unqualified opinion' on its financial statements and the Committee wished to thank the staff involved in the drafting and collating of the report.
- The Committee heard a very positive overall summary from the external auditors of the external audit work and the judgements on the CCG's financial statements and the overall opinion was that it was 'a huge achievement'.
- Less good news had been received about the impact of the CCG's financial problems which meant that again the CCG's regularity opinion was qualified and its value for money was qualified with an 'Adverse' conclusion.
- New for this year were the statutory recommendations reports, which had been responded to and would be followed up in the autumn firstly through the Audit Committee, which would then be reported back to the Governing Body. This had not been a surprise but obviously the auditors were concerned about the increasing size of the CCG's deficit and in what appeared to be a lack of control over financial management.
- The Committee had finally been given permission to share the results of the Mental Health Investment Standard report from 2018/19. External audit had concluded that the CCG's Compliance Statement had been 'properly prepared'. This would be formally reported nationally the next day (9 July).
- This had been the last Audit Committee meeting under the existing arrangements before the move towards meeting as a committee in common with Telford and Wrekin CCG's Audit Committee. Mr Timmis expressed his gratitude to all the Lay Members, particularly over the past year, who had supported him as Chair of the Audit Committee. Mr Timmis was extremely grateful for the way in which they had dealt with the vast quantity of information that had been presented to the Audit Committee and the good natured way in which they had dealt with some very difficult issues.

17.2 Dr Povey reiterated these sentiments by also thanking everyone involved.

RESOLVE: THE GOVERNING BODY NOTED the content of the report.

Minute No. GB-2020-07.086 – Healthwatch Shropshire Update

18.1 Using PowerPoint presentation slides, Ms Cawley presented her report on 'Health Care, Social Care and Well-being services during the COVID-19 Pandemic' (Survey conducted from 9 April – 31 May 2020): Summary of Findings and Recommendations.

18.2 Ms Cawley highlighted that as Healthwatch Shropshire's (HWS) main function was public engagement through largely face-to-face meetings, the organisation had been required to completely change the way that it worked through the COVID-19 period. This had significantly changed the emphasis of the work that they were doing and so had been relying very much on surveys through the HWS website and hot topics where there was a call for comments on a particular issue.

18.3 HWS was about to share some reports that came from work carried out before the lockdown, which included a report on social prescribing for 16-25 year olds. The report on Health Care, Social Care and Well-being services during the COVID-19 Pandemic, which was shared at this meeting, was being published with its appendices the next day.

18.4 Dr James queried the age breakdown of the respondents to the survey included in the report.

18.5 Ms Cawley clarified that 82% of the respondents had been within the age group of 45 years to 84 years and 52% had been within the age group of 55 years and 74 years. Ms Cawley reported that responses had been received from the whole age range, which HWS had been pleased about because the survey had been conducted online through the HWS website.

18.6 Dr Povey said that one of the questions that had been raised a number of times by the CCG was how impactful was the communication that was available.

18.7 Ms Cawley reported that the report included the sources of that information. A lot of people did refer to the information published on the government websites but they did also refer to the local authority website and workplace websites had been a really key source of information for staff, for example the police service. HWS was keen to explore how the system was using and sharing information. For example, a lot of groups, such as faith groups had been known to have shared health information, which people had relied upon during the lockdown.

18.8 Dr Povey thanked Ms Cawley for the presenting the HWS report which had been interesting.

FOR INFORMATION ONLY/EXCEPTION REPORTING

Minute No. GB-2020-07.087 – Single Strategic Commissioner Update (for information)

19.1 The Single Strategic Commissioner Update prepared by Miss Smith had been circulated for information only.

RESOLVE: ***THE GOVERNING BODY NOTED the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin.***

Minute Nos. GB-2020-07.088 to GB-2020-07.091

20.1 The following minutes of the Governing Body Committees were received and noted for information only:

- Finance & Performance Committee – 25 March
- Quality Committee – 25 March
- North Locality Board – 27 February
- South Locality Board – 5 March

RESOLVE: ***THE GOVERNING BODY RECEIVED AND NOTED the minutes as presented above.***

Minute No. GB-2020-07.092 – Any Other Business

21.1 There were no further items raised.

DATE OF NEXT MEETING

It was confirmed that the next scheduled Governing Body Part 1 meeting is:

- Wednesday 9 September 2020 – time and venue to be confirmed.

Dr Povey thanked Members for their attendance and officially closed the meeting at 3.40pm.

SIGNED …….. DATE ……

NHS
Shropshire
Clinical Commissioning Group

Submitted Questions by Members of the Public
for the Governing Body meeting 8 July 2020

Name Date & Time	Submitted Questions	CCG Summary Response
Diane Peacock	All the questions below relate to COVID-19 fatalities emerging from international data as early as mid-March indicating that the highest concentration of extremely vulnerable older people are those living in enclosed settings such as residential care homes.[1] The fact that some countries and some regions have had higher death rates in care homes than the UK and Shropshire should in no way detract from the urgent analysis needed at national and local levels, in order to understand what is needed to minimise the impact of pandemics such as COVID-19 on those most vulnerable communities now and in the future. **1.** Which weeks since 1 March saw the largest number of **hospital discharges** into Shropshire care homes? [1] The data produced by CQC which is used by the ONS, NHS and NHSx does not differentiate between types of care home i.e. residential care homes (without nursing facilities), joint care/nursing homes and stand alone nursing homes.	*SCCG does not hold this information. This question will need to be directed to Shrewsbury & Telford Hospital NHS Trust.* ***Mrs Sam Tilley, Director of Planning***
	2. What guidance and support did SCCG working with the local authority provide for care homes in Shropshire having difficulties accessing suitable types and quantities of in-date PPE and COVID-19 swab testing for their residents and staff?	*Shropshire and Telford & Wrekin CCGs implemented an Incident response structure in March 2020 to respond to all elements of the pandemic. This included a specific Task Group focused on the Care Sector led by the Local Authorities but with multi-agency input. Through this group a range of support was secured for the Care Sector and an action plan was developed to target this support. This included specific support regarding supply and use of PPE, access to infection, prevention control (IPC) training and support, mutual aid in relation to PPE supply was provided via both the NHS and Local Authority supply chain and a daily care home tracking tool was used to monitor PPE supply to the care*

Name Date & Time	Submitted Questions	CCG Summary Response
		sector. In addition, Care Homes have been supported by our local testing cell to access swab testing via local, regional and national testing options in line with national guidance. ***Mrs Sam Tilley, Director of Planning***
	3. In Northern Ireland[2] at the height of infection transmission, NHS staff were deployed to support care homes. According to SCCG's May minutes the Regional Chief Nurse stated[3] [date indeterminate] that as well as it being a priority to place returning staff in post, [it was as well] *seen as the right match for some returning staff to be deployed to work in care homes..* How many **'returning' NHS clinical staff** normally contracted to work in the hospital or community trust or in primary care **were deployed to work in Shropshire care homes?** [2] https://www.theguardian.com/world/2020/apr/22/northern-ireland-nhs-staff-sent-to-care-homes-to-help-fight-covid-19 [3] SCCG Governing Body meeting 13th May 2020 minute No. GB-2020-05.054 – COVID-19 Update, para. 9.31.	*This is not information that the CCG holds. It is suggested that this information request is directed to the individual organisations of interest.* ***Mrs Zena Young, Executive Director of Quality***
	4. Which weeks since 1 March saw the greatest deployment of **bank/agency staff** to cover for staff absences/sickness in Shropshire care homes?	*This is not information that the CCG holds. It is suggested that this information request is directed to the individual organisations of interest.* ***Mrs Zena Young, Executive Director of Quality***
	5. Which weeks since 1 March did Shropshire care homes register the highest number of a) suspected/confirmed[4] COVID-19 **outbreaks** and b) **deaths** of residents in care homes with COVID-19 mentioned on death certificates? [4] Presumably this information was provided by primary care, community care, the local authority, WM ambulance service and/or by care homes and collated locally or by CQC.	*SCCG does not hold this information. Please redirect your query to Shropshire Council.* ***Mrs Sam Tilley, Director of Planning***
	6. What quality monitoring processes and clinical risk assessments did SCCG, working with the local authority, put in place from 19th March 2020[5] to prevent or - at the very least - minimise excess deaths of care home residents across Shropshire? And to ensure that the following did not contribute to unacceptable levels of risk? • Hospital discharges and new admissions to care homes	*The CCG participated in the system multi agency Emergency Preparedness Response to COVID-19, in line with Government guidance to the response. This included the supply chain of PPE to all care settings.* *The system implemented the relevant guidance for hospital discharges, testing of care home residents and staff, and enhanced infection*

Name Date & Time	Submitted Questions	CCG Summary Response
	• Lack of appropriate types and volume of PPE as late as May 2020 • Limited and potentially inequitable access to testing for residents and staff[6] • High levels of in-house staff sickness • Use of bank/agency staff working in multiple care settings. [5] HM Government and NHS **COVID-19 Hospital Discharge Service Requirements** 19th March 2020. https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements [6] Government announcement pledging that as from 6th July Care home staff *will be tested for coronavirus weekly, while residents will receive a test every 28 days to prevent the spread of coronavirus in social care.* https://www.gov.uk/government/news/regular-retesting-rolled-out-for-care-home-staff-and-residents	*prevention training offer.* *It also offered the full Care Home support model: In summary the guidance expects CCGs, working with primary care (all practices) and community providers to ensure:* • *timely access to clinical advice for care home staff and residents with a nominated clinical lead within general practice for each home* • *proactive support for people living in care homes, delivered by remote means wherever possible - including through personalised care and support planning as appropriate* • *primary and community services work with the care home to identify those patients at the highest risk and provide support through a multidisciplinary team (MDT) where practically possible* • *sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit.* • *provide appropriate and consistent medical oversight and input from a GP and/or geriatrician* • *support the introduction and use of remote monitoring of COVID-19 patients using pulse oximeters and other equipment and the prescription and supply of oxygen to care homes for treatment, where clinically indicated.* ***Mrs Zena Young, Executive Director of Quality***
Linda Senior	I have previously asked questions about the reduction in the above service and have been fobbed off. **Is it true that there is only one GP available for home visits in the whole of Shropshire?** **I request that the CCG finally makes available the Shropdoc 6 month review of the changes made to the GP OOH service in October 2018 and any other material relating to Shropdoc considered by the board in the last 2 years.**	***Please see the response below in relation to these questions***

Name Date & Time	Submitted Questions	CCG Summary Response
Sue Campbell	**I ask for the CCG to immediately publish its '6 month review' of the Shropdoc GP OOH service and any other reports or data related to Shropdoc (any of its services, its performance, and its funding) considered by the Board or Executive since July 2018.** **Please remind me of which Shropdoc bases have been closed or reduced, and what the changes are. Also please publish the extent of the financial cuts to the Shropdoc OOH service. I know the finance was sharply reduced in October 2018. By how much? Has GP OOH funding been reduced subsequently? Again by how much?**	***Please see the response below in relation to these questions***
Ron Berry	**Will the CCG now publish its 6 month review of Shropdoc? I believe this was a review of changes made in October 2018, so you're running a bit late.**	***Please see the response below in relation to this question***
Jane Asterley-Berry	I sometimes attend your public Board meetings. Having Board meetings in public is an important part of your accountability towards local people. **I fully understand the difficulties around COVID-19, but will you arrange for your Board meetings to be live streamed, and for a recording to be available online?**	*Due to COVID 19 the CCG has followed government guidance and has been convening virtual Governing Body meetings.* *Further official guidance issued by the Chief Operating Officer of NHS England/Improvement has said that NHS organisations should continue to avoid having face to face meetings and continue with their virtual arrangements.* *The CCG will continue to keep this under review.* ***Miss Alison Smith, Director of Corporate Affairs***
	In line with those concerns about accountability. You made sweeping changes to the Shropdoc GP Out of Hours service in October 2018. There was no public Consultation. You said it wasn't necessary because changes were temporary, and would be fully reviewed after six months, with the outcome of the review made available to the public. The same commitment was made to local HOSCs and to the Joint HOSC. **Will you now publish the six month review and any other material you hold Relating to Shropdoc services over the last two years?**	***Please see the response below in relation to this question***

Name Date & Time	Submitted Questions	CCG Summary Response
Marilyn Gaunt	***1. Shropdoc*** The initial July 2018 integration of Shropdoc with the NHS 111 service resulted from a national policy, but the subsequent changes around funding, bases and staffing were a local initiative. The changed Shropdoc service – commissioned by the CCG and delivered via a contract with the Community Trust - began in October 2018. Requests from members of the public for public engagement or consultation were rejected. Around the July changes, we were advised that there was no need for this as it was a national decision. Around the local changes, we were told the changes were not set in stone, and there would be a comprehensive '6 month review' of the service that would make recommendations for any required changes. The review report and recommendations were to be shared with the public, and any required public involvement could take place at that stage. ***When will the review report and recommendations be placed in the public domain? Several requests for the information have, to date, been turned down.*** Yet again, the CCG has refused to publish its '6 month review', due – we thought – in April 2019. Your excuse this time is that this is 'historic' and 'largely redundant'. Fine. **There is no reason for not publishing then, is there?** **Please publish any reports and data on Shropdoc performance that have been considered by the CCG Board or CCG Executive since service cuts in October 2018.** If your Board is unable – again – to show basic accountability around this by publishing the requested information, please treat this as a Freedom of Information request. Rest assured that continued failure to provide this information will result in a robust challenge, both publicly and to the Information Commissioner.	***Please see the response below in relation to these questions***

Name Date & Time	Submitted Questions	CCG Summary Response
	2. Page 80 of the integrated papers for your May 2020 Board show QIPP savings of £757,000 for 'OOH Service'. **Is the 'OOH Service' the Shropdoc Out of Hours service – the lifeline for people across Shropshire, and particularly for those of us living in rural areas?** How much was slashed from the Shropdoc OOH service in October 2018? Was it the rumoured £2 million? (I have no interest, by the way, in overall funding for the IUC service. I want to know about the ***Shropdoc OOH service*** funding). **What risk assessment took place before your Shropdoc cuts in October 2018 and your further cuts in 2019/20 through QIPP savings? What Equality Impact Assessment took place? What public consultation – in 2018 or in 2019/20 – took place?** **Presumably you have evaluated the impact of those changes? What were your findings? Will you publish the full impact of those service cuts now – both the October 2018 cuts *and* whatever subsequent cuts you implemented through QIPP savings in 2019/20?** **How do you square the on-going failure of the CCG to involve patients and the public in a meaningful way with your legal obligations under Section 14Z2 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)?**	***Please see the response below in relation to these questions***

Name Date & Time	Submitted Questions	CCG Summary Response
Gill George	**1. <u>Finance</u>** The situation reported to your May Board has evidently been overtaken by events. The CCG ended 2019/20 with an in-year deficit of £47.3m, against a control total from NHS England of £12.3m. The NHSEI control total for 2020/21 was for £22.7m deficit. The CCG did not regard this as achievable and submitted a plan for a £50.1m deficit. **Does the Board believe that Shropshire CCG is historically underfunded? There is a consistent year-on-year pattern of a substantial gap between allocation of funding and what is required, under a series of different Accountable Officers and despite substantial QIPP savings being made.** From the July Finance paper, the CCG seems to be in deficit of around £10m by Month 4 of the financial year. The paper reports a fundamental change to CCG funding arrangements, with allocation of funds for Months 1-4 according to a new NHSEI formula, and with an expectation that CCGs will 'break even'. **Can you explain in 'layperson's language', your current best understanding of what this will mean for the CCG's finances? Does a 'break even' requirement mean that the CCG will be obliged to implement spending cuts far greater than those it had intended, or will NHSEI adjust its allocation to meet local need?**	*The CCG have, for a number of years, seen our spend exceed the financial allocation given to us. Our accounts are subject to external audit and reports published by our auditors (which are available on the CCG's website) reflect this position. We do recognise our duty to spend within our means and are working hard to address this. Our approach to financial recovery is system focused, recognising that decisions on funding taken in one area impact on others.* *We are still waiting for guidance on budgets for the rest of 2020/21 as currently we only have an allocation for month's 1-4. In the meantime, we are working to model what our spend for the year might be though this in itself is difficult given the many scenarios that might arise during our response to COVID19 and broader recovery of services.* *NHSE/I are working on the allocation formula for this year and we are expecting to receive a full year budget soon that will include in it an uplift to help us to deal with COVID19. Until we receive that budget, assess what it could deliver given our current demand and capacity models and also review any guidance issued, it is difficult to comment further.* ***Mrs Claire Skidmore, Executive Director of Finance***
	2. <u>Public Involvement and Consultation</u> There is a legal duty on CCGs to ensure public involvement and consultation, including: • in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are	*When developing QIPP schemes the CCG will identify what impact the proposed change will have on patients and using statutory guidance, case law, best practice to consider what level of involvement the change needs; 1) informing/*

Name Date & Time	Submitted Questions	CCG Summary Response
	delivered to the individuals or the range of health services available to them, and • in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact. This is taken from Section 14Z2 of the NHS Act 2006, as amended. The minutes of the May Board meeting confirm the CCG's implementation of £16m QIPP savings in 2019/20, against your target of £19.8m. **Can you summarise which of these QIPP savings were deemed by the CCG to require public involvement and consultation, what criteria were used to make this judgement, and what form the public involvement and consultation took? If you can provide links to the written outcomes of your consultation and engagement programmes, this would be helpful.** I understand from the July Finance paper that QIPP is paused for now, but my expectation is that the CCG will resume its QIPP programme as soon as NHSEI allows this. The list of proposed QIPP savings includes items that clearly fall under the remit of S.14Z2. For example, a £1m reduction in MSK spend at RJAH must surely affect the manner in which services are delivered or the range of services available. So in all probability will £30K savings on stoma care. The planned £250,000 saving through requiring self-care via OTC medication will impact most on the poorest people in our communities; on people with a disability that affects their mobility and therefore their access to shops; and of course on people in rural areas who are not close to a pharmacy and who are only allowed to purchase a limited supply of paracetamol when they travel there. Within each of those categories, it will be people with chronic pain who are most affected. There are many other examples in the list of proposed QIPP savings that will surely be covered by S.14Z2 requirements. **What are your current/future plans for public involvement and consultation?** I assume this will have been an inherent part of your QIPP planning.	*communicating to the public, 2) engagement with service users or wider public or 3) if it requires statutory consultation.* *None of last year's QIPP schemes 2019/20 and none for 2020/21 required or require full public consultation by the CCG, although some transactional QIPP schemes, had already had national consultation undertaken by NHS England. There were examples of some QIPP schemes that have or will require only informing/communication level of involvement. In other QIPP schemes patient engagement was undertaken or is being planned.* *At the moment due to COVID 19, work on QIPP schemes has ceased due to the need to redeploy staff to support the local health economy. However, as part of the NHS restoration phase CCG staff will be reviewing each scheme to confirm if it should resume or be amended.* ***Miss Alison Smith, Director of Corporate Affairs***
	3. <u>Palliative and End of Life Care</u> My strong view is that there are current gaps in policies and service provision from Shropshire Community Trust and from Shropdoc. A service that works for 'most people most of the time' is just not good enough when it comes to dying and death. **Will the CCG support or initiate a service review with service user and family involvement, and with HOSC involvement? If the COVID-19 situation**	*Across the Shropshire, Telford and Wrekin health and care system in its response to Covid-19 there has been specific work relating to palliative and end of life care pathways including anticipatory care planning for people on end of life care pathways. There was a specific task and finish group that led this work and included the*

Name Date & Time	Submitted Questions	CCG Summary Response
	precludes this, will the CCG plan for this in the future, but in the meantime support a rapid review and consequent changes that will provide tighter safeguards for people currently being left with patchy or poor support?	*experience of professionals across all services, and individuals and families. We have also commenced specific psycho-social support for people who have or are recovering from Covid-19. Improved pathways have been implemented across services, with newly mandated care planning paperwork and guidance. This will be reviewed over time to capture the experiences of those using it, and to make any improvements in line with our commitment to continuous quality improvement.* ***Mr Steve Trenchard, Interim Executive Director of Transformation***
	4. <u>Shropdoc</u> Is Shropdoc there for people when they need it? No, not always. The consequences for individuals can be profound. **Will the CCG finally release to the public the long overdue '6 month review' of October 2018 changes to the GP Out of Hours service? Will the CCG release any other information it has on Shropdoc performance since October 2018, and how this compares with previous years? What funding changes have been made to Shropdoc, and within that, to the GP OOH service and to Shropdoc's community hospital support? What has the impact of COVID-19 been on Shropdoc?**	***Please see the response below in relation to these questions***

CCG Summary Response to Questions relating to Shropdoc
Shropshire, Telford and Wrekin CCGs recognise that the OOH procurement has caused concerns to the public and recognise that there is much that we could have done better. As we review this process it is clear that although there are some issues that were beyond the control of the CCG there is much we could have done to be more transparent and engaging in the processes we undertake. *We hope that we have answered the facts as much as we are able to in the document below noting that:* • *We are unable to publicly share the review documents as they have not formally been through our own governance processes due to the disputes in relation to the recommendations.* • *We are unable to share the detailed financial information or any financial or contractual discussions as they are commercially sensitive and not in the public domain.* • *We do recognise that although the procurement was not subject to statutory consultation as there were no proposed material changes in the model at the time, we should engage with the public about any proposed developments of services and make a commitment to doing so in the future.*

- *The CCGs' wish to be as transparent as possible, in all other matters, in relation to the commissioning of services.*
- *We need to talk to the public about the significant national clinical workforce challenges due to the older workforce retiring and lower numbers entering training and the impact this has in Shropshire. Although positively, during COVID-19 response a number of medical and other clinicians have re-joined the workforce.*
- *We need to talk to the public about the new models of care that involve a range of healthcare practitioners that work directly with patients not just a medical model of care (doctor only).*

Ms Claire Parker, Director of Partnerships

INTEGRATED URGENT CARE 111/OOH TIMELINE – PROCUREMENT/IMPLEMENTATION	
Procurement	2018 - Regionally led on behalf of West Midlands CCGs by Sandwell and West Birmingham CCG in response to a national directive to implement a new Integrated Urgent Care specification T&W CCG were the local lead commissioner on behalf of both T&W and Shropshire CCG's
Specification	**Core specification** in line with the national requirements – key changes for Shropshire locally was that there would be no direct access for patients to OOH -all must go through NHS111 first with direct booking of patients into OOH. This was mandated. **Local specification** – this included services not covered by the core specification plus it gave the opportunity to address the local issues that had been challenging such as: • Medical cover to the community hospitals/MIUs (Shropshire only) • Elements of urgent care which providers defined as 'nursing' and therefore in their view was excluded from out of hours work, for example blocked catheters (S & TW). • Mental health act capacity assessments (Shropshire only) • Flu anti-viral treatment response (Shropshire only) • Margins cover (S&TW) The local specification required that bidders demonstrated in their model that they could provide geographical cover throughout the county; it specified where the current bases were, but did not specify where they should be in future to allow bidders to demonstrate innovative models of care and delivery.
Evaluation Team	Included commissioners from both TW & S CCGs: quality, finance, contracting and a patient representative from both CCGs.
Contract Award	July 2018 the contract was awarded to Shropshire Community NHS Trust (Shropcom) who proposed a delivery partnership with Shropdoc the incumbent OOH provider. Shropcom model proposed a change to the delivery model from the historic one – this only affected Shropshire, as there was no material change for T&W Contract start date 1st October 2018 – term 3 years 8 months
Key differences in the new model	Shropdoc continued to operate bases in Shrewsbury, Telford, Whitchurch and Ludlow. The bases in Oswestry and Bridgnorth closed from 1 October.

	• Detailed changes to bases were as follows: o Opening times at the Telford base were extended from 8am o Shrewsbury base was staffed by a GP until 12 midnight every day o The Ludlow base was closed overnight o The Whitchurch base would only operate at weekends o The Bridgnorth and Oswestry bases would be closed • Other changes to the service were: o Introduction of a Community Nurse Car 7 days a week o Introduction of a winter weekend GP relief car to help during periods of high activity • Home Visits would still be available if deemed clinically appropriate. These could be provided by a GP or by an Urgent Care Practitioner. Extract from joint CCG/Provider FAQ (which went to HOSC 5.11.18) published following contract award and concerns about the change in model: • *Decisions on which bases should not be retained as part of the new model were not taken lightly. They followed evidence-based research that analysed activity levels.* • *A review of the proposed delivery model has been completed, which incorporated the expected impact of introducing the NHS111 service. This was informed by evidence from other areas where NHS111 has already been implemented, and has been done to ensure the service can continue to respond to demand whilst continuing to deliver clinically safe services to the population within the resources available.* • *The removal of the Oswestry and Bridgnorth bases from the model impacts on 10% of patients who use the current service. The Whitchurch base will now pick up patients from Ellesmere across to Oswestry, while Telford and Ludlow clinicians will meet the Bridgnorth demand.*
Contract Mobilisation	Following contract award mobilisation commenced. Director of Contracting led with weekly meetings arranged between commissioners and providers to oversee mobilisation.
3 month/6 month Review	Following the award of the contract for the new model of care the CCGs and Providers jointly committed to undertaking: • **3 Month Review**: providers and commissioners to review demand and performance against the targets within the new contract and

	• **6 Month Review**: providers and commissioners to work with key stakeholders to consider performance and issues that have emerged since the new service went live. This was important to allow commissioners to assess the impact of the changes made, and to ensure the new arrangements remain clinically safe. Patient representation would be included in the review process to provide their perspective on how the service was performing. Commissioners and providers would also be providing updates to their public Board/Governing Body meetings. A joint Review Team was established that included representatives from across the healthcare system. The decision to involve a wider stakeholder group impacted on timescales for completing the review due to diary availability. However, the value of wider involvement was felt to be of significant benefit. The review team met and different aspects of the model and its impact were assessed and analysed.
Review Outcome	The review concluded in September 2019. The Provider had identified the following key issues related to the new model and performance:- • Demand at the weekend exceeds what could have been predicted in the CCG procurement • Time to base visit had deteriorated particularly in South Shropshire • Palliative care/end of life pathways via NHS111 to access urgent medical care OOH needed revision • The way in which the CCGs have grouped and are monitoring KPIs make them very difficult to achieve. The Provider was asked for proposals to address the issues identified. Most of the recommendations in the review have been addressed collaboratively but the review has not been formally presented at either of the CCG's Governing Bodies. Following the review, a quality assurance visit was made and it was noted that a number of key issues had been addressed. Most notably that due to lack of access to base appointments in the south locality the Bridgnorth base was re-opened at weekends. There have also been improvements in recruitment and retention of GP members, partly triggered by the COVID response but this does appear to be more sustainable. Although not back to the levels of 5 years ago, it is a much more resilient position and the GP rota is 96% full up to October2020. To be clear, whilst there is only one GP covering the service overnight, this is not the only clinician available who can see patients. There are Urgent Care Practitioners on duty, who are autonomous practitioners, but who can call on the GP for advice if needed. This is in line with national models of utilising the skills and experience of healthcare professionals with a spectrum of skills not

	only in OOH services but in a range of healthcare settings, including in hour services.
Contract performance	During the mobilisation/implementation phase of the new contract, the CCGs agreed not to apply the financial penalties associated with non- achievement of the KPIs. This was initially set at 6 months post contract start but following the 3 month review was extended to 12 months to 30.9.19.
Patient engagement	Patient reps from both CCGs were on the procurement evaluation panel Patient reps/Healthwatch from both CCGs were on the review panel At the time of the tender the CCGs did not engage with the public on the model changes because no significant changes were proposed and due to the commercially sensitive nature of procurement everything is confidential until contract award and the end of the 10 day stand still period. The contract was awarded on the basis of the model in the bid.
Governance	The final review report has not been shared publicly as there remains dispute with the provider on the recommendations. Both Governing Bodies have received verbal updates in the confidential session.
Areas of dispute	The key areas of dispute: **Activity/KPIs Non achievement and Penalties:** The contract overall shows that demand is below forecast, whereas Shropcom dispute that this does not capture all the activity. The recording of activity has been worked through with the providers. The original model and in line with the national directive that there should be no re-triaging of patients following the outcome of the NHS111 pathways disposition. **Geographical inequity** – As part of their review recommendations the provider put forward no proposals on what they would offer to resolve the issues in relation to the loss of bases including pop-up clinics which were never instigated. However, since the review the provider have now developed a solution to resolve the geographical inequity issue. **Rota Fill OOH** and **Rota fill Shifts in the 111 CAS** There are significant workforce and recruitment issues nationally and in Shropshire. A significant number of GPs do not wish to provide OOH work compared to a few years ago and coupled with national shortages and local shortages (retirement etc) the rotas cannot be easily filled.
National position	Pre COVID there were indications of a change in the national model to further integrate, to include primary care extended access and UTCs and therefore another procurement exercise was expected. This was put on hold due to COVID, but there will be learning coming out of COVID that will inform future national plans. OOH have been fully engaged in the COVID response locally and no issues have occurred. The learning across the system will be fed into any future service change as part of a wider engagement exercise.
Financial position	As stated above in 2018 CCGs were nationally mandated to use NHS111 services and hence the call handling and telephone advice elements of the previous Shropdoc Contract ceased in the latter part of the year. This was known well in advance of the date of commencement and the CCG worked with ShopDoc and NHS111 to manage the transition of this service. Around the same time, the two CCGs were planning the procurement of a new contract for OOH services as the previous contract term was coming to an

	end. The specification set for the new contract excluded all elements of call handling and telephone advice that moved to NHS111. Hence, the financial envelope required to pay for the new OOH contract was lower as a result of this (approx. £1.2m between Shropshire and Telford & Wrekin CCGs). There was a reduction in spend due to a project to manage and avoid hospital admissions which went towards the CCGs Quality, Innovation and Productivity Performance (QIPP)- this was not a funding cut but a change in activity. The CCGs held a joint procurement exercise for the new contract and Shropshire Community Health NHS Trust were successful in being awarded the contract. They are working in partnership with Shropdoc to provide OOH services and the CCG supported this sub contracting arrangement as set out in their bid. As with any procurement process of this type, all bidders submitted their proposed price for the service the CCGs required and therefore the payments that the CCGs now make are based on the contract sum agreed as part of the procurement process. We are unable to comment on support provided to the community hospitals as this is an arrangement between Shropdoc and Shropshire Community Health NHS Trust. Detailed financial arrangements other than those in the public domain are commercially sensitive and the CCGs are unable to comment.

NHS
Telford and Wrekin
Clinical Commissioning Group

Telford and Wrekin Clinical Commissioning Group Governance Board

Minutes of the Meeting held on Tuesday 14th July 2020 at 1.30pm Via Zoom

Present:

Dr Jo Leahy	JL	Chair
Mr David Evans	DE	Chief Officer
Miss Alison Smith	AS	Director of Corporate Affairs
Mrs Claire Skidmore	CS	Executive Director of Finance
Mrs Zena Young	ZY	Executive Director of Quality
Mrs Claire Parker	CP	Director of Partnerships
Dr Julie Davies	JD	Director of Performance
Mrs Sam Tilley	ST	Director of Planning
Mr Steve Trenchard	STr	Interim Executive Director of Transformation
Dr Adam Pringle	AP	GP/Primary Care Health Professional CCG Board Member
Dr Ian Chan	IC	GP/Primary Care Health Professional CCG Board Member
Mrs Carolyn Fenton-West	CF-W	GP/Primary Care Health Professional CCG Board Member
Mrs Rachael Bryceland	RB	GP/Primary Care Health Professional CCG Board Member
Dr Martin Allen	MA	Secondary Care Clinician
Mr Geoff Braden	GB	Lay Member, Governance
Mr Peter Eastaugh	PE	Lay Member, Primary Care
Mr Neil Maybury	NM	Lay Member, PPI
Mr Patrick Spreadbury	PS	Assuring Involvement Committee (Chair) – Observer
Mrs Harpreet Bangar	Hba	CSU
Mrs Helen Bayley	HB	Head of Quality & Nursing
Mrs Francis Sutherland	FS	Head of Mental Health

Also in attendance:

Mrs Lisa Rowley	LR	Minute Taker

37.20 Welcome

Dr Leahy welcomed CCG Board members to the meeting and explained how the virtual meeting would work using Zoom.

38.20 Apologies

Apologies were noted from Mrs Liz Noakes, Mrs Gail Fortes-Mayer, Mrs Nicky Wilde and

Dr Deborah Shepherd.

39.20 Members' Declaration of Interest

No new declarations of interest were noted.

40.20 Minutes of the Governance Board Meeting held on 12th May 2020:

The minutes of the meeting held on 12th May 2020 were reviewed and accepted as an accurate record of the meeting.

41.20 Matters Arising/Actions

20.20.1: Integrated Performance & Quality Report

Dr Pringle also noted the perinatal mortality data was based on out-of-date figures. Mrs Christine Morris agreed to update the perinatal mortality data.
Update 12.05.20: Mrs Young agreed to pick up this action.
Update 14.07.20: Mrs Young advised this action has been picked up through the Clinical Quality Review Meeting (CQRM) and an update report will be presented to PPQ meeting on 28th July, 2020. **Action completed.**

20.20.2 - Primary Care Commissioning Committee Chair's Report

Mrs Fran Beck recognised the need to keep patients informed and engaged and agreed to arrange for a member of the primary care team to attend the next Telford Patient First Group meeting to provide an update around PCNs. Claire Parker Sept 2020
Update 12.05.20: Mr Spreadbury said that a discussion had taken place around arranging a meeting, however due to the current situation this had been put on hold until later in the year.

20.20.7: SaTH CQC Update

Dr Pringle referred to the Emergency Department risk on the Board Assurance Framework (BAF) "improve performance over winter" and "failing to identify providers in difficulty" and said this risk was no longer valid. Mrs Morris said this risk was not specific to the acute trust and could refer to any provider such as care homes or GP practices. Mrs Morris agreed to review and update the BAF.
Update 12.05.20: Mrs Bryceland highlighted that even though there had been a significant decrease in the number of patients attending A&E, the Shrewsbury and Telford Hospital NHS Trust (SaTH) were still failing to achieve the 95% 4 hour waiting target. Mr Evans commented that there had been some progress in terms of improvements and on one day recently the Trust had nearly achieved 95%. In general terms, however it was currently around 85%. Mr Evans noted he did not want to sound complacent and agreed that there was more work that needed to be done to achieve the target. Mr Evans went on to say that the new Chief Executive of SaTH, Louise Barnett, accepted that the issues were internal. It was noted that the current bed base at SaTH was between 50% and 55%. Mrs Young informed members that she was currently updating the BAF and would be doing a review of the elements pertaining to quality.
Update 14.07.20: Mrs Young advised that the BAF has been updated. A discussion has taken place between Mrs Young and Miss Alison Smith whether the CCGs will be moving to a joint process. **Action Closed.**

42.20 Assurance

42.20.1 COVID-19 Update

Mrs Tilley shared a presentation and the following key points were highlighted:

The current position remains at incident level 4 in terms of NHS England's current definitions which means that all incident response structures remain in place until such time as NHSE step the CCGs down.

Consideration is being given to whether the current situation should be moved from a pandemic stage to an outbreak phase.

Local prevalence rates experienced a later peak than other areas across the country. Prevalence rates are declining both in the community and within hospitals. A small number of outbreaks are being seen in a range of settings and these are being managed by the Local Authorities and Public Health England.

There has been sufficient critical care and community capacity to meet the demand which has not been as acute as expected. Activity levels in relation to COVID continue to decline.

There are no patients within Shropshire in the ITU's and this has been the trend for the last two weeks.

An area of focus throughout the response period has been in relation to PPE which has now stabilised. Particular focus is currently around the stability of the supply of FFP3 masks which require wearers to be fit tested. Any changes required regarding the supply of FFP3 required a refit testing programme which has implications for the acute trust. This is being closely monitored.

Swab testing capacity has continued to increase, a combination of local, regional and national options are being utilised. Antibody testing continues to be rolled out and a good response locally has been seen.

Risks have been identified within the black asian minority ethnic groups and steps have been taken to ensure that these needs are responded to. NHSE's risk assessment tool has been utilised across staffing groups to ensure risks are being identified and support is in place. NHSE's Assurance Framework has been utilised to assist in managing responses.

Mrs Young highlighted that antibody testing for all CCG staff is well accessed. Testing is also available for non-substantive members of staff. There is also the facility for shielded people to have the test.

Mrs Tilley informed that a significant area of focus for the CCG is around restoration in terms of the stage of response. A letter received in April 2020 from NHSE/I set out the requirements around restoration where stringent and high level expectations of how the restoration work will be approached. In order to move this forward, work is taking place around capacity modelling elements of social distancing, IPC, PPE, workforce and estates.

Health protection is a key element and the Government has produced guidelines regarding the implementation of Health Protection Boards which are led by Local Authorities. A collective board across Shropshire and Telford & Wrekin is in place which is aligned to the national test and trace programme. The National Test and Trace Programme looks at how national and local arrangements come together to provide responses. Aligned to this is the development of outbreak control plans which have

been completed by Shropshire and Telford and Wrekin local authorities with input from Public Health England. The main focus of these control plans is prevention, the containment of outbreaks and the suppression of infection. Shropshire is currently seeing small outbreaks but these are within the expected range.

Mr Maybury asked whether Shropshire and Telford & Wrekin are approaching local outbreaks as those seen in Herefordshire.

Mrs Tilley responded that Shropshire have not had outbreak situations that have warranted local lockdowns.

Mrs Tilley pointed out that an outbreak is when there are two cases that are in the same setting or linked therefore, an outbreak is quite small number. Shropshire would be in a position to implement local lockdown should this be needed. The tactical Command Group will be carrying out a test exercise on how this would be implemented if needed.

Mrs Tilley said that there is no evidence to suggest that the levels of prevalence that is being seen and the information coming through from the local outbreak management arrangements, suggest that Shropshire is heading for a local lockdown. The rates in Shropshire are lower than Leicester where they have had to implement a lock down across the city.

Mr Maybury highlighted that a recent news feed stated that government agencies are predicting a second wave of 110,000 deaths and sought clarity on how the surge capacity would be identified, where it is going to take place and what numbers are involved.

Mrs Tilley responded that it is important to caveat the information recently published regarding a potential second wave as being estimates and the data published is erring on the side of caution and looking at the worst case scenario. Shropshire's peak was lower than a lot of areas nationally therefore modelling would be on similar levels. The surge arrangements in place for the first wave were sufficient and restoration plans regarding re-invoking surge plans continue.

Dr Davies advised that a contingency plan is in place for the unknown. The only difference will be in winter when there will be the additional surge for critical care; an additional 15 beds will be given to the Shropshire/Staffordshire critical care network and it is expected that these will be made use of with colleagues in Staffordshire rather than using SaTH's theatres. Planning has been undertaken for a small secondary peak from the middle of June which has not materialised. NHSE/I has asked the CCGs to plan for the worst case scenarios during winter as was seen in March this year which is a small contingency to provide assurance.

Mr Maybury asked what numbers were involved in relation to test and trace.

Mrs Tilley responded that all testing arrangements that were previously highlighted remain in place and there is testing capability through the laboratory at SaTH which is mainly focussed on testing patients that are admitted and discharged in line with guidance. There will also be capacity for testing for staff via the MOD mobile testing site which moves around the county of Shropshire and also the regional testing site in Ironbridge. All options remain available and will continue to be available to allow the level of testing needed.

Mrs Tilley added that when an individual gets a positive result, they are followed up by the Test and Trace team who will go through with them their contacts and move to arranged contact tracing and will follow up with their known contacts which is being managed through the local authorities and NHSE/I.

42.20.2 Integrated Performance & Quality Report:

Members received a copy of the report with the papers for the meeting and the following key points were noted:

The Chair assumed members of the Board and read the report and invited questions or comments.

Mrs Young highlighted that CQC still have concerns regarding the quality of services and care delivery at SaTH, both CCGs are well sighted on these concerns. These concerns have been tested through quality assurance checks. These measures continue and progress and concerns are reported at quality forums and sub committees of the CCGS Governing Boards.

Following concerns raised by CQC, the CCGs have undertaken quality assurance checks in both maternity and medical wards. There remain areas that need improvement in the medical wards and many issues pertain to SaTHs ability to put right such as documentation completion. However, SaTH have relaunched their documentation and their approach to recording risk assessments and care quality and the CCGs are optimistic that their improved way of documentation will demonstrate compliance.

There are learning points in relation to Maternity which were shared with the Trust however; maternity appears to be doing better as far as CQC are concerned.

There are issues around the culture at the Trust and this is going to take a sustained leadership approach over the next year or two.

The CCGs are working closely with the Trust regarding the discipline around the quality governance approach in relation to Serious Incident (SI's) reporting. The CCGs are also working closely with the Trust in terms of assurance required and being realistic about the pace of progress.

Mrs Bryceland referred to the deployment of staff involved with Looked After Children (LAC)/Child Protection and asked if there was any feedback that has caused any issues and whether there have been any increased issues with risks to those children.

Mrs Young responded that none of the CCG safeguarding staff were redeployed and that the CCG maintained their cohort of LAC input on both Shropshire and Telford & Wrekin sites. The national guidance was around health visitors and stepping them down from certain elements of face to face contacts but there was still a significant amount of activity with non face to face contact especially around looked after children.

Mrs Young stated safeguarding generally has been a considered piece of work over the period of lockdown and there has been a significant amount of work to make sure the CCG's approach in Shropshire and Telford & Wrekin have risk stratified vulnerable people. There have been various forms of line of sight even though face to face interaction has not been possible.

Mr Braden asked what is being done to maintain visibility regarding Looked After Children (LAC) and queried whether assurance outside of physical visits can be provided.

Mrs Young responded that there is a live and dynamic process in place which triangulates information in that all agencies come together to have a focussed discussion about children particularly those at a higher risk. LAC would be deemed as a high risk and regular conversations about triangulating sources of information

including the schooling element about every child under Shropshire's jurisdiction.

Mr Evans added that another level of assurance is that Safeguarding Executives which includes the police and other agencies continue to meet during this period and are monitoring the data that is coming through. Mr Evans pointed out that there has been a spike in domestic abuse which may be of concern.

Mrs Young said that she had joined a focus group meeting around early years support with Telford Local Authority who provided assurance in that they have a full suite of staff attending to child services and that staff have not been redeployed.

Mr Trenchard said that in terms of oversight in the system during COVID, there is a tactical group that reports into the mental health and learning disability systems wide group and Telford and Shropshire teams have been meeting on a weekly basis where they risk stratify children and have been working particularly on physical and emotional health concerns.

Mrs Young advised that a Safeguarding Annual Report will be presented at the next PPQ meeting which will provide further detail how the CCGs have maintained sight around safeguarding.

Following discussion the CCG Governance Board:

- Noted the contents of the report

42.20.3 Finance
Finance Report – Month 2

Mrs Claire Skidmore assumed that members had read the report and invited questions and comments:

Mrs Bryceland asked for clarity regarding COVID expenditure and questioned whether this expenditure would be drawn back from a government source or would it be a loss for the CCG.

Mrs Skidmore advised that the budget has been set from the national team. Following the sign off of the CCGs operating budget, a budget was given for the first four months of the year which was based around historic expenditure. COVID expenditure is being accrued over and above planned spend therefore the CCGs would receive an additional reimbursement. The report shows the CCGs total expenditure which includes the COVID spend and the variance to budget. The forecast to the end of month 4 will be £5.4m over budget of that £4.2m is attributed to COVID which is expected to be reimbursed.

Dr Chan asked if the current financial position predicted is based on the fact that a block payment arrangement is in place for providers and questioned how far the CCG is in terms of adopting the block payment within the system.

Mrs Skidmore responded that the block arrangement with the main provides is likely to continue for the remainder of the financial year through the nationally mandated route. Providers will be given a reset block amount for year and this will be part of the guidance agreed.

Mrs Skidmore advised that she will be leading a working group which is a sub group of the systems directors of finance group, looking at the design of provider

contracts for next year. Mrs Kay Holland, Deputy Director of Contracts will be leading discussions to agree and enact a new contract form with SATH, RJAH and ShropCom.

Following discussion the CCG Governance Board:

- Noted the information contained in this report.

42.20.4 Learning Disabilities & Autism Update

- **LeDeR Annual Report**

The Chair assumed members had read the report and asked for questions and/or comments.

Mrs Sutherland advised that this cohort of patients have been long stay patients and data shows that Shropshire are one of the highest performing SCPS for admission avoidance. There have been four discharges (6 discharges since COVID) in the last four weeks and this has slowed down since COVID which has caused some issues, however, the target set for quarter 3 will be met.

There is a need to discharge some of the very long stay patients however, an offer of support has been received from NHSE/I regarding providing consultancy to help with this work.

Mrs Sutherland informed the Board that there is still a lot of work to be done regarding annual health checks with people with learning disabilities. The Intensive Health Outreach Team are supporting practices in order to get the annual health checks going.

Mr Maybury referred to the mortality section of the report and highlighted that the average age of death in 2019 was 49 and the national average was 40, there was a high number of pneumonia related deaths and asked whether there is any particular reason behind that and whether a homelessness issue was involved.

Mrs Bayley responded that the average age of death was lower this year and that last year the average age of death was 58 years, nationally last year was 60 years. The reason for the overall average being lower is that there were more in the under 40s category.

Mrs Bayley referred to the question about homelessness and stated that of the reported deaths this year, homelessness does not feature in the figures.

Mrs Bayley advised that there have been 58 deaths since LeDer started in June 2017 and the highest place of death has been in hospital. There have been a variety of deaths this year. Pneumonia has been the leading cause of death for the last two years. A high number this year of those that died had received annual health checks; this has risen to 75% from 47%. The learning outcomes from previous years have improved.

Dr Davies said that as part of the development for the performance reporting is to focus on a dedicated Learning and Disability Dashboard to enable a more proactive approach in this area and this will be taken forward over the coming months.

Mrs Young advised that there is a requirement for LeDer reports to be published on the CCG's website by the end of July 2020 however, due to the timing of Governance Board taking place before PPQ where a detailed report will be presented, Board is asked to approve this report subject to any conversations and points that PPQ might raise following which the report would be amended before publication at the end of this

month.

Mr Trenchard said that given that the CCGs are in improvement territory with NHSE/I, the improvement plan should be looked at either through the newly formed quality committee on a regular basis and also report back to Board going forward and suggested that 3 months would be a good time.

Mr Trenchard added that in relation to the additional consultancy support, it is hoped that the work carried out by Claire Parker regarding the individual commissioning team and also bring together a system improvement plan for both learning disabilities and autism in order that the Governing Body is sighted on both issues.

Mr Evans highlighted that this should be presented to Board in September as this is under review with NHSE/I.

Following discussion the CCG Governance Board:

- Noted the update report from the LD&A Board
- Approved the LeDer annual report prior to its publication on the CCG's website

42.20.5 Shropshire and Telford & Wrekin System Restore and Recovery Process

Members received a copy of the report with the papers for the meeting and the following key points were noted:

Mr Trenchard assumed members had read the report and invited questions and comments:

Mr Braden asked whether the recruitment of a number of nurses at SaTH will continue to help with the workforce challenges.

Mrs Young responded that regular updates are received from SaTH regarding their workforce challenges. The Trust is addressing workforce issues in relation to Emergency Department and Paediatric nurses via an internal competency programme. Progress is being made and the Trust is currently ahead of their internal trajectory.

Mrs Young stated that the NMC have advised that the cohort of overseas nurses are being mobilised and the Trust are optimistic that a large number of overseas nurses and doctors will be in place by the end of July 2020.

Mr Trenchard advised that a System Group chaired by Victoria Rankin are looking at all aspects of bringing people back into work.

Mr Evans contributed that restoration and recovery is a very complex process and there are a significant number of factors that are going to impact on every systems ability to restore at pace, this will have an impact on how quickly that can be done not just in terms of staffing but in terms of PPE supply and sustainability, whether or not social distancing will change over the coming months and the potential for a second spike added to which there is a significant backlog in elective care and diagnostics. Mr Evans stated that he did not believe that despite rhetoric, the backlog will not be cleared until 2022.

Following discussion the CCG Governance Board:

- Noted the content of the report.

43.20 <u>Governance</u>

43.20.1

Members received a copy of the report with the papers for the meeting and the following key points were noted:

The Chair assumed members of the Board and read the report and invited questions or comments.

Mrs Tilley said that it is hoped that the learning from COVID will help the CCG how to take forward governance arrangements to ensure they continue to be an enabler in the new normal.

Miss Smith highlighted that a letter had been appended to the report from NHS England regarding stepping governance arrangements back up which she believes supports the proposal. There is still a caveat in that there is a second surge of COVID that the CCGs would need to take a view of potentially stepping down their governance arrangements to allow staff to focus on what is required around COVID. This needs to be kept under review and it is suggested that the accountable officer and chair take a view in August as to whether the CCGs go back to the normal regularities of the new committees or whether they remain as they are. DE/JP August 2020

Following discussion the CCG Governance Board:

- Reviewed the current temporary governance arrangements adopted during Covid 19 management response; and
- Approved the timescale of reverting back to normal governance arrangements from September 2020, with the caveat that this is reviewed in August by the Chair and Accountable Officer.

44.20 <u>For Information</u>

44.20.1 Committee Chairs Reports:

44.20.1.1 Planning, Performance Quality Committee – 26th May 2020

This item was presented for information only.

44.20.1.2 Audit Committee – 23rd June 2020

This item was presented for information only.

44.20.1.3 Audit Committee – 21st April 2020

This item was presented for information only.

44.20.2 Single Strategic Commissioner for Shropshire and Telford and Wrekin CCG – Update Report

This item was presented for information only.

45.20 <u>Any Other Business</u>

Mr Evans wished to thank all board members who will not be part of the new board for all their contributions they have made over the year and in particular a special thanks to Dr Leahy for her unfailing support to him personally and to the CCG.

It was noted that there was no other business to discuss.

The meeting closed at 2.45pm

46.20 Items raised by members of the Public

Dr Leahy advised that a list of questions from Gill George has been received and these will be responded to within 2 weeks, the answers will be published on the CCGs website.

47.20 Date of Next Meeting:

Tuesday 9th September 2020 – VENUE TO BE CONFIRMED

Shropshire Clinical Commissioning Group

ACTIONS FROM THE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING – 8 JULY 2020

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2020-07.072 – Minutes of Previous Meeting – 13 May 2020	Mrs Stackhouse to make the agreed amendment to the draft minutes as noted in paragraph 5.1.	Mrs Sandra Stackhouse		Complete 23.07.20
GB-2020-07.074 – Matters Arising [b/f GB-2020-01.010 – Shropshire CCG Strategic Priorities]	Mr Trenchard to bring back a progress report on the MSK Alliance Agreement to the next formal Part 1 meeting. Item to be included on the agenda.	Mr Steve Trenchard	Next meeting	*To be included on JSCC agenda
[b/f GB-2020-03.034 – Update on Transforming Midwifery Care]	Dr Povey and Mr Evans to write a formal letter to NHSE/I conveying the Governing Body's frustration that it had not received further information on the proposals submitted for consideration by the national panel.	Dr Julian Povey / Mr David Evans	As soon as possible	Complete
[b/f GB-2020-05.055 – Performance and Quality Report]	Mrs Young to escalate the concerns raised by Healthwatch on behalf of patients to SaTH with the request to urgently address the concerns raised.	Mrs Zena Young	As soon as possible following meeting with Ms Cawley	Mrs Cawley has raised the concerns directly with Ms Bailey – Interim CNO, SaTH.
GB-2020-07.075 – Public Questions	Miss Smith to review the process for receiving and responding to questions received from the public, particularly with regard to the regularity of similar questions received covering the same areas.	Miss Alison Smith		Complete
	Mrs Stackhouse to circulate copies of the questions received from the public and the CCG's responses to	Mrs Sandra Stackhouse		Complete - 22.07.20

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
	Members when they are published with the draft minutes on the CCG's website.			
GB-2020-07.076 – COVID-19 Update	Ms Robinson to come back to the CCG to confirm if there was any further up-to-date information on the antibody testing for Shropshire patients. *[Received and circulated to Members on 09.07.20.]*	Ms Rachel Robinson		Complete – 09.07.20
GB-2020-07.078 – Performance and Quality Report including integrated, secondary and primary care	Dr Davies to share the data on the ambulance crew on-scene timings with Members when received.	Dr Julie Davies	When information is received	
	Dr Davies to double-check the data quoted for Qtr 2 on page 10, section 6, of the Performance and Quality Report and to email clarification of the information to Members.	Dr Julie Davies	As soon as possible	
	Mrs Young to seek a professional view on whether there are any tools that can be applied to test whether a patient experience has been harmful to their well-being as well as their physical well-being.	Mrs Zena Young	As soon as possible	NHSEI have published Best Practice for Clinical Harm reviews in September 2020, which includes reference to psychological harm.
	Dr Davies and Mrs Young to review the structure of the Performance and Quality Report for presentation to future meetings.	Dr Julie Davies / Mrs Zena Young	For next meeting – 09.09.20	Complete

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
	Ms Parker to include the waiting list numbers and timescales for the ASD and ADHD pathways in the SEND report. Mr Trenchard to provide an update on the new ASD and ADHD pathways to the next meeting.	Ms Claire Parker Mr Steve Trenchard	As soon as possible For next meeting – 09.09.20	 *To be included on JSCC agenda
GB-2020-07.080 – Board Assurance Framework (BAF)	The Executive Team to review the current BAFs to see whether further improvements can be made including looking at the inclusion of the levels of the original risk, present risk and risk aimed for.	Miss Alison Smith / Executive Team	As soon as possible	Complete
GB-2020-07.084 – Update on SEND Inspection Report	Ms Parker to present to the next meeting an update report on SEND together with the final draft of the written statement of action in readiness for publication on 25 September. Item to be included on the agenda. The Executive Team to agree a process for providing the Governing Body with assurance around SEND.	Ms Claire Parker Mrs Sandra Stackhouse Ms Claire Parker / Executive Team	Next meeting – 09.09.20 As soon as possible	Complete Included on agenda – 9.09.20

Telford and Wrekin Clinical Commissioning Group
Board Meeting – Part One (Public)
ACTION LIST
As at 14th July, 2020

NHS
Telford and Wrekin
Clinical Commissioning Group

	Agenda Item and Date	Action	Actioned By	Date
1.	20.20.2 (10.03.20)	**Primary Care Commissioning Committee Chair's Report** Mrs Fran Beck recognised the need to keep patients informed and engaged and agreed to arrange for a member of the primary care team to attend the next Telford Patient First Group meeting to provide an update around PCNs. **Update 12.05.20:** Mr Spreadbury said that a discussion had taken place around arranging a meeting, however due to the current situation this had been put on hold until later in the year.	Fran Beck Claire Parker	May 2020 September 2020
2	43.20.20.7 (14.07.20)	**Governance** The accountable officer and chair to take a view in August as to whether the CCGs go back to the normal regularities of the new committees or whether they remain as they are.	Dave Evans/Julian Povey	September 2020

NHS Shropshire CCG

NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 9 September 2020**

Item Number:	Agenda Item:
GB-20-09.100	Shropshire CCG and Telford and Wrekin CCG Quality and Performance Report

Executive Lead (s):	Author(s):
Julie Davies Director of Performance Julie.davies47@nhs.net Zena Young Executive Director of Quality zena.young@nhs.net	Charles Millar Head of Planning Performance and BI Helen Morris Senior Performance Analyst Niki Jones Senior Information Analyst Helen Bayley Associate Director of Quality & Nursing (with input from quality team)

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

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

Executive Summary (key points in the report):

The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. It supersedes the previous CCG Improvement and Assessment Framework (IAF). The NHS OF does not set out how outcomes should be delivered; it is for NHS England to determine how best to deliver improvements by working with CCGs to make use of the tools at their disposal. This paper reports on our current challenged areas across the OF, but the appendices usually provide further information to consider such as quality issues, Continuing Healthcare (CHC) indicators and the NHS Constitution. Pages 2-3 of this report show performance against key areas of focus:

- A&E
- RTT
- Cancer
- Dementia

Further detailed is shown in Appendix 1. Appendix 2 shows our performance against all NHS indicators.

During the ongoing pandemic situation, the scope and detail of this report 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). Recovery planning is underway but the process is likely to take some time, and any resumed services will have reduced capacity due to the need for social distancing.

In terms of performance key areas of concern continue to be related to the ability to restore services back to pre-Covid 19 levels in the context of social distancing limitations on capacity. This is particularly pertinent to Elective access and Diagnostic access.

Performance around A&E remains a concern moving in to the winter with an unknown expectation around Covid 19 on top of winter pressures.

Cancer performance remains encouraging with priority being given to these and other urgent cases. Performance on the 62 day standard is forecast to recover at the end of October. There are concerns that cancer referrals for some tumour sites continue to be below normal levels (Lung and UGI).

Recovery of key Mental Health Indicators is likely to be influenced by the willingness of patients to present as the service resourcing is in place for services such as IAPT

Key Quality Points:

- Shrewsbury and Telford Hospitals NHS trust (SaTH) remain the most challenged provider and cause for concern within the health system.
- The trust is to have an alliance with University Hospital Birmingham (UHB) to further support and develop the quality and performance issues..

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

Recommendations/Actions Required:
The Board are asked to note the actions being taken to address identified issues.

1 Key Performance Challenges

At month 3 of 2020/21, unless otherwise indicated

Area, Local Lead	Indicator	Target *or National rate*	Latest Position		Change from last period		Headline issues/actions
			SCCG	TWCCG	SCCG	TWCCG	
A&E	**4-hour A&E** (SaTH, M04)	95%	**81.4%**		↓		Ambulance conveyances to A&E reduced due to COVID 19 19. Cat 3-4 Ambulances now go via 111 clinical assessment service. ED Attendances relatively low at PRH, but recovering towards pre-Covid 19 levels. SaTH has mostly maintained level one escalation levels during the pandemic; this resulted in improved performance against targets. A system wide front door and discharge operational group is in place to ease flow into and out of SaTH and to support during the pandemic. SaTH continues to work with ECIST to improve operational processes and standards. The system wide UEC group has been re-focussed to work particularly on initiatives to reduce demand on A&E. In particular it will be working closely with WMAS to reduce conveyances and to explore how greater use of NHS111 (NHS111 First) may be used to defray demand. There is a clear difference in the levels of activity between RSH and PRH sites with the former showing much stronger levels of recovery back to pre Covid 19 levels. This applies for both A&E attendances and ambulance conveyances. At both sites it is the younger age groups where the majority of the reduction in activity during Covid 19 occurred and it is this section of the population which is still showing the lower levels of activity. This is thought to be contributing to a change in the case mix of patients admitted from A&E
RTT	**Referral to Treatment** within 18 weeks	92%	**53.3%**	**58.2%**	↓	↓	The reduction of elective work during the Covid 19 period is reflected in worsening performance against RTT indicators. There are increasing

	Referral to Treatment waits > 52 weeks	0	133	88	↓	↓	numbers of longer waiters including 52 week waiters. The impact of capacity limitations arising from the need to operate social distancing rules is likely to mean increasing numbers waiting and an increase in long waits. System wide work is being undertaken to ensure patients are treated in line with clinical urgency so that cancer patients and other urgent cases continue to receive necessary treatment. Work is being undertaken to identify the gaps in elective capacity. The working groups set up under the Restore and Recovery Programme have been tasked with developing mitigations and identifying rebalancing capacity where possible.
	Diagnostic waits of more than 6 weeks	1%	65.4%	66.6%	↑	↓	Performance has been severely impacted by Covid 19 and will continue to be compromised as a result of the need to introduce social distancing procedures. Bids for additional mobile diagnostic units have been submitted to NHSE/I but no confirmation about these has yet been received. Planning assumptions are currently constructed that allow for only partial recovery of capacity compared to pre-Covid 19 levels so that performance is likely to be compromised for some time into the future
Cancer Waits	**31 days** to cancer treatment (surgery)		86.7%	100%	↓	↑	Cancer performance has generally held up well during the Covid 19 crisis as priority has been given to cancer patients. The expectation is for levels of performance to continue to improve over the next few months. Referrals decreased substantially during the Covid 19 peak but now recovering to just slightly below normal levels. Significant capacity issues in diagnostics impact on performance but cancer and other urgent cases are being given priority.
	62 days from referral to cancer treatment	90%	70.3%	63.8%	↑	↓	

	62 days, referral from screening to treatment	85%	0%	0%	↓	↓	Performance on the 62 day standard is currently expected to recover by November. Use of the Nuffield continues to support cancer care under the remit of the nationally agreed contract and this is planned to continue through the rest of the year. Gynaecology, and Breast. Cancer Assurance Meetings continue, with Commissioner attendance. Best Practice Pathways continue to be discussed fortnightly with Commissioner attendance. The impact of Covid 19 has inevitably delayed a number of projects but these are now re-starting including Breast Project Holistic Need Assessments, Personalised Follow up and Treatment Summaries. Learning/ experience is being shared across West Midlands Lead Cancer Nurse /Managers.
Dementia	**Dementia** Diagnosis Rate	66.7%	65.2%	59.5%	↑	↓	TWCCG remains below target. Planned events for dementia awareness in practices are on hold due to Coronavirus. Shropshire CCG performance has improved slightly, but is still failing to achieve target due to the coronavirus outbreak, the patients within this cohort, are the ones that are currently shielded. Work to re-establish activities in practices around dementia awareness are being planned in September as the impact of Covid 19 on these events recedes. The potential success of these will be dependent on willingness of patients to present and of finding different ways of delivering the service where this is a problem.
Mental Health	IAPT Access	25% at year End	2.17% (cumulative at M4)	1.26% (cumulative at M4)	↑	↑	During Q1 there was a significant reduction in activity as a result of Covid 19 impacting on numbers of patients presenting. M4 has seen a partial recovery in numbers but they are still well short of pre-Covid 19 levels. Staffing resources a rein place to provide the service, so recovery will be influenced by initiatives to encourage patients to present. Work is being undertaken with MPFT to identify options for increasing presentation and forecasting work being explored jointly to assess the likely demand trajectories. Given the low level of achievement against the target in Q1 and the likely recovery pathways, it will be difficult for the CCGs to achieve the year end target of 25 % access.

1.1 Much of the remaining reporting topics that would normally form part of the report have been suspended during the Covid 19 crisis. It is not yet clear when these will resume.

1.2 Appendix1 shows further detail on the indicators reported here and Appendix 2 shows latest details from the CCG Oversight Framework. Future reporting to the Governing Body will be structures around the key metrics within the Oversight Framework identifying metrics where performance is Good, Average and Poor. Focus will be on those metrics where the rating is Poor and those where performance has deteriorated over a number of successive periods.

2 Quality Concerns/ Key Points - Providers

Provider	Areas of Concern, current position and actions
2.1 Shrewsbury and Telford Hospitals NHS Trust	
Quality of care: CQC inspection reports, following the visits on 9 and 10 June, were published on 14 August. Overall ratings have reduced to 'inadequate', with deterioration in medical care and EoL care ratings. Concerns were noted in completion of patient risk assessments; record keeping; culture and leadership. NHSEI have been working with the Trust on a new package of support, with a new Improvement Director appointed and the trust is to have an alliance with UHB, details of which are still being finalised. **Cancer services**: 12 patients received their first definitive treatment for cancer after 104 days in May 2020 (the latest reported data). 10/12 of these were Urology patients. One Colorectal and one Upper GI. The trust state the vast majority of breaches are clinically justified due to the complexity of the patient's pathway, however there is acknowledgement that Covid 19 has also had an impact in relation to these. Capacity issues regarding diagnostics and treatment include waits for MRI, TRUS and biopsy, outpatient and surgical capacity continue. The policy for breach reporting has been revised by the Trust, the CCG have shared comments and are to attend Governance harm review meetings to gain assurance of robust monitoring processes. **Maternity Services**: consultant unit births have seen a further decrease this month with the reopening of Wrekin MLU and reinstatement of home birth service, which is positive. Overall consultant unit bookings have reduced for a third month which is in line with the national trend, with a 3% fall nationally. Initially during Covid 19 booking consultations took place over the phone, following feedback from midwives and women, face to face bookings recommenced during June 2020. Smoking rate at delivery has continued to increase over the last 3 months, however as carbon	

monoxide monitoring during pregnancy was halted nationally due to Covid 19, Public Health are providing support and are undertaking telephone consultations only at this stage.

A new maternity performance dashboard has been developed. The first draft is being reviewed within the Trust and will then be shared with the CCG in September. The benefits of a new dashboard will be that it will be assessed in line with the correct targets and performance indicators, based on the latest local and national information.

Neurology: Following quality and patient safety concerns raised in relation to the fragility of this service, a paper proposing a way forward was submitted to Telford & Wrekin PPQ Committee and approved in July. There was a timing issue with the equivalent approval from Shropshire and that is being managed via Chair/AO approval due to the transition to the new joint governance structure. The recommendation was to move from the previously agreed phased approach, and for all neurology activity to go from SaTH to Royal Wolverhampton Trust. SaTH has not accepted any new patients for some time, therefore the CCG contracts and commissioning teams do not expect a long delay in transitioning the full service.

RTT: The reduction of elective work during the Covid 19 period is reflected in worsening performance against RTT indicators. There are increasing numbers of longer waiters including 52 week waiters (as outlined in the performance section). The Trust is completing harm proformas as required. It has been agreed the CCG will have sight of this harm review and risk stratifying process.

Serious Incidents: Significant improvements have been made within the Trust in relation to reporting and monitoring processes of SI's. A new Clinical Governance team is being established, with recruitment processes underway. The new team and processes will be managed by the central Patient Safety/ Governance team to ensure consistency of reviews and subsequent measures taken to embed the learning. There are currently 40 open SIs, with an additional 3 stopped clocks due to external investigations. 4 serious incidents were reported in July. 2 related to falls, 1 in maternity and one Never Event in Dermatology. All of which are currently undergoing investigation. There have been no 12 hour ED breaches reported in ED in July.

Falls: improvement work has commenced aimed at all wards which includes ensuring that all patients have a full falls risk assessment completed on admission and that for those patients assessed as at risk a falls prevention care plan is implemented. The Enhanced Supervision Policy and The Trust's Slips, Trips and Falls Policy have been reviewed. The implementation of this work is being overseen by the matrons and audited as part of their Nursing Quality Assurance Metrics audits. The CCG is reviewing this through its quality assurances processes.

Discharges: A Safer Discharge task and finish group has been set up by the CCG and is linking to the SaTH discharge review group. The quality team are making plans to an audit the different facets of discharge which have been raised as N2N concerns: Safeguarding issues; Medicine management; FFA; transport; communication.

MCA/ DoLS: The trust have completed an audit to identify the quality and completion of the documentation related to Mental Capacity Assessments and Deprivation of Liberty Safeguards. This has identified additional staff training needs. The audit will be undertaken on a monthly

basis by the Trusts Adult Safeguarding Team. The CCG are working closely in support of the monitoring and implementation to requirements to improve this area of practice.

Quality Assurance visits: CCG quality assurance visits, both announced and unannounced to SaTH have continued throughout the Covid 19 pandemic. The quality leads also continue to attend joint Exemplar visits with SaTH colleagues. Key issues identified during these visits are: *Environment* (Cleanliness and estates work); *IPC* (urinary catheter management and cleanliness); *Documentation* (patient transfers, reporting allergies, risks assessments); *Falls* (monitoring of Lying and standing blood pressure, falls indicators); *Nutrition and Hydration* (completion of Food charts, patient weights, fluid balance charts); *Tissue Viability* (Repositioning charts, top to toe assessment, pressure ulcer prevention); *Patient Experience* (Patient communication, knowledge of care & treatment plan), *Workforce*: (staff support, staff morale).

The Trust have developed an action plans in response to the findings from the CQC; CCG and their own internal mechanisms. The CCG continue to work closely with the Trust, NHSEI and partners to provide support and challenge in driving forward the measures required to improve.

2.2 Robert Jones and Agnes Hunt Orthopaedic Hospital

Delayed discharges: The discharge rate reported as a concern in last month's report has much improved. This is in part due to the Covid 19 response, but also acknowledges the measures put in place following the new ways of working for spinal patients which was introduced in January 2020. Delayed discharges are down from 7.23% to 2.82% in June.

RTT: Due to service changes related to Covid 19, the number of patients waiting Over 52 Weeks for treatment has continued to increase. During July 68 English patients and 77 Welsh patients were reported as waiting over 52 weeks. The total number of breaches has increased by 1509, rising from 2537 in May to 4046 at the end of June for patients on waiting lists for more than 18 weeks. The Trust reported this is likely to continue to increase significantly until full services resume. The Trust provided assurance at CQRM that consultants are risk stratifying patients and completing harm proformas as required. It has been agreed the CCG will have sight of this harm review and risk stratifying process at the next QA visit.

Serious Incidents: As the time of reporting the trust currently have 3 serious incident open and under investigation. Two under 60days and one over. One is a HCAI/Infection Control Incident; one is a treatment delay and one relating to a surgical incident in theatres.

2.3 Midlands Partnership FT

Serious Incidents/ Never Events: There were 7 STEIS reportable SIs during July 2020.
2 x failure to obtain an appropriate bed for a child; 2 x unexpected /potentially avoidable deaths; 2 x unexpected death of community / out-patient;

1 x suspected suicide. RCA reports are now being submitted for CCG review which relate to incidents which occurred since the start of the COVID 1919 pandemic. This factor and the impact that this may have had on the incident will be considered as part of the review process.

These incidents are managed following the NHS England Serious Incident Framework. The RCA reports will be reviewed. Further work is being undertaken to develop the collaboration between MPFT, commissioners (health and social care) and other agencies, e.g. Public Health England, to effectively enable lessons learned, action plans, and wider learning to be shared and further remedial action identified and developed. This will include those people known to mental health services and those who have not accessed services.

ASD Waiting List: Commissioners are aware that waiting times will continue to increase, due to a reduced number of face-to-face assessments being completed during Covid 19-19. The sustainable future model for neurodevelopmental pathway has been agreed and financial approval from NHSEI is awaited. Work continues to take place across the wider health care and education system to achieve a multidisciplinary approach to neurological development support. Other performance reports have not been formally reviewed by CCG during Covid 19-19 pandemic.

The next CQRM meeting is scheduled for 28/8/2020 and an update on the status of ASD waiting times and NHSEI funding is expected.

2.4 Shropshire Community Healthcare NHS Trust

Serious Incidents/Never Events: There have been 7 SI reported on STEIS for May and June 2020: Six were in relation to pressure ulcers. No Never Events have been reported for May and June 2020.

Wound Care: A Themed review on recent Wound Care Audit was presented and discussed at CQRM. This was an audit of community nursing teams' use of dressings. The audit identified that in majority of cases staff used dressings which were available as part of local formulary which has recently been updated and approved. It also highlighted use of silver dressings and length of time between dressing changes as areas for further investigation. CCG medicines management team are leading on this work and are part of LHE group.

2.5 GP Led Out of Hours Service (SCHT)

SCHT leads on OoH contract, subcontracting Shropdoc since 1st Oct '18.

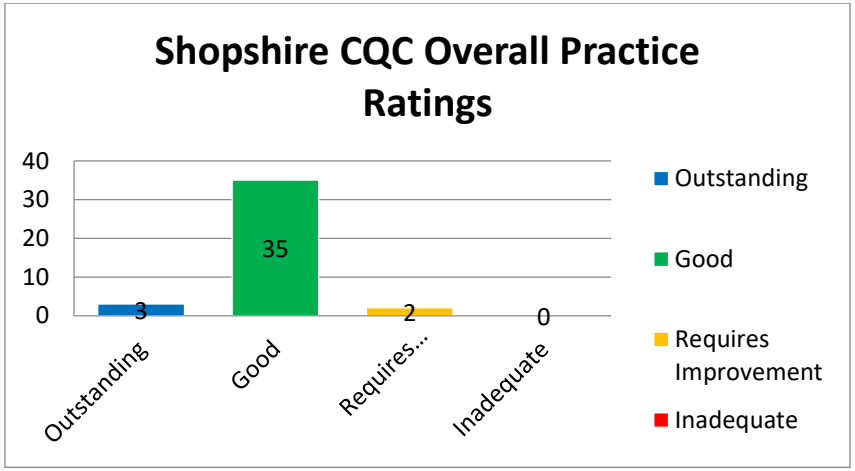
Quality Assurance visit: A visit was undertaken on 1st July 2020 to Shropdoc headquarters, Shrewsbury following concerns received. Since November 2019 Shropdoc had employed two new Associate Medical Directors with a specific focus on quality, CQC compliance and the Information Hub. We were satisfied that the concerns raised have been addressed and that appropriate steps have been taken to maintain this improvement going forward. Highlights to note from the visit:

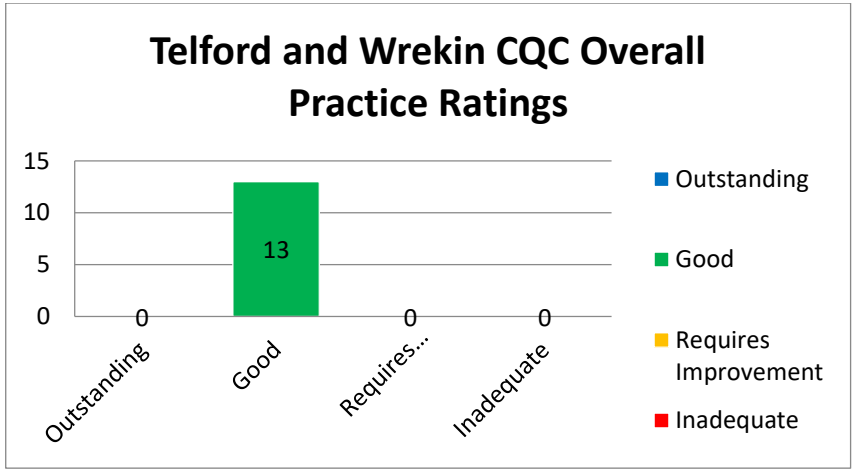
- Good incident reporting processes
- The provider is developing own KPIs for investigation reporting
- There is to be more understanding of links with SCHT. One particular link to note was the shared process for prescribing audits and work ongoing with review of Quality Assessment Framework
- Use of clinical guardian audit process
- Documentation was available from the outcome of an audit which was conducted by Audit South West in July 2019

2.6 Primary Care

A comprehensive report is submitted to Primary Care Commissioning Committee separately.

Care Quality Commission (CQC) Inspections: The CCG Locality/commissioning Managers and CCG Quality Lead offer quality assurance visits to practices to support with implementation of their CQC action plan. The CCG's Primary Care team and Quality team are currently working jointly to ensure the quality offer is consistent across Shropshire, Telford & Wrekin. An update of plans will be provided within the next Board paper.





National GP Patient Survey 2020: Results from an England wide survey administered by Ipsos MORI on behalf of NHS England providing practice level data about patients' experiences of their GP Practices during January – March 2020 has recently been released.

The report is very detailed and whilst there are variations in feedback across both CCGs and practices when reviewing patients' perceptions about their Overall Experience of their GP Practice the following can be noted:

	National	Shropshire CCG 46% Response Rate	T&W CCG 35% 35% Response Rate
Rated as Good	82%	85%	75%
Rated as Poor	7%	6%	12%

Full results can be accessed via:

https://www.gp-patient.co.uk/surveysandreports

Quality Lead is working with locality and commissioning managers to identify Practices which require additional deep dive into results and support

to improve in areas identified as impacting on patient experience such as access to appointments.

Primary Care Services have been restored following CCG sign off. In particular cervical screening has recommenced with reported that all practices have been submitting samples for analysis.

Annual Health Checks: The CCG and partners are refocusing its work on Annual Health Checks for people with Learning Disabilities. There is significant variation in uptake of AHCs. A mulit-agency approach is being developed to ensure system buy-in to improve this area of work. For example the Local Authority have embedded a reminder of AHC's within their care act review documentation which means social workers will highlight the importance of these reviews to the individual, their families and carers. MPFT Intensive health outreach team (IHOT) have been contacting practices to offer support and training and guidance to undertake the AHCs. They have provided LD awareness and annual health check training to GP Practices. The IHOT team have agreed to attend LD Social Work Team meeting and the care provider meeting that LA leads to reinforce the importance of prompting re AHCs as a key part of their work

The National team are indicating that they expect 67% achievement during 2020/21, with a target of 75% by the end of 2024.

2.7 West Midlands Ambulance Service (WMAS)

There are no quality concerns to report by exception.

2.8 Care Homes

Information sharing meeting between CCG, local authority, CQC and Healthwatch are held via video conferencing facilities. Working with local authority (LA) quality monitoring officers the CCG quality nurse for care homes is monitoring care homes across Shropshire, Telford and Wrekin and will undertake a joint CCG/LA visit to any care home where high risk concerns are known.

Homes requiring increased monitoring/ cause for concern: There are currently no care homes under level 4 scrutiny. The CCG's continue to provide the care sector with IPC advice and support in collaboration with Public Health England, CQC and Local Authorities.

2.9 Independent Providers

The CCG continues to support all providers to restore services aligned to CCG processes and COVID 19-19 safety measures. Whilst formal contractual meetings have been suspended, regular quality overview meetings are being held to ensure quality standards are being consistently upheld to provide safe and accessible services to all patients. It is encouraging to see the smaller Providers now adapting their services, with effective triaging and risk assessment of waiting lists, which have inevitably increased following a period of significant reduced activity.

Smaller Providers requiring increased monitoring/ cause for concern: There are no concerns to report by exception in relation to the smaller providers.

3 Quality Concerns/ Key Points - System

3.1 Infection Prevention & Control (IPC)

The CCG IPC service continue to support the local health & social care response to the Covid 19 pandemic with a number of specific work streams including the facilitating the IPC work stream, and supporting the Personal Protective Equipment, Primary Care and Care Sector Task & Finish Groups along with the provision of advice & support to primary care and the care sector including care homes with suspected/confirmed cases and outbreaks of Covid 19. This work is extending to include IPC training support to the Domiciliary Care sector, in line with the Chief Nursing Officer for England (CNO) mandate.

The CCG's are working closely with Shropshire and Telford & Wrekin Local Authorities as part of the system Health Protection Board in the delivery of their respective Local Outbreak Control Plans.

The 2020/21 infection targets for CCGs and NHS Trusts have yet to be published. It is anticipated that the zero tolerance MRSA bacteraemia will continue in 2020/21 and reduction targets will be set for *Clostridium difficile* infection and Gram-negative bacteraemias (GNBSI), including Escherichia coli, Klebsiella and Pseudomonas. The CCG IPC service continues to monitor rates of these infections across the STP together with infection outbreaks/incidents and subsequent monitoring/ implementation of actions.

The CCG Head of IPC has been invited by NHSE/I to join a Project/Programme Board to develop an IPC safety support programme. The support programme will initially be made available to acute, community and mental health trusts, with a focus on those organisations that have been identified by regional teams as meeting one or more of the following criteria:

- A sustained outlier rate of nosocomial COVID 19 infection, longer than 3 weeks
- Wider criteria such as poor performance against other mandatory infections triangulated with:

- Intelligence from CQC inspections or visits e.g. Section 29A notice in place
- Regional team concern
- Infection outbreaks or cluster management have a sustained and severe impact on delivery of services

- Trusts proactively seeking specialist advice and support

The CCG Quality/IPC Nurse will be holding a 'Winter Planning Forum' for care homes at the end of September, to support the care home staff when caring for residents with influenza and norovirus infections. The session will also include recognising deterioration early warning tools, clinical frailty scale assessment and SBAR communication tool.

3.2 Safeguarding

3.2.1 Safeguarding Adults

A safeguarding Adults report will be provided to Board next month. Nothing by exception to report this month.

3.2.2 Safeguarding Children

A safeguarding Children report will be provided to Board next month. Nothing by exception to report this month.

3.2.3 Looked After Children: High numbers of hosted children in Shropshire - out of area LAC continue to be placed, now approximately 551 children/young people, 221 in Telford impacting on service delivery and timely care. Reporting at CQRM this Quarter was very pleasing; the data demonstrated the effort that the LAC health team had made to ensure that children in care and the outcomes of this vulnerable cohort did not receive impact in terms of meeting their health outcomes, during the pandemic. The data itself in terms of exception reporting and clarity of reporting was very detailed, and provided a good analysis of the data which showed managed risk. The audit for Review Health Assessments presented for Quarter4, demonstrated that the quality of the assessments was exceptional, out of 18 assessments audited: 13 assessments were outstanding, 4 good and only 1 required improvement.

4 Compliments and complaints

When reviewing the feedback received directly by both CCGs the following summary is to be noted:

5 compliments have been received in July of which 3 related to the POD service and 2 to the support provided by the CCGs' Insight Team.

11 complaints with no clear theme emerging given the wide and diverse range of issues raised.

6 MP Letters, with 4 related to access issues from a variety of services associated with the impact of COVID 19 restrictions.

54 queries were also received via the PALS route predominantly related to access issues associated with the impact of COVID 19 restrictions.

5 Concerns

A total of 36 NHS to NHS Concerns were raised regarding care provided across a range of providers.

19 (50%) related to SaTH, 13 of which referenced concerns about poor and unsafe discharge.

In response to this the safer discharge group has been set up as described in the SaTH section of this report.

A detailed quarterly Insight report will be shared at the next Board meeting.

6 Patient Experience

As previously referenced, the nationally reported Friends and Family Test (FFT) has been paused throughout the COVID 19 period with the most recent results reviewed from patients receiving care during February 2020. It is anticipated that this will soon be reinstated with a refreshed and updated methodology, to include additional supplementary questions, thereby increasing effectiveness. This information will give providers and commissioners valuable and additional insight into patients' experiences which will be fundamental to transforming and improving services.

In the absence of the FFT reporting tool, Providers continue to be encouraged and supported to seek innovative ways to continue to capture patient experience feedback. This is particularly relevant in order to capture patients' views on new ways of working with increased reliance on remote and telephone consultations. Staff feedback will be very important to consider too, given the need to ensure their confidence around

clinical risk management

Appendix 1 Exception Reporting: Priority Areas

1. A&E Waits at Shrewsbury and Telford Hospitals (month 4, 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%**	**81.4%**		↓	n/a

2. RTT and Diagnostic Waits

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%**	**53.3%**		↓	Nov 2018	**58.2%**		↓	Dec 2018
AP	Referral to Treatment > 52 weeks	**0**	**168**		↓	Feb 2020	**88**		↓	Mar 2020
AP	Diagnostic test waits > 6 weeks	**1%**	**65.4%**		↓	June 2019	**66.6%**		↓	Feb 2019

3. Cancer Waits

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	31-day wait for cancer treatment (surgery)		**86.7%**		↓	May 2020	**100%**		↔	May 20
HR	62-day wait from GP referral to cancer treatment	**85%**	**70.3%**		↑	Mar 2017	**63.8%**		↑	Dec 2018
HR	62-day wait for treatment after referral from cancer screening	**90%**	**0%**		↓	Sept 2019	**0%**		↓	Dec 2019

4. Dementia Diagnosis Rate

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%**	**65.2%**		↑	Apr 2020	**59.5%**		↑	Mar 20

5. IAPT Access Rate

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	**25% by year end**	**2.17% at m4**		↑	New target level for 20/21	**1.26% at M4**		↑	Dec 19

Appendix 2 The NHS Oversight Framework

Preventing Ill Health and Reducing Inequalities								
Sub-section	Local Lead	KPI	Target	England value	Rank against 10 peer CCGs		Latest value (date)	
					SCCG	TWCCG	SCCG	TWCCG
Child Obesity	VP/FE	Children aged 10-11 classified as overweight or obese	n/a	34.2%	5/11	11/11	31.25% (2015-18)	37% (2015-18)
Frailty	EP	Injuries from falls in people aged 65+	n/a	2065	1/11	1/11	860 per 100K (Q2, '19/20)	532 per 100K (Q2, '19/20)
	EP	Combined score, inequality in unplanned hospitalisation for chronic ACS conditions or urgent care sensitive conditions	n/a	2211	1/11	1/11	955 (Q2, '19/20)	985 (Q2, '19/20)
Anti-microbial resistance	LW	Appropriate prescribing of antibiotics in primary care	<1.16	0.94	5/11	1/11	0.95 (yr to Nov '19)	0.86 (yr to Nov '19)
	LW	Appropriate prescribing of broad spectrum antibiotics	<10%	8.4%	3/11	5/11	7.6% (yr to Nov '19)	6.8% (yr to Nov '19)
Maternity	VP/FE	Choices in maternity services	n/a	60%	1/11	11/11	67.6% (2018)	55% (2018)
	VP/FE	Maternal Smoking at Time of Delivery (SaToD)	<15% (TW)	10%	3/11	9/11 (Q2)	10% (Q2, '19/20)	14% (Q3, '19/20)
Quality of Care and Outcomes								
Urgent Care	SC/EP	Proportion of patients having at least 3 emergency admissions in final 3 months of life	n/a	7.4%	2/11	1/11	4.9% (2017)	6.2% (2017)
Care Ratings	ZY	Use of high quality providers: hospitals	n/a	n/a	7/11	10/11	58 (Q1, '19/20)	58 (Q1, '19/20)
	ZY	Use of high quality providers: primary care	n/a	n/a	5/11	9/11	68 (Q1, '19/20)	65 (Q1, '19/20)
Diabetes	CR/SE	Diabetes patients receive all recommended treatment targets	n/a	39.1%	8/11	11/11	38% (2018/19)	34% (2018/19)
	DF	People newly diagnosed attend structured education	n/a	12.1%	8/11	8/11	7.6% (2017/18)	6.3% (2017/18)
Primary Medical Care	CR/SE	Carers with LTC feel supported to manage their condition	n/a	0.57	3/11	9/11	62.8% (2019)	0.52 (2019)
	CR/SE	Patient Experience of GP services	n/a	83%	1/11	9/11	88% (2019)	77% (2019)
Cancer	HR	Cancers diagnosed at an early stage	n/a	52%	10/11	4/11	49% (2017)	52% (2017)
	HR	GP RTT for cancer within 62 days	>85%	78%	9/11	10/11 (Q2, 19/20)	68%	69%
	HR	One-year survival for all cancers	n/a	73%	8/11	9/11	73% (2017)	70% (2017)
	HR	Cancer patient experience	n/a	n/a	7/11	4/11	8.8 (2018)	8.8 (2018)

Maternity	VP/FE	Neonatal mortality and stillbirth per thousand births	n/a	n/a	8/11	11/11	4.3 (2017)	7.7 (2017)
	VP/FE	Women's experience of maternity services	n/a	83%	9/11	4/11	81% (2018)	83% (2018)
Mental Health (MH)	FS/CD	IAPT recovery rate	>50%	52%	7/11	1/11 (Q2, 19/20)	46% m4 20/21	59.4% m4 20/21
	FS/CD	IAPT: access to psychological therapies	5.5% per quarter	4.7%	7/11	4/11 (Q1, 19/20)	2.17% at m4 20/21	1.26% at m4 20/21
	FS/CD	EIP: recommended care package within 2 weeks of referral for first episode of psychosis	>50%	77%	8/11	4/11	75% (yr to Sep '19)	80% (yr to Sep '19)
	FS/CD	Out of Area placements for acute MH inpatient care	n/a	129	9/11	0/11	131 (M08, 19/20)	317 (M08, 19/20)
	FS/CD	Patients on GP Severe Mental Illness register receiving Annual Health Check	n/a	30%	5/11	4/11	34% (Q2, 19/20)	34% (Q2, 19/20)
	FS/CD	Delivery of MH investment standard	n/a	n/a	1/11	1/11	Compliant	Compliant
	FS/CD	DQMI: quality of MH data submitted	n/a	n/a	9/11	6/11	90% (M07, 19/20)	93% (M07, 19/20)
MH	VP	CYP and eating disorder investment as proportion of MH spend	n/a	n/a	n/a	n/a	Unknown	unknown
Learning Disability (LD)	FS	Reliance on specialist inpatient care for people with LD and/or autism	n/a	n/a	7/11	7/11	56 per million (Q2, 19/20)	56 per million (Q2, 19/20)
	FS	Proportion of people with LD receiving Annual Health Check	n/a	51%	9/11	6/11	53% (19/20)	44% (19/20)
	FS	Proportion of registered population on GP LD register	n/a	0.5%	9/11	0.5%	0.52% (18/19)	0.47% (18/19)
	FS	LD mortality review completed within 6 months of notification	n/a	n/a	n/a	n/a	Unknown	unknown
Dementia	FS	Estimated diagnosis rate for people with dementia	>66.67%	68%	1/11	8/11	69.8% (M11, 19/20)	64.5% (M11, 19/20)
	FS	Care planning and post-diagnostic support	n/a	78%	3/11	10/11	79% (18/19)	76% (18/19)
Sepsis	ZY	Annual statement provides evidence that sepsis awareness raising amongst healthcare professionals is CCG priority	n/a	n/a	8/11	4/11	Red (2018)	Green (2018)
Elective access Data for June 2020 unless stated	AP/BE	Patients wait up to 18 weeks from referral to treatment (RTT)	>92%		4/11 (M09, 19/20)	3/11 (M09, 19/20)	12432 (53.3%)	7801 (58.1%)
	AP/BE	Overall size of waiting list	Local	n/a	5/11 (M09, 19/20)	2/11 (M09, 19/20)	23320	13412
	AP/BE	Patients waiting over 52 weeks RTT	0	1398	2/11 (M09, 19/20)	1/11 (M09, 19/20)	168	88
	AP/BE	Patients waiting over 6 weeks for diagnostic test	<1%		4/11 (M09, 19/20)	8/11 (M09, 19/20)	4605 (65.3%)	4455 (66.6%)
	AP/BE	Evidence-based interventions	n/a	n/a	5/11	6/11	Amber (Q2, 19/20)	Amber (Q2, 19/20)

New Service Models								
Personalisation	CP	Personal Health Budgets	n/a	102	11/11	7/11	10 (Q2, 19/20)	55 (Q2, 19/20)
Urgent Care	EP/SC	Emergency admissions for urgent care sensitive conditions per 1000 registered patients	n/a	2497	1/1	1/11	1716 (Q2, 18/19)	1496 (Q2, 18/19)
	EP/SC	A&E patients admitted, transferred or discharged < 4hours	>95%	87%	11/11 (M12, 19/20)	11/11 (M12, 19/20)	67.9% m12 19/20	
	EP/SC	Average Delayed Transfers of Care days per 100000 pop'n.	n/a	11	2/11	2/11	7 (M09, 19/20)	4 (M09, 19/20)
	EP/SC	Population use of hospital beds following emergency admission	n/a	982	3/11	5/11	815 (Q2, 19/20)	922 (Q2, 19/20)
Primary Care	CR/SE	Patient experience of getting appropriate GP appointment	n/a	n/a	n/a	n/a	unknown	unknown
Seven Day Service	ZY	Achievement of clinical standards in delivery of 7-day services	n/a	n/a	5/11	2/11	2 (2017/18)	2 (2017/18)
Continuing Healthcare	YC	CHC full assessments take place within hospital setting	<15%	6.2%	1/11	1/11	0 (Q2, 19/20)	0 (Q2, 19/20)
Paper-free at point of care	AP	Use of NHS e-referral service (ERS) to enable choice at first routine elective referral	100%	99%	1/11	1/11	100% (M04, 19/20)	100% (M04, 19/20)
Finance and Use of Resources								
Financial stability	CS	In-year financial performance	n/a	n/a	8/11	8/11	Red (Q2, 19/20)	Red (Q2, 19/20)
Improvement	CS	Expenditure in areas with identified scope for improvement	n/a	n/a	n/a	n/a	n/a	n/a
Medicines	LW	Reducing low-priority prescribing	n/a	n/a	5/11	1/11	Amber (Q2, 1920)	Green (Q2, 19/20)
Leadership and workforce								
Primary Care	CP	Number of GPs and nurses per 1000 weighted pop'n	n/a	1.06	9/11	5/11	1.21 per 1000 (M12, 18/19	0.99 per 1000 (M12, 18/19)
Governance	AS	Probity and corporate governance	n/a	n/a	1/11	n/a	Fully compliant (Q2, 19/20	Fully compliant (Q2, 19/20)
Workforce engagement	AS	Staff engagement index	n/a	3.82	7/11	8/11	3.73 of 5 (2018)	3.68 of 5 (2018)
	AS	Progress against workforce equality standard	n/a	0.14	3/11	5/11	0.10 (2018)	0.11 (2018)
Local system	DE	Effectiveness of working relationships	n/a	n/a	11/11	9/11	57% (18/19)	69% (18/19)
Leadership	DE	Quality of CCG Leadership	n/a	n/a	11/11	8/11	Red (Q2, 19/20)	Amber (Q2, 19/20)
Engagement	AS	Compliance with statutory guidance on patient and public participation in commissioning health and care	n/a	n/a	2/11	1/11	Green Star (2018)	Green Star (2018)

NHS Shropshire CCG

NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 9 September 2020**

Item Number:	Agenda Item:
GB-20-09.101	SaTH SOAG (Safety Oversight and Assurance Group) Update report

Executive Lead (s):	Author(s):
Zena Young Executive Director of Quality zena.young@nhs.net	Zena Young Executive Director of Quality

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

History of the Report (where has the paper been presented:		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Due to the timing of the first CCG Board Meeting in Common, this paper has not previously been presented to the Performance and Quality Committee in Common. The respective CCG Boards have previously received regular information and updates on the SaTH Quality position.	Bi-monthly	

Executive Summary (key points in the report):

- SaTH was subject to comprehensive inspection during 2019, report published April 2020, and focused inspection in April 2020, report published August 2020. The trust currently has 26 requirement notices applied to their registration, requiring enhanced reporting to CQC and these areas are the focus of their initial improvement activity.
- Continuing concerns in the most recent report were centred around:
  - End of Life and RESPECT/ DNACPR documentation
  - Incomplete patient care assessments for falls, tissue viability and nutrition.

- The purpose of this report is to provide an update to Board on progress with achievement of safe and sustainable services at Shrewsbury and Telford Hospitals NHS Trust (SaTH) as reported to the System Oversight and Assurance Group (SOAG) meeting 26 August 2020.

- At the meeting SOAG received updates from SaTH on the following items:
  - Alliance with UHB
  - Progress with SaTH Quality Improvement Plan, including associated metrics
  - Discussion regarding System Improvement
  - Details of SaTH 'Getting to Good' programme
  - Workforce & Culture

- The CCG noted the following areas:
  - Confidence that SaTH reporting to CQC would be reduced as a result of progress in some key areas eg Maternity.
  - Mixed assurance at ward level on progress with fundamentals of care/ documentation/MCA and DoLS. A CCG-led QA programme continues.
  - Positive assurance on progress with achieving training in paediatric competencies for adult ED nurses. Trust achieved their target ahead of time.
  - Insufficient progress on recording and achieving 'Time to Triage' in ED – both child and adult attendances. Further SaTH executive actions underway.
  - Positive assurance on progress regarding Serious Incident governance and case management.

Attached slide set provides detail.

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

Recommendations/Actions Required:
The Board are asked to note the actions taken and progress made to address identified issues.

The Shrewsbury and Telford Hospital NHS Trust

SaTH Oversight and Assurance Group
26th August 2020

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Agenda Item 3 – Progress update from last SOAG meeting

SaTH / System

Agenda Item 4 – New Working Arrangements

- Improvement Alliance
- Governance

SaTH

Improvement Alliance with UHB

- University Hospitals Birmingham NHS Foundation Trust (UHB) will enter an Improvement Alliance with the Trust to provide leadership expertise to support the Trust to offer clinically safe and sustainable patient services, improving the quality of care provided to patients. The Alliance is supported by NHSE/I and will take effect from 1st September 2020 as a medium term arrangement.
- Since 2013 UHB has been commissioned by the NHS to provide clinical, governance, managerial and leadership capacity and capability to support the wider health economy, particularly trusts in distress or special measures.
- As part of the changes, the current Chair has stepped down and Dr Catriona McMahon will take on the role.
- UHB will be seconding a Director of Nursing to SaTH and releasing two senior members of staff to support the Improvement Alliance (Chief Transformation Officer and a Medical Director).
- Committees in Common will be formed to monitor the effectiveness of the Improvement Alliance and milestones of the improvement plan.
- Engagement events are scheduled for the 1 September with both Chief Executives and SaTH teams.

Agenda Item 5 – Quality Improvement Plan

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Quality Improvement Plan

The Trust CQC Improvement plan has been developed and was agreed by Trust Board in May 2020. Weekly Confirm and Challenge sessions are being held with the Care Groups to drive and assure actions. Update of action status by Care Group as at 19th August 2020 as detailed below.

Group	Scope	Total Actions	Embedded	Complete	In Progress	Off Track	Not Yet Started	Percentage Complete
Trustwide	Trust Wide	121	-	52	67	1	1	43%
Urgent and emergency care	Urgent and emergency care	157	7	110	39	1	-	75%
Medical care	Medical care	25	-	23	2	-	-	92%
Scheduled Care	Surgery	37	-	27	10	-	-	73%
	End of life care	9	-	5	4	-	-	56%
	Outpatients	2	-	2	-	-	-	100%
	Critical Care	2	-	-	2	-	-	0%
Women & Children	Maternity	34	1	24	9	-	-	74%
	Children and Young People care	13	-	5	8	-	-	38%
Total		**400**	**8**	**248**	**141**	**2**	**1**	**64%**

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Quality Improvement Plan:

Table below indicates that as at the 19 August, the Trust has completed actions to address 34 of 88 'Must Take' Action areas for improvement (39%)*.

Group	Scope	Total Must Take	Embedded	Complete	In Progress	Off Track	Not Yet Started	Percentage Complete
Trustwide	Well Led	5	-	2	3	-	-	40%
Urgent and emergency care	Urgent and emergency care	36	-	10	25	1	-	28%
Medical care	Medical care	18	-	7	11	-	-	39%
Scheduled Care	Surgery	11	-	6	5	-	-	55%
Scheduled Care	End of life care	6	-	2	4	-	-	33%
Scheduled Care	Outpatients	2	-	2	-	-	-	100%
Scheduled Care	Critical Care	-	-	-	-	-	-	0%
Women & Children	Maternity	8	-	5	3	-	-	63%
Women & Children	Children and Young People care	2	-	-	2	-	-	0%
Total		**88**	**-**	**34**	**53**	**1**	**-**	**39%**

**Note: The CQC reports contain 94 actions, of which 6 were duplicated for End of Life Care across the two sites, thus progress is tracked against 88 unique actions.+*

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Agenda Item 6 –System Improvement Plan

Dave Evans
Louise Barnet

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System Improvement Plan

- System response to challenges
- Building on Covid response
- New contracting models
- Staffing support in key areas

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System Improvement Plan

- Phase 3 restoration
- ED Front Door
- Think 111 First
- Community/primary care offer
- Centralisation of services
- Transforming Maternity Services
- MSK Alliance

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Agenda Item 7 – Improvement Offer and Expected Impact

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ECIST

Getting to Good Programme

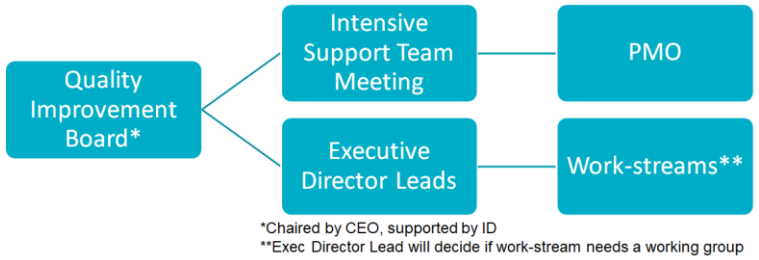
'Getting to Good' Programme Structure

The 'Getting to Good' Programme has 11 workstreams (purple) and 10 plan enablers (green):

'Getting to Good' Programme Governance

The Intensive Support Team (IST) has a series of leads who report into the Improvement Director. The IST leads work with the Executive Director leads to provide support, advice and guidance to achieve agreed milestones and outcomes.

Meetings will be held fortnightly to review the plan holistically, and escalate and risks or issues in a timely manner. The fortnightly Intensive Support Team meetings will report into the monthly Quality Improvement Board, chaired by the Chief Executive.



Planned Outcomes

- Improved outcomes, safety and experience for patients, families and staff.
- For the first year of the QIP, the main planned outcomes are the lifting of Section 31 breaches of regulation, meeting Section 29a requirements and improvement in the overall CQC rating from ‘inadequate’ to ‘requires improvement’.
- The ultimate aim is ‘getting to good by 2022/23’.
- A QIP dashboard will be developed with key outcome measures for each work-stream that will be monitored against agreed trajectories on a monthly basis by the Quality Improvement Board.
- Achievement of agreed milestones will also be monitored at the Quality Improvement Board.
- The Quality Improvement Board slide pack will form the basis for regional and national oversight groups.

The Shrewsbury and Telford Hospital NHS Trust

Agenda Item 8 – Culture – Key Actions

Louise Barnett

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New Vision and Values

- We have agreed our new vision and values for the Trust. The values we live by and the way we behave help define who we are. This is true in both our personal and professional lives.
- They provide a roadmap for us to deliver our vision - '*to provide excellent care for the communities we serve'* and help ensure that through our values, we are**:**
  - **P**artnering – working effectively together with patients, families, colleagues, the local health and care system, universities and other stakeholders and through our improvement alliance
  - **A**mbitious – setting and achieving high standards for ourselves personally and for the care we deliver, both today and in the future. Embracing innovation to continuously improve the quality and sustainability of our services
  - **C**aring – showing compassion, respect and empathy for our patients, families and each other, caring about the difference we make for our community
  - **T**rusted – open, transparent and reliable, continuously learning, doing our best to consistently deliver excellent care for our communities

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New Vision and Values

- Our ‘PACT’ is our shared commitment to embrace and live these Values. It is important that we all embrace these through our behaviours and I want your help to define these supporting behaviours so that they are meaningful both to you as individuals, and in your teams.

- We are hosting a number of focus groups to get your views and ideas on how we can best go about engaging as many staff as possible in shaping our behaviour framework, and to find out your initial thoughts on what these behaviours should be.

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Improving SaTH Culture

It is recognised that successful culture change is a work of years rather than months and some key areas of improvement focus are shown below. The People Strategy has a 3-year programme of work to improve performance. Significant changes as a result of Covid-19 are driving new ways of working, interacting with and valuing staff.

Leadership	Measures/Risk
• Investment in key Executive Director posts • Board Development programme • Tailored OD programmes for ED and W&C • Review of Leadership Devt - Medical Leadership and Leadership and Mgmt Devt programmes (eg: the Engaging Manager programme) • Comprehensive coaching offer and Think On coaching to support solution focused coaching - lnk in with improving Safety Culture and Service Improvement • NHSI/E culture assessment & programme to start 20/21	Staff Survey Line mgr score Visibility of leaders Key Risk to delivery is CV-19 wave 2. Mitigation is integration of online, digital and remote solutions

Enablers – Accountability & Decision Making	Measures/Risk
• Review of senior mgr structure and meetings to simplify decision making and increase visibility • Establishment of Innovation & Investment Committee for transparent decision making • Redesigned Risk Management process and training for greater accountability and improved decision making • Great working across system and STP working on systems issues and problems (eg Covid) • Values work integrated in objectives and appraisals for all staff	Staff Survey Pulse Scores (FFT) Appraisal quality Trust improvement plan quality Key Risk to delivery is CV-19. Mitigation is integration into all aspects of daily work

Communications and Consultation	Measures/Risk
• Director-led Listening Into Action programme • Values Vision and Mission – engagement and consultation led by CEO and Directors • Development of underpinning behavioural framework • Introduction of improved communications and monthly cascade process down and up across whole organisation – increased leader visibility • Proactive and honest communications programme from CEO and EDs esp. on areas of high sensitivity • Strong Covid comms well received by staff – daily Med Dir. briefing, Workforce Dir., SaTH Heroes etc	No of people engaged in Values and Vision work Staff Survey Pulse surveys Key Risk to delivery is failure to sustain comms focus Mitigation is integration into all aspects of daily work

Engagement and Support	Measures/Risk
• Comprehensive support programmes for staff for psychological and wellbeing • 3 staff networks set up for BAME, LGBTQ+, and Disabled colleagues • Introduction of Values Cards – over 1,00- sent in first few weeks • Strengthening of FTSUG function • Secondment to focus on recognition and reward • Coaching and team support offers • Commitment to improvement of work/home/life balance, flexible working etc	Staff Survey engagement & E&D scores, BAME risk assessment level WRES and WDES responses Key Risk to delivery is CV-19. Mitigation is OD, FTSUG and EDI teams strengthening

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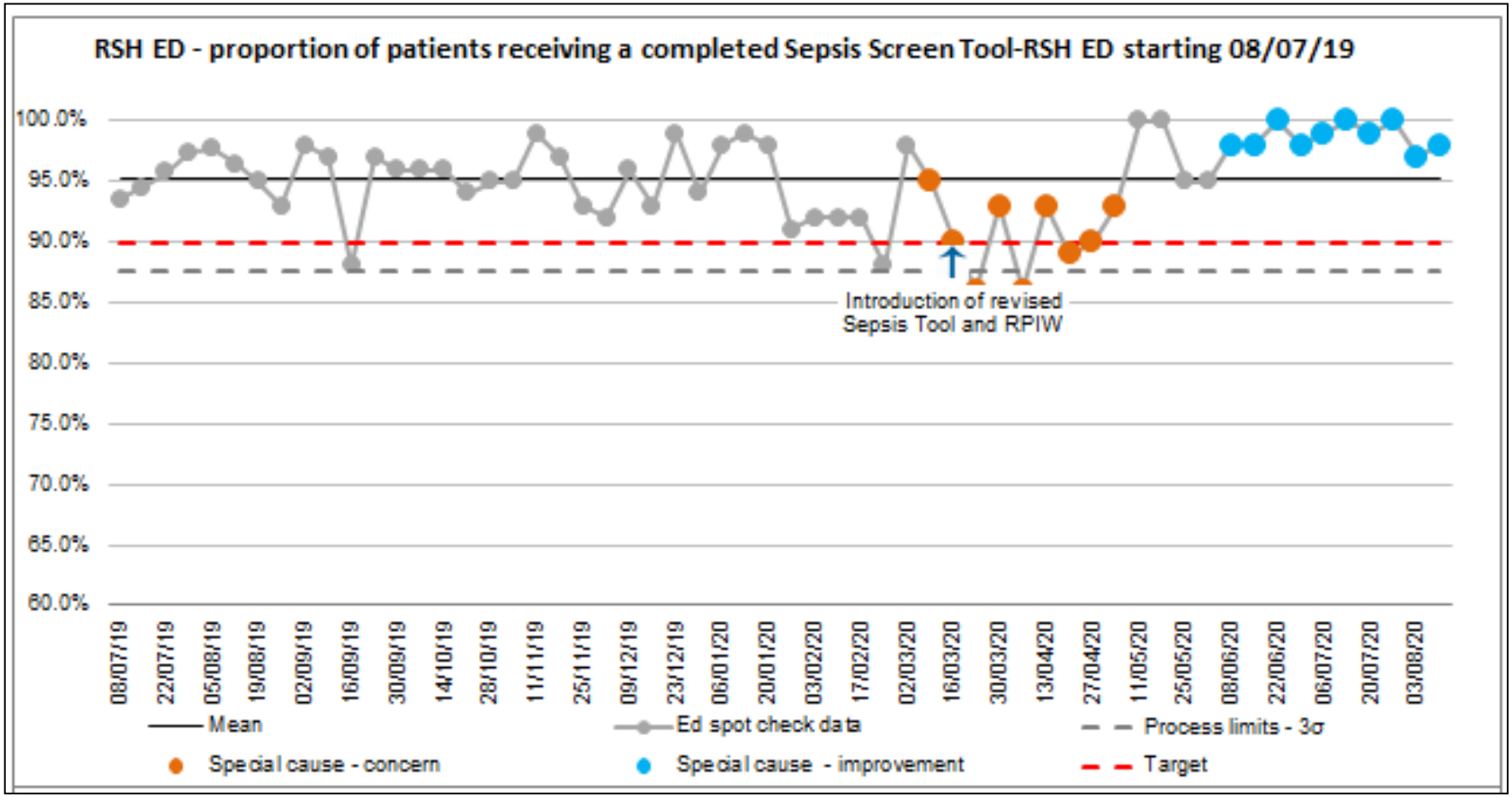
Agenda Item 9 – Metrics and Assurance

RSH – Sepsis Tool Completed on Admission
(Data updated to include week 10th August – 16th August 2020)



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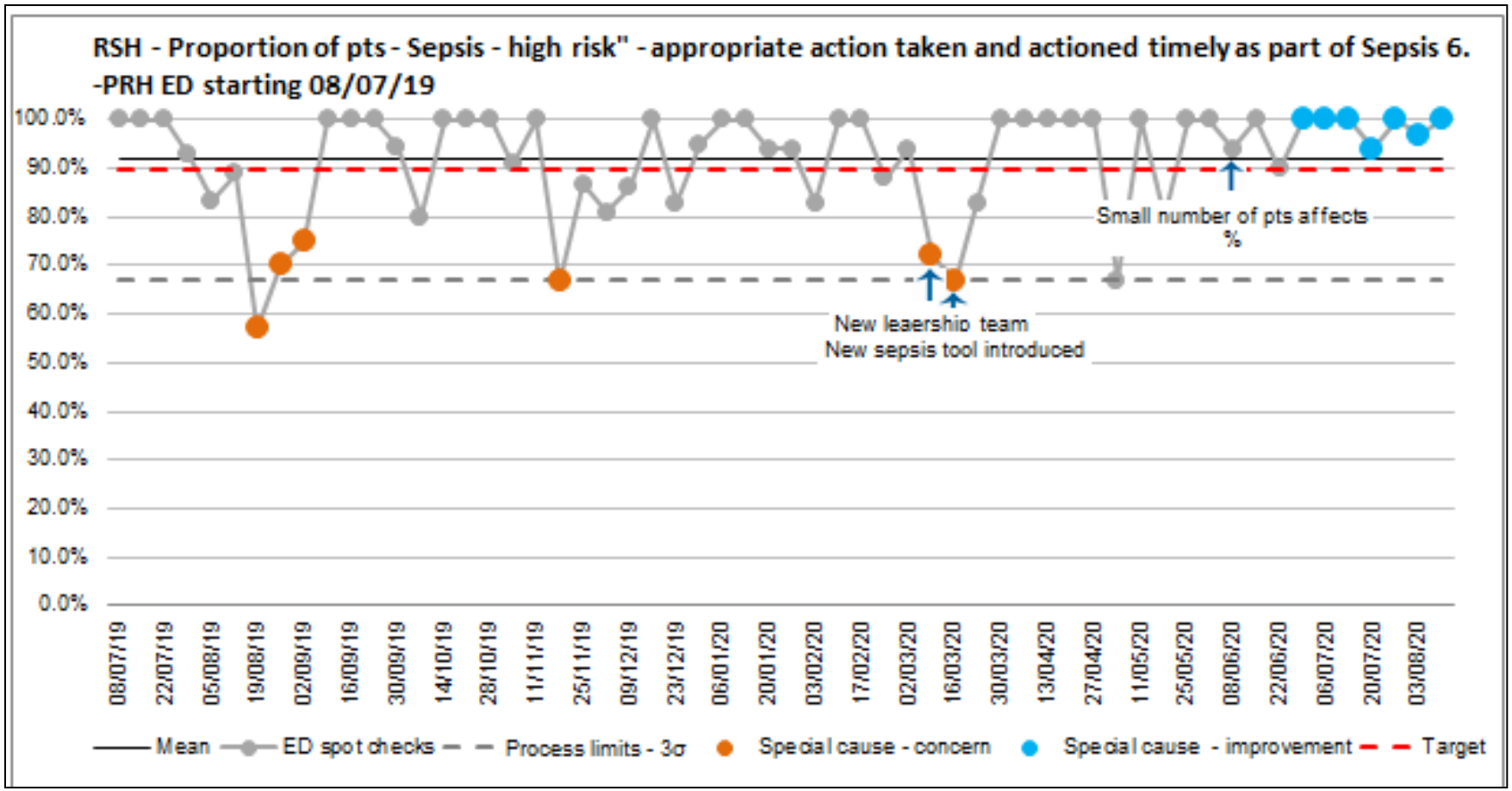
RSH– High Risk – action taken as part of sepsis 6

(Data updated to include week 10th August – 16th August 2020)



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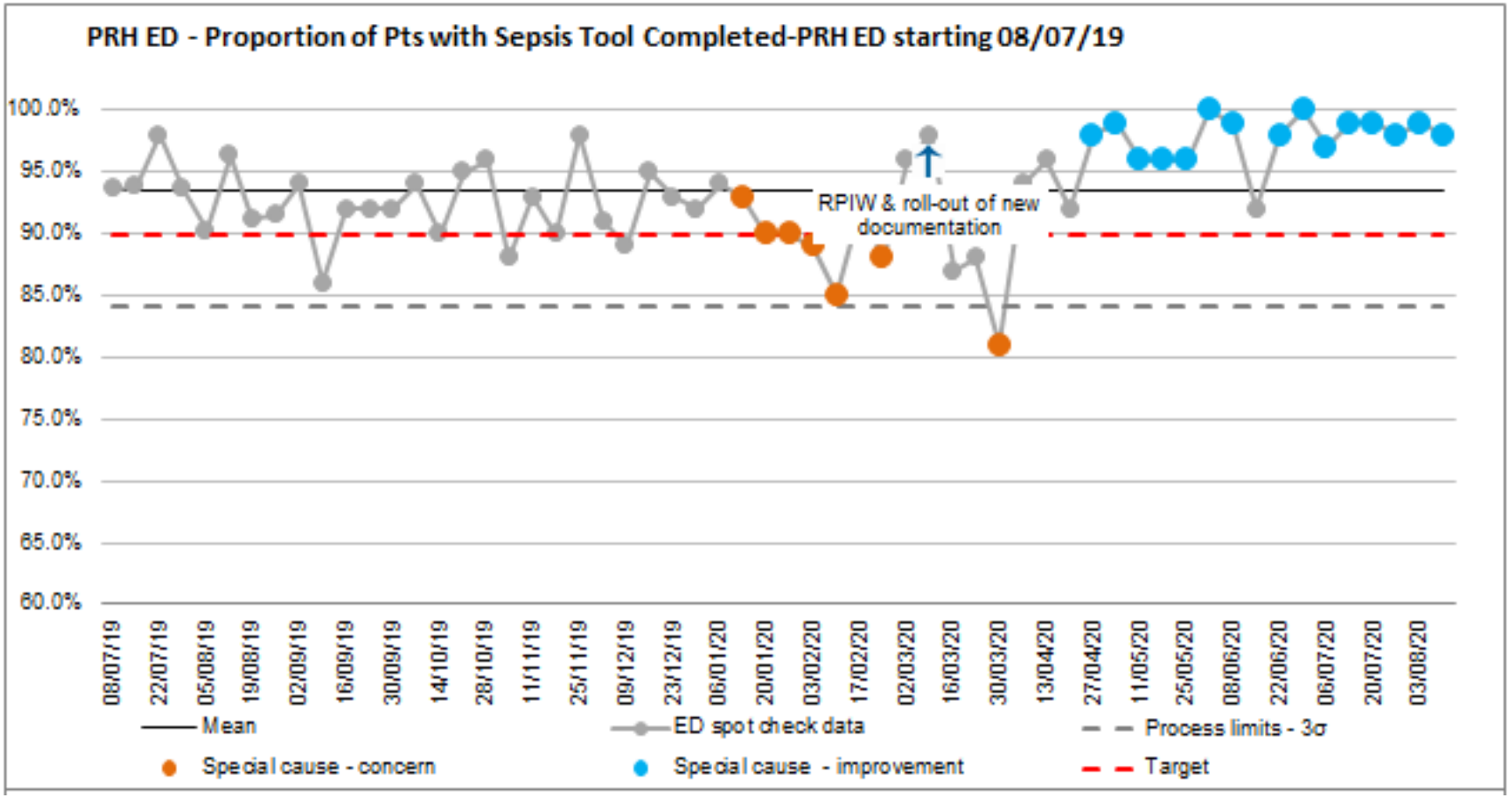
PRH Emergency Department – Sepsis Tool Completed on Admission (Data updated to include week 10th August – 16th August 2020)



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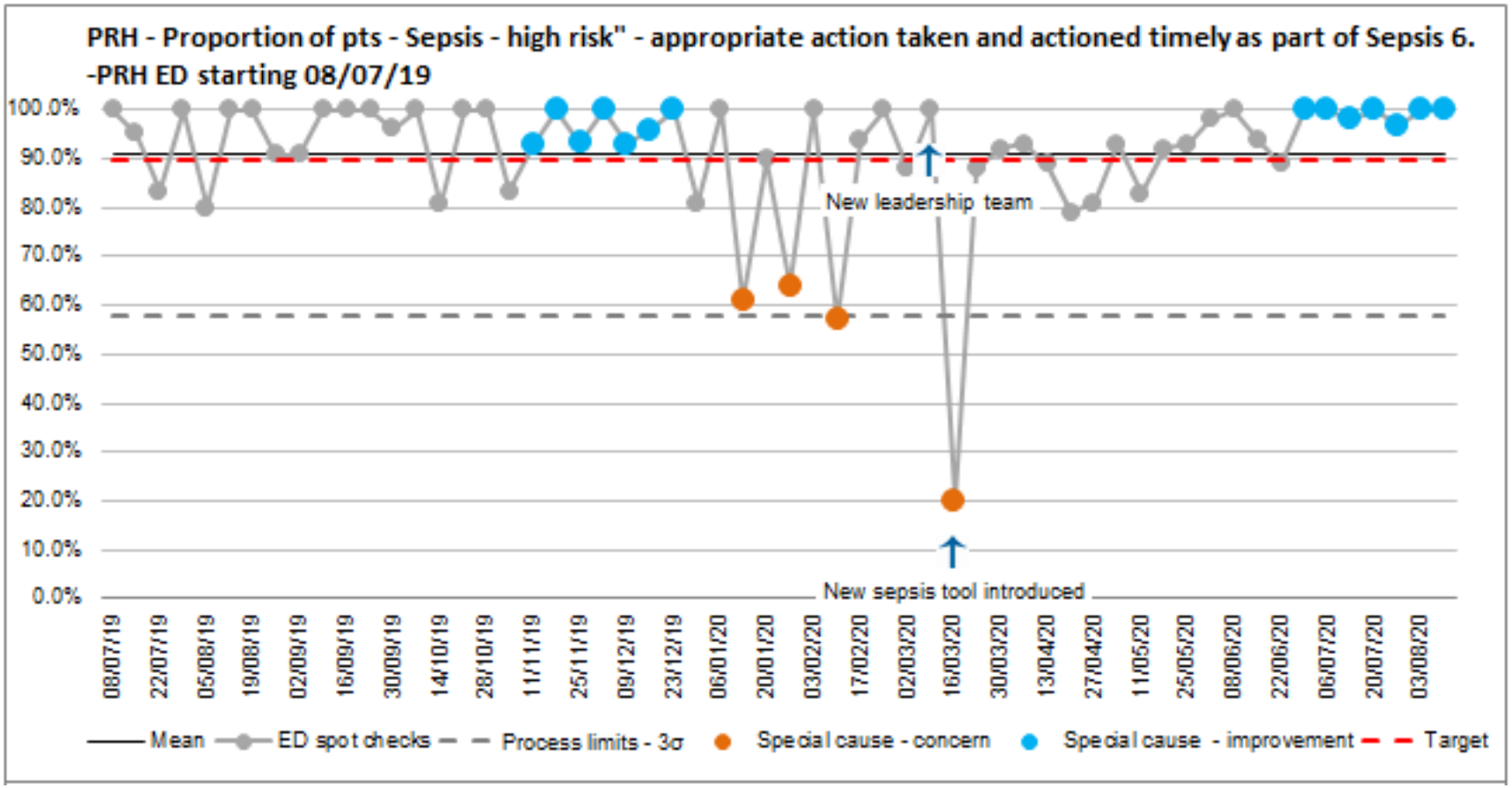
The Shrewsbury and Telford Hospital
NHS Trust

PRH – High Risk – action taken as part of sepsis 6
(Data updated to include week 10th August – 16th August 2020)



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Emergency Department: High Risk – action taken as part of sepsis 6

The results from the ongoing screening audit compliance show:

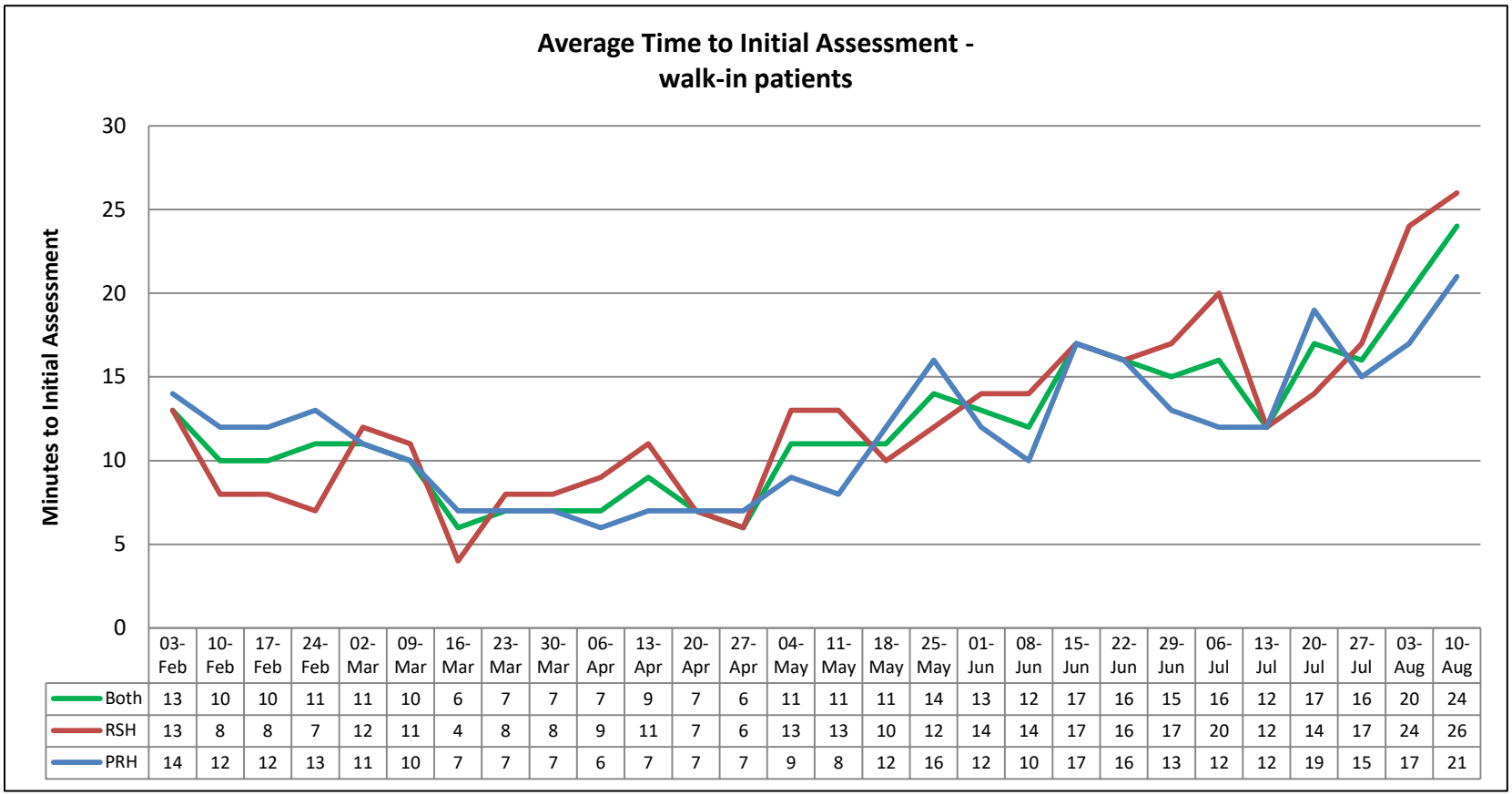
- Sustained improvement with sepsis screening 95% throughout July 2020 particularly at RSH site
- Sustained improvement with timely treatment

Actions taken to improve compliance and embed these improvements across the 2 ED Departments:

- Embedding of the 2 hourly safety huddles at patient bed side to ensure timely addressing of any issues.
- Quality walks by the Senior Nursing staff in ED continue to take place to address compliance.
- Ongoing teaching commenced.

ED Initial Assessment (Adults)

(Data updated to include week 10th August- 16th August 2020)



	03-Feb	10-Feb	17-Feb	24-Feb	02-Mar	09-Mar	16-Mar	23-Mar	30-Mar	06-Apr	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun	22-Jun	29-Jun	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug
Both	13	10	10	11	11	10	6	7	7	7	9	7	6	11	11	11	14	13	12	17	16	15	16	12	17	16	20	24
RSH	13	8	8	7	12	11	4	8	8	9	11	7	6	13	13	10	12	14	14	17	16	17	20	12	14	17	24	26
PRH	14	12	12	13	11	10	7	7	7	6	7	7	7	9	8	12	16	12	10	17	16	13	12	12	19	15	17	21

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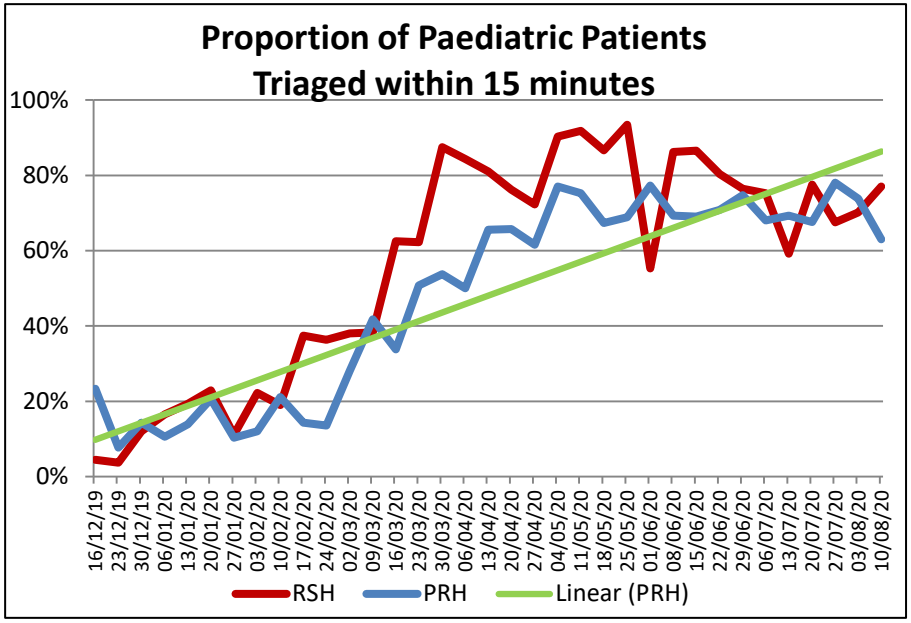
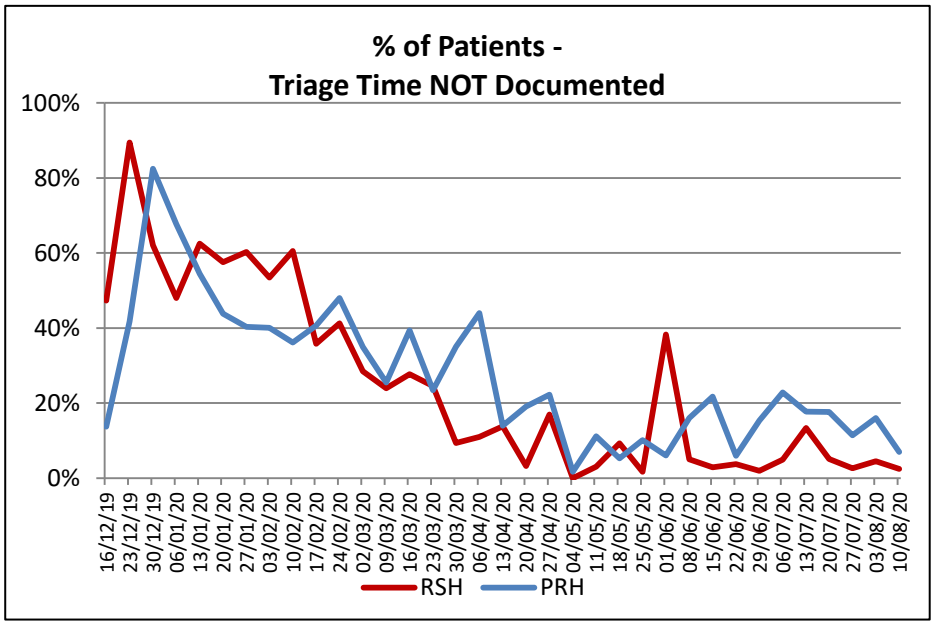
Paediatric Triage

(Data updated to include week 9th August – 16th August 2020)

Triage within 15 minutes



Recording of Triage Time Documented



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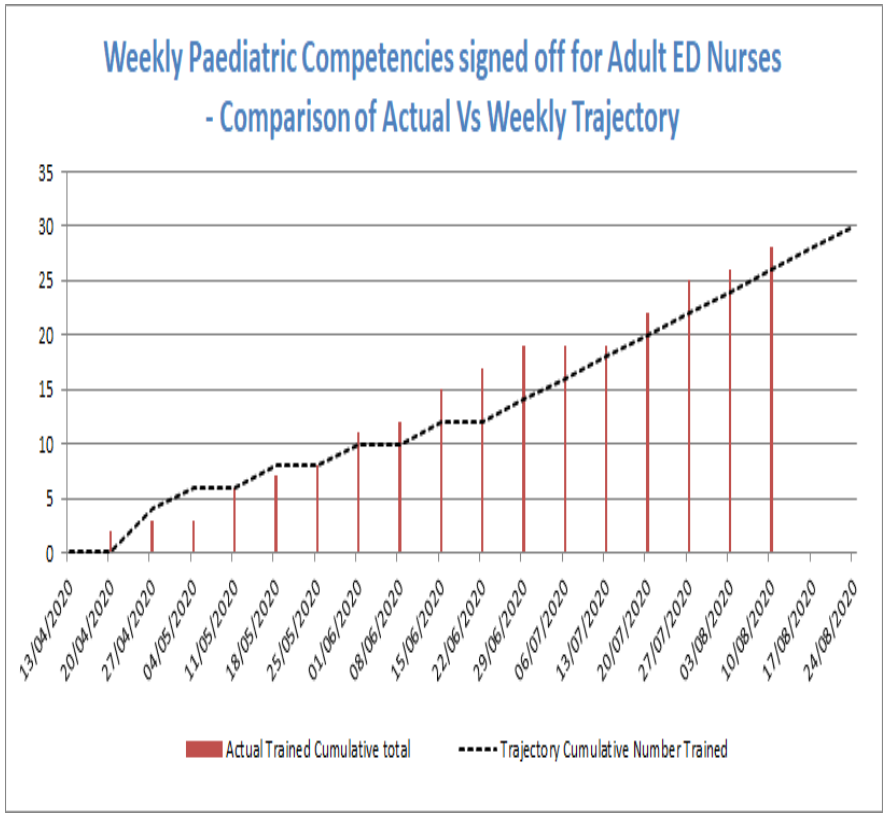
Paediatric Staffing in the Emergency Departments

Paediatric Staffing Plans include aiming to have 2RSCNs and 1 Adult ED Nurse with EPLS Training on each shift , each day in each ED Department. As a minimum there should be 1RSCN and 1EPLS nurse on each shift.



Review of the Paeds Staffing for July 2020:

- 96% of shifts across the 2 Emergency Departments had a minimum of 1RSCN & 1 EPLS nurse (5 shifts were not covered)
- At RSH, 94% of shifts at RSH had a minimum of 1RSCN and 1 EPLS nurse on duty (4 shifts not covered).
- At PRH 98% of shifts had a minimum of 1RSCN and 1 EPLS nurse on duty (1 shift was not covered).

Adult ED Nurse Paediatric Competencies:

The completion of paediatric competencies and sign off for Adult Paediatric Nurses in the ED is above trajectory with 28 nurses signed off against a trajectory of 24 (as of 10th August 2020).

The Target of 30 nurses was achieved on 20th August 2020.

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Matron feedback – Assurance Audits

Commissioner Quality Assurance

Zena Young
Executive Director of Quality
STW CCG's

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NHS Shropshire Clinical Commissioning Group

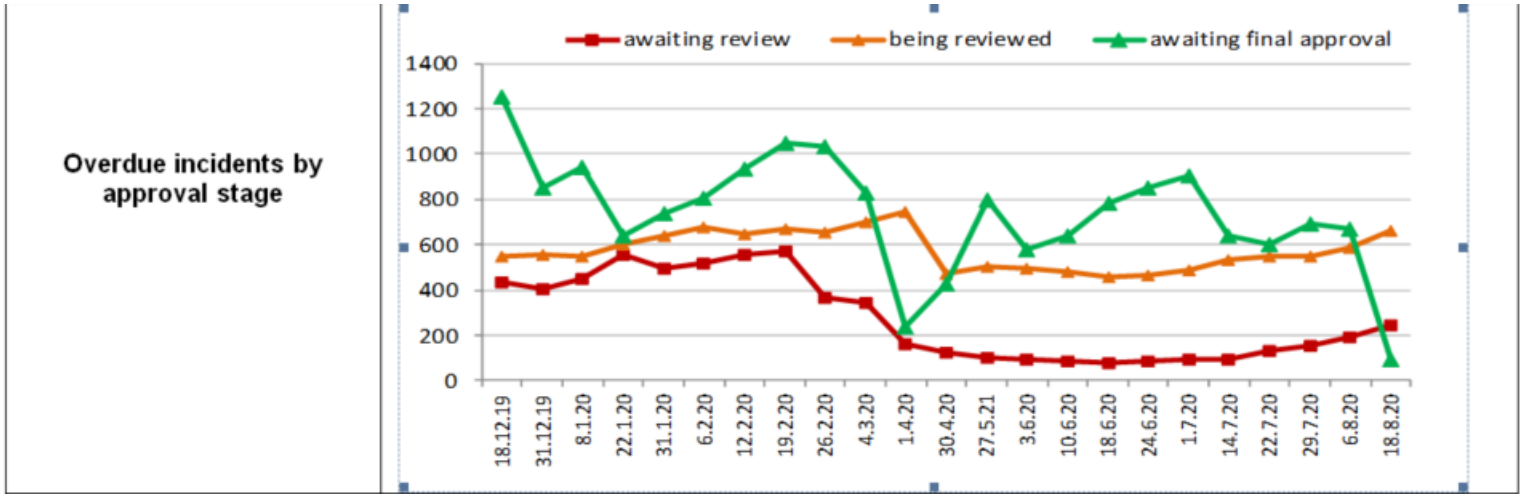
NHS Telford and Wrekin Clinical Commissioning Group

QA and oversight mechanisms

- Monthly main CQRM and dedicated Maternity CQRM.
- CCG attend: IPG, Safeguarding, Mortality committees.
- Receive some papers from other internal assurance fora.
- LMNS Programme Board – relaunch of work streams August 2020.
- Fortnightly Joint Assurance call inc NHSEI – ED focus.
- Monthly Serious Incident Review Group (SIRG).
- Joint exemplar visits with trust.
- CCG independent quality assurance visits.

Key progress area:

- SI's – process & number overdue. Collaborative approach: co-produced process: achieving better quality RCA's; reducing overdue and open SI's.



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Themes from ward QA visits

- Variable progress between wards.
- Documentation changes underway – iterative changes, training plan to support change.
- Generally improved recording of fundamentals of care assessments, eg Falls/Bed rails/TV/Nutrition - however not consistent.
- MCA/ DoLs / BIA – generally improved, but not yet fully / consistently observed.
- Worry wards remain – leadership & support are key.

Workforce

Rhia Boyode
Workforce Director

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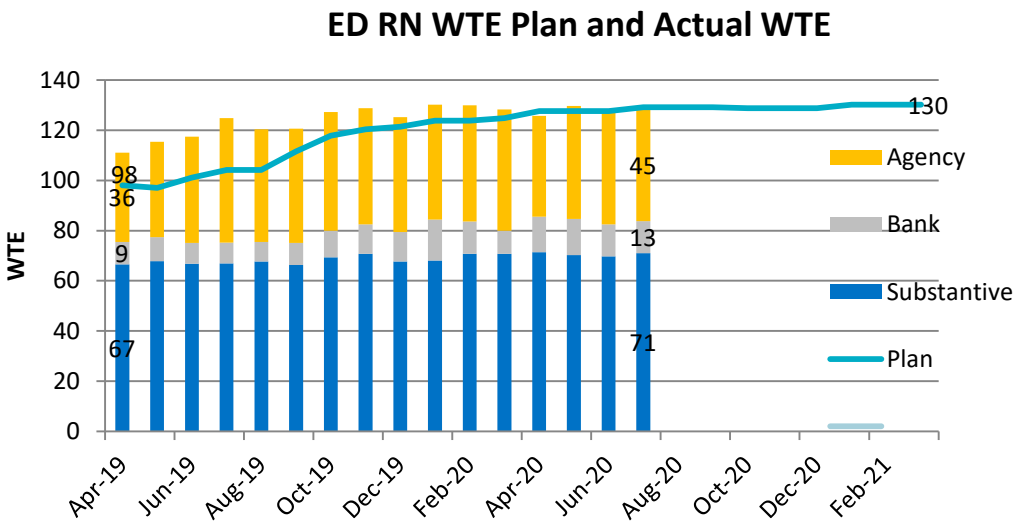
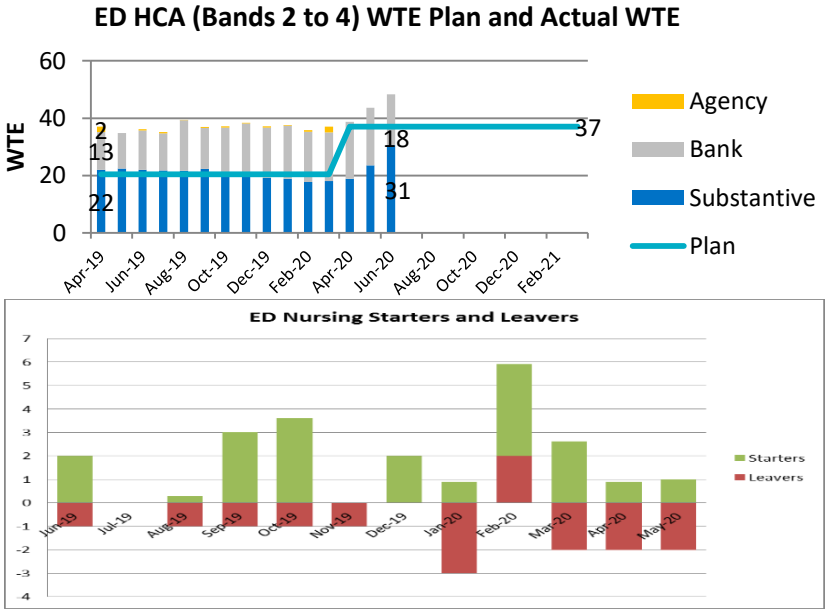
Emergency Department Nursing





Role	Risk/Current Situation	Mitigation	Retention
Band 5	33 are for ED (15FTE for PRH and 18 FTE for RSH). 17 nurses recruited (including newly qualified) and will be commencing between June through to end of 2020/21.	• OSCE Ready Nurse cohort 2 – due to arrive and sit OSCE in October (delay due to limitations around available OSCE slots) Total for ED 14. • HEE Nurses yet to book start date – will likely book onto 15th October cohort as long as checks are complete(will have 2 months OSCE training with overseas team before sitting OSCE and gaining PIN) Total for ED 9 • Total nurses still to arrive - OSCE Ready –for ED Nurses (11 A&E PRH / 9 A&E RSH) • Recruitment for ED Paediatric Nurses underway. • Paediatric rotation to be implemented in ED to help ensure that all clinical areas are adequately staffed in line with national guidelines. • Minimum Paediatric Nurse cover in accordance with national guidance was achieved for all shifts at RSH and PRH in June 20, and no harm or incidents were recorded	• Band 7 staff have completed 360 self assessment and will have PDP in place. • Developing our on boarding service for overseas nurses and revisiting the exit interviews process. Development s will be communicated on a regular basis, including via a monthly On boarding newsletter to all staff.
Band 6	Additional sister /charge nurse recruited and to commence 9 August.	Continued UK recruitment supported by SaTH recruitment and retention strategy.	
Band 7	Currently 11 in post (2	Implementation of ED cultural and leadership development programme to support	

Summary Emergency Department - Workforce Dashboard

Table 1 Statutory Compliance Report

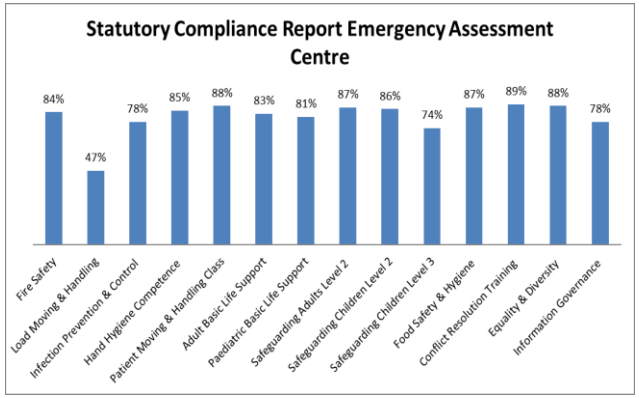


Table 2 Overall % Compliance

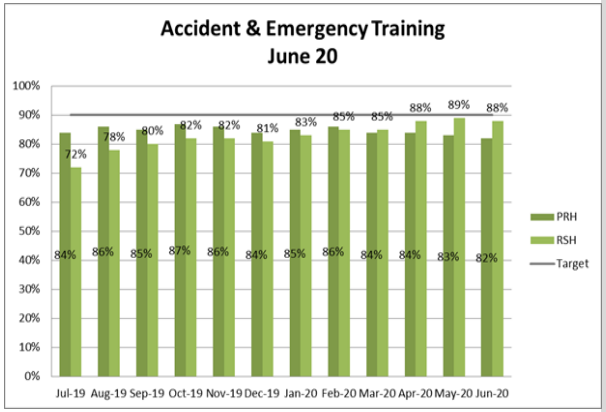


Table 3 Paediatric Competency Trajectory

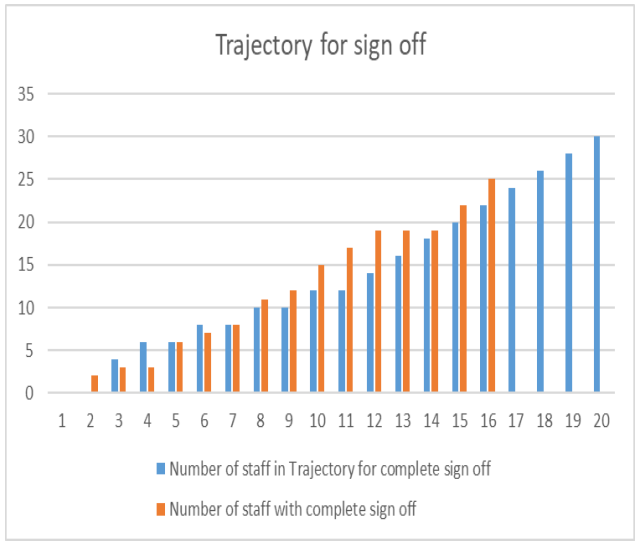


Table 4 Appraisal % by site

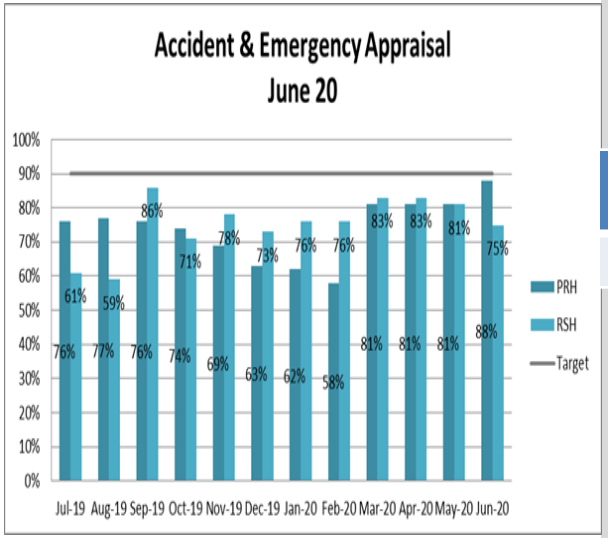


Table 1 SSU – Overall Training 82%

Table 2 The overall accident and emergency 82% is - showing an increase

Statistics	A&E PRH	A&E RSH
Training	82%	88%

Monthly collaborative meetings are taking place to ensure the Statutory Compliance data is an accurate reflection of what training has taken place within the department.

Education team have been working through this to align the centrally and locally held data, It is envisaged that July data will reflect this. Reporting of this data is around the 8th and 10th of every month.

Table 3
Paediatric Competency Trajectory
The number of staff who have been fully signed off for all their paediatric competencies is 25 which is above the planned trajectory of 22 by w/c 27/07/20.

Table 4 Appraisal by site - Overall % for ED is 85%

Statistics	A&E PRH	A&E RSH
Appraisal	88%	75%

Appraisal triangulation and trajectories are being undertaken within the Care Group.

HCA with an overall figure of 93%
Nursing with an overall figure of 76%
Medical and Dental at 78%

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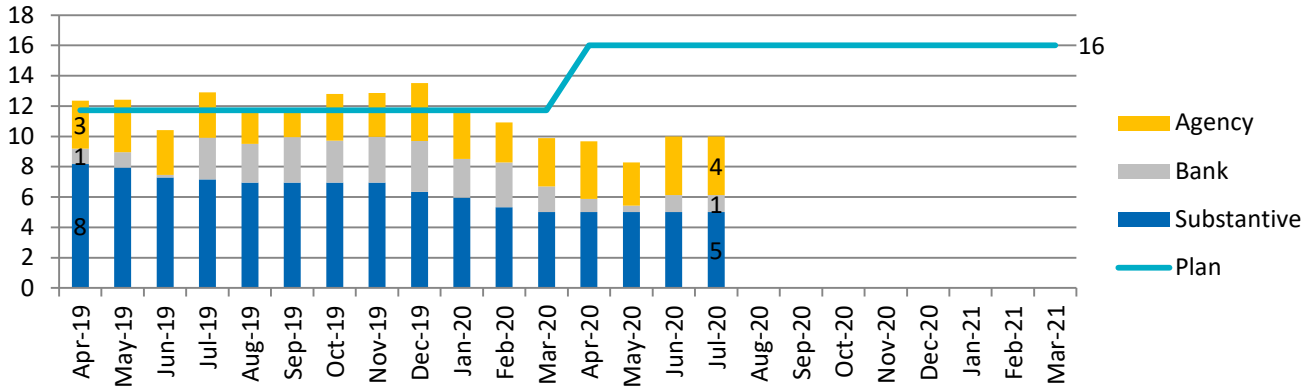
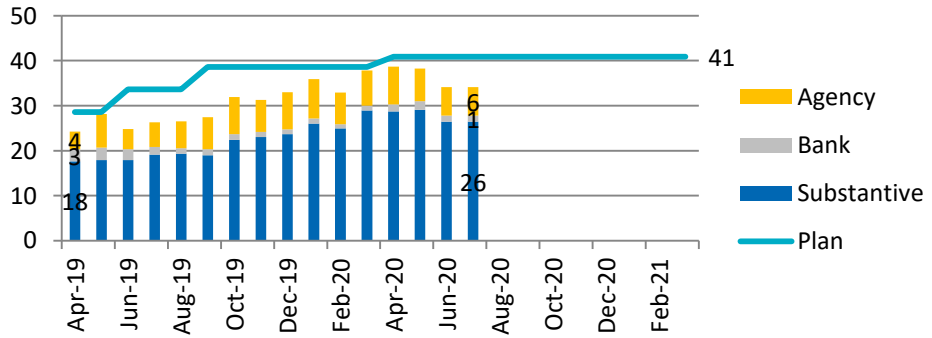
Emergency Department Medical Teams

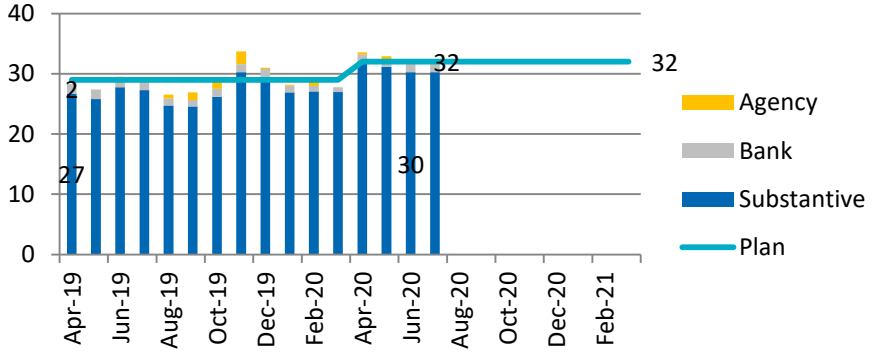
ED Consultants WTE



ED Middle Grades WTE



ED Junior Grades WTE



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ED Doctors

Role	Budget	In -post	Update
Consultant	16wte	5 WTE (Long Term NHS/Agency Locums = 5)	• Pending New Starters • 1x substantive Consultant appointed and due to commence September • 1x Consultant seconded for 12 months, due to commence September 2020 • 1x Substantive offered and accepted but will not start until September 2021 • 1x offered Locum Consultant post but in discussions about job plan & annualised contract – Interest in Education but currently lives outside of UK • 1 x offered Locum Consultant post, due to start October 2020 • Agreed regional rates for additional hours worked for internal locums delayed until 1st September 2020 due to number of gaps left vacant. This will be a further risk from September onwards
Specialty Doctors /SAS/MG	41wte	26WTE ((Long Term NHS/Agency Locums = 8)	• Recruited 14 International Doctors (in post) 5 on rota during day or supported at night. • 17 MG able to work independently. • Additional 7 doctors delayed due to COVID 19. • Newly recruited doctors require a minimum of 6 months support before working on rota. • 3x doctors have resigned due to being successful obtaining a place on GPVTS Training. All due to leave end of July. No reflection on Trust– ED Consultants commended re training given in short time to enable them to be eligible to apply • Agreed regional rates for additional shifts worked for internal Drs to commence 1st August 2020.
ED Doctor (SHO Level)	33wte	31WTE	• From August 2020 both sites will have 16 Drs. • Following Jnr Dr Refresh in October 2019 requiring Drs to work 1 in 3 weekends rather 1 in 2, Guardian of Safe working Agreement for 12 months for ED Drs to continue to work 1 in 2 expires, October 2020. Additional 5 Drs required per site to ensure same number of Drs working per weekend post Guardian of safe working agreement • Agreed regional rates for additional shifts worked to commence 1st August 2020

Summary ED People Plan

A initial programme has been developed to enable the Care Group to meet both its current and future opportunities and challenges. The Care Group recognised that a number of tools and frameworks could help development its staff – prior to any Trust or National Programmes being undertaken. This was to ensure that staff within ED realise their potential, feel recognised, valued and listened to and trusted. Ultimately, it supports our teams to deliver the safest and kindest care. The plan is to build a consistent future state and a journey of excellence.

Actions to date and ongoing

- Ongoing of analysis of 2 years worth of data being pulled to understand the journey in order to tell the story. Levers and Starters information now being gathered.
- Well being sessions, Team Huddles ongoing and champions still being progressed. Clinical lead to start from September.
- Band 7 staff have completed 360 self assessment and 1:1 meetings have been planned in with Betty Lodge to take this forward – with PDP plans and the potential to undertake a full 360 assessment – depending on each individual.
- Ongoing work to triangulate all Mandatory and Statutory Training and Appraisals with Care Group and Corporate colleagues to ensure accuracy of data – Validation and triangulation processes underway. Movement being seen in % against Target.
- Fortnightly ED SLT meetings to keep the momentum and the plan live
- All Mandatory and Statutory training to be completed and planned

Actions to take forward

- Alternative Metrics being formulated to capture getting to good – August / September
- Behaviour Framework work with ED Teams following trust session on values and behaviours - what we Expect to see/Don't want to ref behaviours – August / September
- Launch and embed the values work once shared.
- Good communication plan to work with Communications team – a plan ED recognise and engage with – including who's who in ED.
- Hold Staff focus groups led by leadership team
  - Share vision and behaviours as above
  - Lessons learnt sessions
  - Wellbeing Workshops
  - Staff Survey Workshops

Summary – Trust Workforce Risk Areas

There following specialties and departments are particularly fragile as there are vacancies and recruitment challenges which contribute to capacity and performance shortfalls.

Specialty / Department	Mitigation
Anaesthetics and Critical Care –There is insufficient Consultant cover at PRH impacting the ability to maintain an out of hours department which could impact both planned and unplanned services.	• Rolling adverts. 1 applicant shortlisted for ITU post. • Recruited to 1 ITU Locum post, delayed coming to the UK due to COVID. • Specialty Doctor appointed, to become ITU NHS Locum Consultant • Appointed to a Paediatric Anaesthetic Consultant • Exploring joint posts with RJAH.
SDEC - Insufficient Consultant capacity in Acute Medicine which is required to manage the increased numbers of patients.	• Development of business case which will review demand and capacity and determine workforce requirements. • Discussion with candidates
Urology - There is insufficient Consultant capacity to meet demand.	• Mitigating the impact with an Agency Locum and two NHS Locums • Advertising for a Locum Consultant. To follow with advert for permanent post. Advert revised with detail on new laser technology. • Collaboration with UHNM for cancer work. • Exploring further networks for benign services. • On the list of urgent services reviews
Respiratory - With increased demand there is not enough capacity in the medical workforce. Demand expected to rise due to COVID / winter	• Development of business case which will review demand and capacity and determine workforce requirements
Ophthalmology – Shortages of key clinical staff has made the provision of this service difficult .	• Business case to be written • Vacant posts to be advertised • New CD in post • On the list for team facilitation / transformation of services
Oral Surgery and Max Facs – Hard to fill post made more difficult due to the dual qualification required.	• Appointed to vacant Max Facs (non cancer) post • Post for Max Facs cancer to be advertised • Exploring collaboration with UHNM

Summary of other workforce risks

- We have highlighted the most fragile areas in the Trust for vacancies and recruitment challenges above. Other areas that we concerned about and working closely with to mitigate impact on services in the future are; Pathology, Radiology and Inpatient Therapies. In light of the demand on diagnostics from the restore and recovery process we are reviewing our medical workforce, specifically the support required for the Community Diagnostic Hubs.
- Our **Pathology** department have been successful in developing new roles such as a Clinical Scientist for Microbiology to mitigate the against the national shortage of Microbiologist as well a recruiting from abroad . As a result our new Specialist Microbiologist commences with the Trust on the 1st September.
- In **Radiology** we currently have 2 x Interventional Radiologist vacancies, however aware of some potential retiree's coming up so this number may increase. This is a national shortage occupation, and unfortunately a recent recruit chose to commence with another Trust due to family reasons. One of the difficulties was that we had a vacant post for the CD for Radiology which is now filled. This does aid with the attraction and recruitment to Radiologist post. We are working with an agency to support us with this recruitment into these hard to fill posts. In Radiology we have also developed new roles such as reporting radiographers, consultant radiographers and ACP's for Breast screening that mitigates the workforce shortfall in Radiology.
- In **Therapies Inpatient**, specifically Physios and Occupational Therapies roles, we have seen as increase in vacancy rates. During COVID we moved the Outpatient Team to support with the Inpatient Services. Furthermore we have been doing well with recruiting through open days and attracting students to commence with the Trust, this does still leaves a gap and we are working with the team to develop an apprenticeship pathway.

UTC

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Covid-19 A&E Business Continuity Plan: MIU/UTC Merger Position Update

- Weekly SaTH Task & Finish Group to review the service to date and gather clinical feedback to inform future planning in place from 10th June which reports into the Trust Wide Restoration Capacity & Locations Meeting
- Weekly system wide MIU/UTC Task & Finish Group in place from 17th June. This group will be responsible for making recommendations to system leads regarding next steps for the service – paper to be submitted with options to system gold early September
- Engagement exercise with both teams (virtual) to capture experience, learning & other feedback completed and fed back to provider
- Both Whitchurch and Bridgnorth continue to provide Specialty Doctor or Consultant cover Monday – Friday 9am – 5pm
- GP/UCP weekend and bank holiday provision at ED RSH resumed on the 4th July and is now in place every Saturday & Sunday 9am – 9pm to address rise in minors activity on the RSH site
- SaTH ENP/ECP workforce now fully integrated back on site at RSH And PRH
- Radiology workforce is limited with reduced hours associated with the repatriation of trauma from 23rd August (9-5).
- New permanent Head of Nursing appointed August 2020 and over seeing governance concerns and issues as addressed from regular contact with UTC – none identified to date

Quality Indicators:

Indicator	July
Total number of patients seen	**439**
Patients seen, treated and discharged within 4 hours	**100%**
Patients assessed/ triaged within 15 minutes of arrival	**100%**
Children left before being seen	**0**

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Recovery


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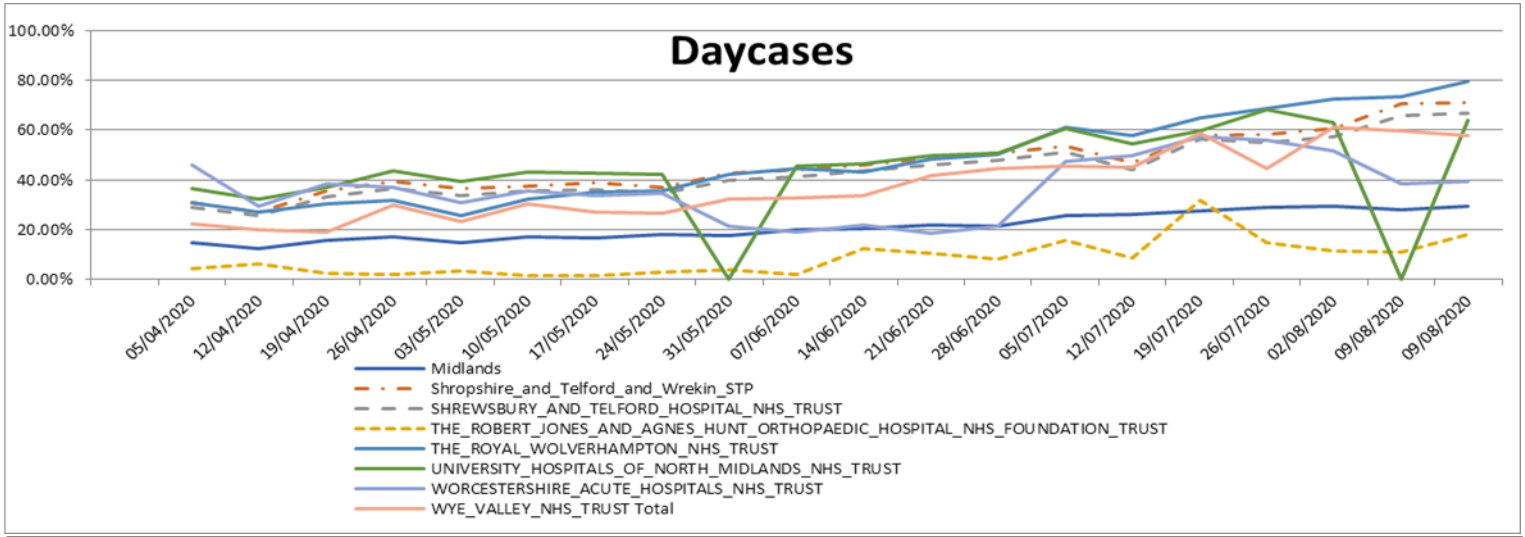
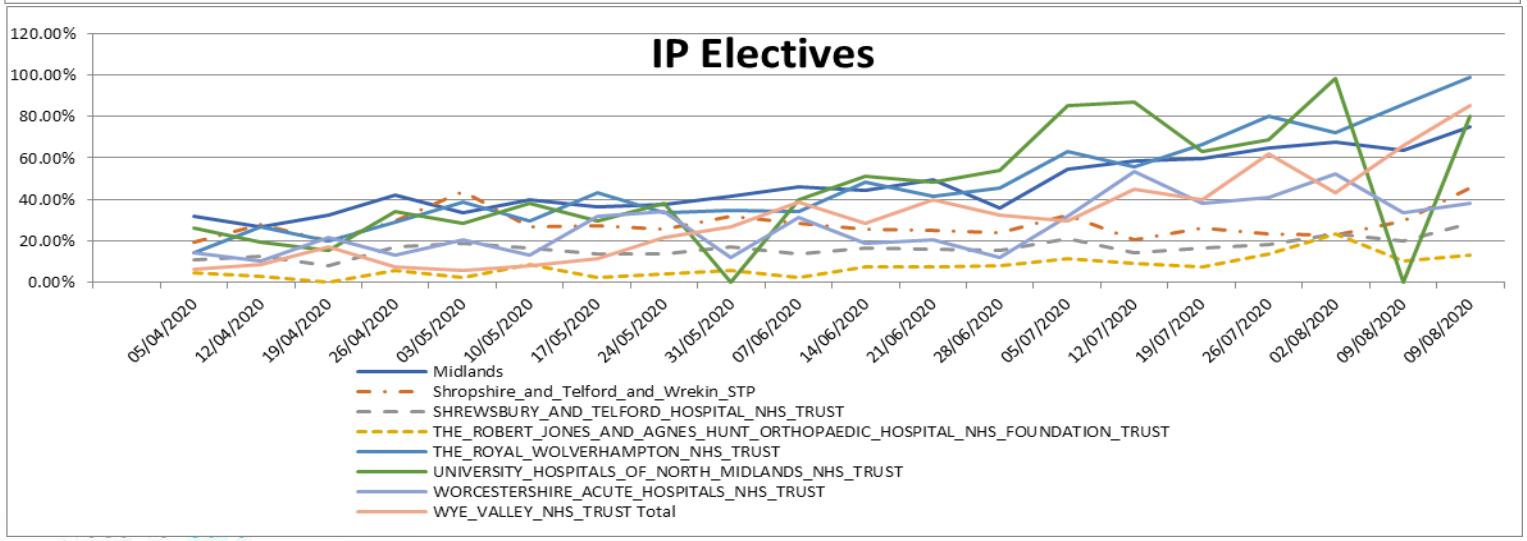
Elective IP/DC





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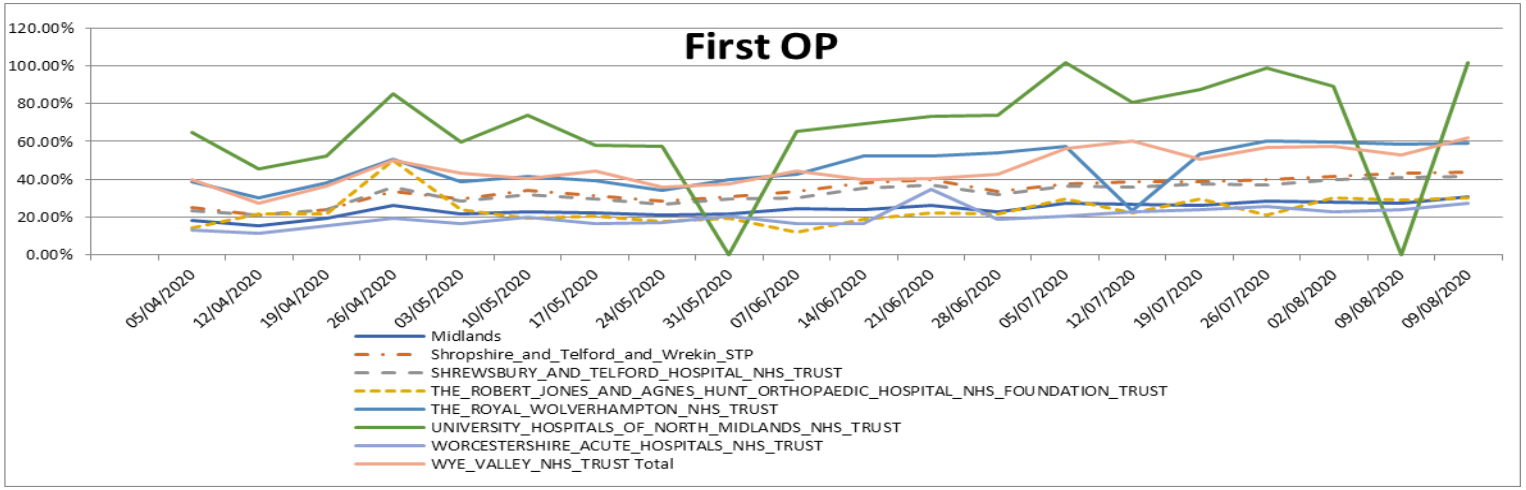
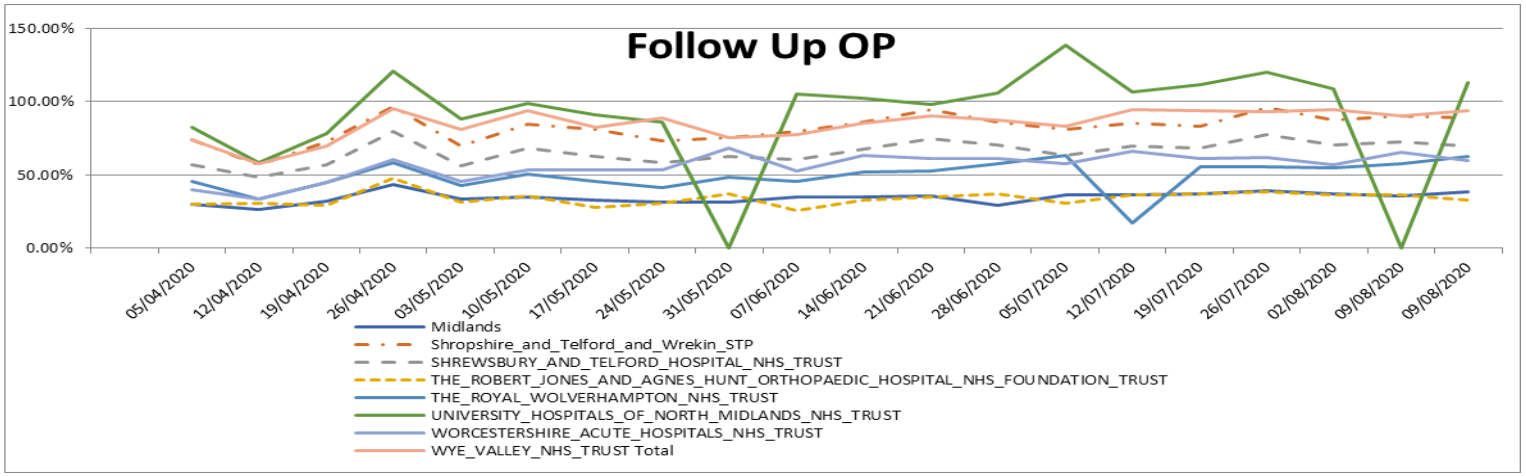
Outpatients





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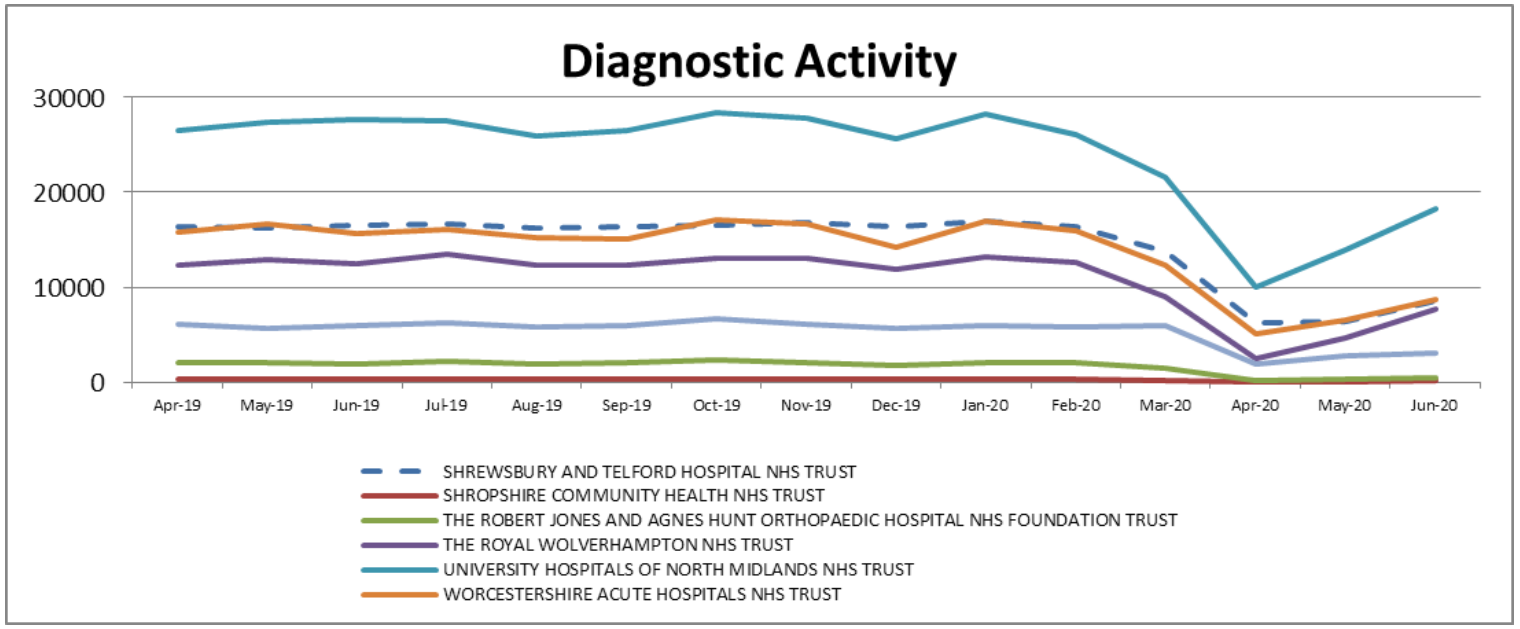
Diagnostics



Diagnostics % of June 19 Activity at June 20						
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	THE ROYAL WOLVERHAMPTON NHS TRUST	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	WYE VALLEY NHS TRUST
52.0%	35.7%	23.1%	61.9%	66.1%	55.0%	50.7%

Proud To Care
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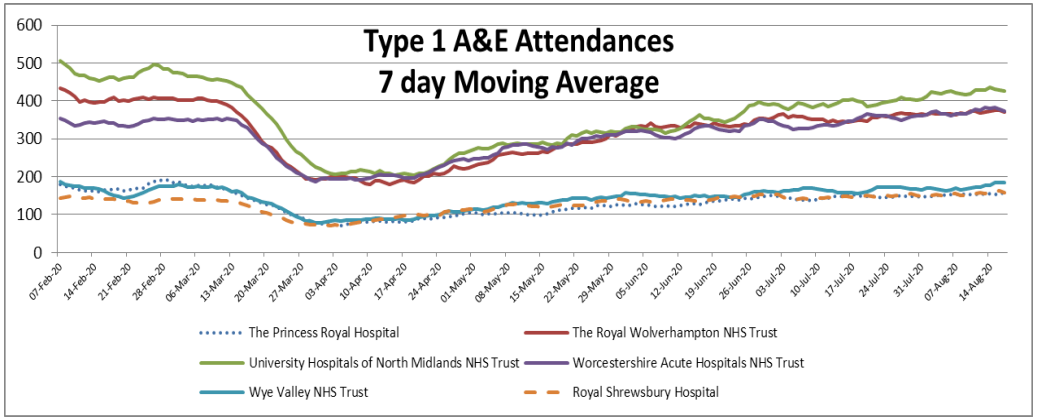
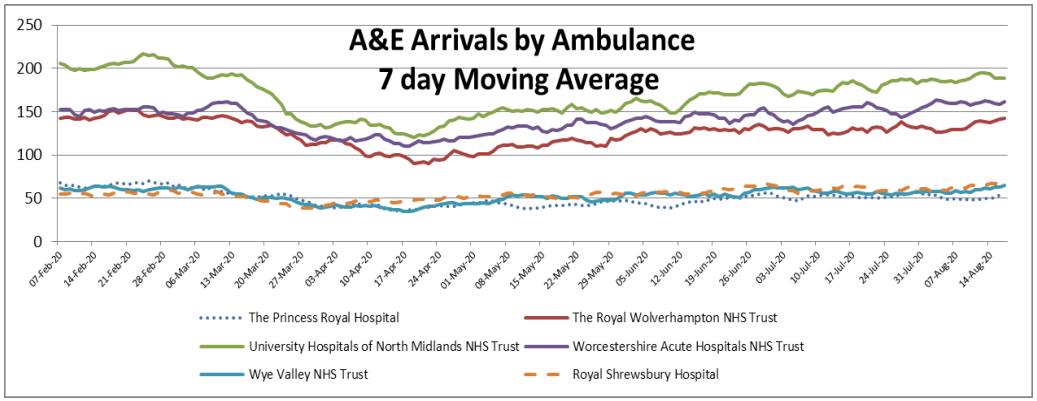
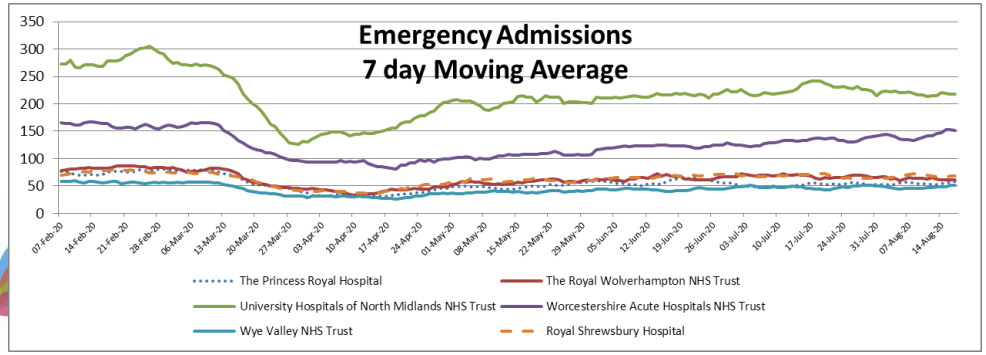
A&E Activity



	Daily Av Feb	Daily Av Jul	Change
Royal Shrewsbury Hospital	140	146	4.49%
The Princess Royal Hospital	174	145	-16.38%
The Royal Wolverhampton NHS Trust	407	358	-12.18%
University Hospitals of North Midlands N	476	397	-16.52%
Worcestershire Acute Hospitals NHS Trus	346	347	0.29%
Wye Valley NHS Trust	169	166	-1.73%



	Daily Av Feb	Daily Av Jul	Change
Royal Shrewsbury Hospital	56	60	7.26%
The Princess Royal Hospital	66	52	-21.49%
The Royal Wolverhampton NHS Trust	145	130	-9.91%
University Hospitals of North Midlands N	206	180	-12.59%
Worcestershire Acute Hospitals NHS Trus	151	150	-0.27%
Wye Valley NHS Trust	62	57	-7.76%



	Daily Av Feb	Daily Av Jul	Change
Royal Shrewsbury Hospital	75	68	-9.76%
The Princess Royal Hospital	75	52	-30.68%
The Royal Wolverhampton NHS Trust	82	68	-17.00%
University Hospitals of North Midlands N	279	227	-18.41%
Worcestershire Acute Hospitals NHS Trus	160	135	-15.87%
Wye Valley NHS Trust	57	48	-16.29%

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meeting in Common - held in public on 9th September 2020.**

Item Number:	Agenda Item:
GB-20-09.102	2020/21 Month 4 Financial Position

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

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):

- M1-4 budgets have been set by NHSEI and are based on 2019/20 Month 11 expenditure. We have not yet been given any allocations post Month 4 and therefore we have not been asked by NHSEI for a forecast position at this stage.

- We have recently been notified that budgets will be allocated in M5 and M6 in the same way as M1-4 and then a new financial framework will be released to cover M7-12. We await guidance from NHSEI on this.

- We have shared some initial Month 12 forecast workings with finance committee members and plan to review the emerging position at the first joint meeting on 23rd September 2020. The initial forecast was shared with significant caveats due to the current uncertainty around allocations and the new financial framework.

- At Month 4 the CCGs reported a combined year to date overspend of £7.1m, £2.5m of which related directly to COVID expenditure in Month 4 and is currently unfunded. We expect a retrospective allocation for this £2.5m during Month 5.

- The Month 4 NON COVID related position is therefore a combined £4.6m overspend. (SCCG £2.2m and £2.4m T&WCCG).

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

Recommendations/Actions Required:
The Governing Bodies are asked to: **Note** the information contained in this report.

Tables included in this report:

Graphs included in this report:

No table of figures entries found.

Schedules appended to this report:

Appendix	**Content**
Appendix A	Summary of M4 COVID expenditure return

NHS Telford and Wrekin CCG/NHS Shropshire CCG – Combined position

Governing Body Meeting in Common September 2020

2020/21 Month 4 Financial Position

Introduction

1. M1-4 budgets have been set by NHSEI and are based on 2019/20 Month 11 expenditure.

2. We have recently been notified that budgets will be allocated in M5 and M6 in the same way as M1-4 and then a new financial framework will be released to cover M7-12. We await guidance from NHSEI on this.

3. We have shared some initial Month 12 forecast workings with finance committee members and plan to review the emerging position at the first joint meeting on 23rd September 2020. The initial forecast was shared with significant caveats due to the current uncertainty around allocations and the new financial framework.

4. At Month 4 the CCGs reported a combined year to date overspend of £7.1m, £2.5m of which related directly to COVID expenditure in Month 4 which is currently unfunded. We expect a retrospective allocation for this £2.5m during Month 5.

5. The Month 4 NON COVID related position is therefore a combined £4.6m overspend. (SCCG £2.2m and T&WCCG £2.4m).

Financial Performance Dashboard

6. Due to the new financial regime described above we do not have a full year control total or plan to measure against which we would normally report in the financial performance dashboard.

7. During the COVID pandemic, new rules have been implemented around payments to suppliers, taking the target from payment within 31 days to 7 days. Our performance against both targets on a cumulative basis is shown in the dashboard. The finance team will continue to monitor this and regularly monitor budget holder workflows to try and improve performance against the 7 day target.

8. The cash target is to have a cash balance at the end of the month which is below 1.25% of the monthly drawdown or £250,000, whichever is greater. This was met for both CCGs in Month 4.

Table 1: Financial Performance Dashboard

Target/Duty	Target	CCG	RAG
Cash	1.25% monthly drawdown	SCCG	G
		TWCCG	G
Better Payment Practice within 31 days (Number of invoices)	>=95%	SCCG	G - 99.1%
		TWCCG	G - 99.5%
Better Payment Practice within 7 days (Number of invoices)	>=95%	SCCG	A - 52.0%
		TWCCG	A - 61.4%

Summary Financial Position

9. The tables below show the summary financial position for both CCGs combined and separately. At the time of Month 4 reporting, budgets had only been set by NHSEI for the first four months of this year. We have recently been notified that budgets will continue on the same basis for Month 5 and 6 and then a new financial framework will be released to cover Months 7-12.

Table 2: Summary Combined Financial Position Month 4

Category	Budget Year to Date (excs. Mth4 anticipated COVID funding)	Anticipated Mth4 COVID Funding	Actual Expenditure Year to Date	Variance Year to Date	
				Exc. COVID Funding	Inc. COVID Funding
	£'000	£'000	£'000	£'000	£'000
Total Resource Limit	**270,693**	**2,529**	**272,417**	**0**	**0**
Acute services	127,925	61	128,136	211	151
Community Health Services	23,721	0	23,567	(154)	(154)
Individual Commissioning	21,608	668	23,009	1,401	733
Mental Health Services	24,526	22	24,459	(67)	(89)
Primary care services	35,590	776	38,063	2,473	1,697
Other	12,062	940	12,955	892	(48)
Running costs	3,039	62	3,756	717	655
Primary Care Co-Commissioning	22,223	0	23,865	1,642	1,642
TOTAL	**270,693**	**2,529**	**277,810**	**7,117**	**4,588**
Deficit/(Surplus)	**0**	**0**	**5,393**	**7,117**	**4,588**

Table 3: Summary Shropshire CCG Financial Position Month 4

Category	Budget Year to Date (excs. Mth4 anticipated COVID funding)	Anticipated Mth4 COVID Funding	Actual Expenditure Year to Date	Variance Year to Date	
				Exc. COVID Funding	Inc. COVID Funding
	£'000	£'000	£'000	£'000	£'000
Total Resource Limit	**178,117**	**1,724**	**179,841**	**0**	**0**
Acute Services	83,260	61	83,333	73	13
Community Health Services	16,818	0	16,736	(82)	(82)
Individual Commissioning	16,105	408	17,173	1,069	660
Mental Health Services	15,639	(25)	15,517	(122)	(98)
Primary Care Services	22,756	689	24,518	1,761	1,072
Other	6,881	534	6,928	47	(487)
Running Costs	1,915	57	2,372	457	400
Primary Care Co-Commissioning	14,744	0	15,504	760	760
Total Expenditure	**178,117**	**1,724**	**182,080**	**3,963**	**2,239**
Deficit/(Surplus)	**0**	**0**	**2,239**	**3,963**	**2,239**

Table 4: Summary Telford and Wrekin CCG Financial Position Month 4

Category	Budget Year to Date (excs. Mth4 anticipated COVID funding)	Anticipated Mth4 COVID Funding	Actual Expenditure Year to Date	Variance Year to Date	
				Exc. COVID Funding	Inc. COVID Funding
	£'000	£'000	£'000	£'000	£'000
Total Resource Limit	**92,577**	**0**	**92,577**	**0**	**0**
Acute services	44,665	0	44,803	138	138
Community Health Services	6,903	0	6,831	(72)	(72)
Individual Commissioning	5,503	260	5,836	332	73
Mental Health Services	8,887	47	8,942	56	8
Primary care services	12,834	87	13,546	712	625
Other	5,181	406	6,027	846	440
Running costs	1,124	5	1,384	260	255
Primary Care Co-Commissioning	7,479	0	8,361	882	882
Total Expenditure	**92,577**	**805**	**95,730**	**3,154**	**2,349**
Deficit/(Surplus)	**0**	**805**	**3,154**	**3,154**	**2,349**

10. We expect NHSEI to apply a retrospective allocation adjustment to fund £2.5m of Month 4 COVID expenditure and therefore the combined NON COVID overspend at Month 4 will be £4.6m.

Year to Date Position

11. The Month 4 combined YTD position in the ledger is an overspend of £7.1m.

12. In month 4 the CCGs have been given a £950k non recurrent non-COVID allocation to contribute towards non COVID cost pressures.

13. We are anticipating a retrospective COVID allocation increase for M4 of £2.5m which would take the YTD overspend to £4.6m.

14. In Month 4 there is a total of £8.1m COVID expenditure included in the position. £2.5m of this remains unfunded. Details are shown in Appendix A but the main areas of COVID expenditure are:
    - £2.3m Individual Commissioning/Mental Health
    - £2.0m Primary Care expenditure
    - £3.6m Local Authority expenditure
    - £0.1m COVID recovery beds
    - £0.1m Running Costs

15. The £4.6m YTD non COVID overspend in the ledger can be broken down into the following areas:
    - £1.7m year to date cost pressure on prescribing due to increases in demand due to the pandemic[1], 'Category M' price increases, NCSO (No Cheaper Stock Options) and less growth in budgets than factored into original plans.
    - £0.2m year to date cost pressure on Acute services due to overspends within Non Contracted Activity. The majority of this is a prior year cost pressure.
    - £0.6m part to full year effect of 2019/20 contract value increases that were flagged in our original plan with regards to patient transport, NHS 111 and Severn Hospice but not funded in the allocation given.
    - £0.7m overall overspend on Individual Commissioning/Mental Health. There is an issue in Individual Commissioning/Mental Health due to growth and price increases being higher than funded by NHSE/I in budgets (our original plan suggested 7% growth and 2% price increase, whereas budgets have been based on 2% growth and 1.4% price increases). We also believe that the full FNC increase was not uplifted in our budgets though as yet, NHSEI have not confirmed this.
    - £1.6m year to date cost pressure on Co- Commissioning. As previously notified to NHSE/I, Shropshire CCG has an underlying overspend against the co commissioning allocation. The new implications of the GP contract have also been factored into the position however no additional funding from NHSE/I has been assumed at this stage.
    - £0.6m running cost overspend due to the delay in the management of change process (which causes slippage in our running cost QIPP); non recurrent spend

[1] Note that prescribing costs are now not reimbursable through COVID funding routes.

in relation to extending executive posts during the COVID period (these haven't been coded to COVID) and costs associated with development of the single strategic commissioning organisation.
- £0.3m cost pressure on BCF for T&W and property services for Shropshire.
- (£0.1m) Community underspend.
- (£1.0m) NON COVID allocation reserve.

16. The CCG year to date position does not assume any further allocations from NHSE/I to address any of the issues above.

17. The year to date position also does not include any investments in relation to the Mental Health Investment Standard or community investments that formed part of our original plan. We await further guidance on this.

18. NHSEI are currently reviewing our year to date position to decide whether further NON COVID funding support will be provided retrospectively.

Contracts

19. In line with NHSEI guidance, completion of written contracts with NHS Trusts and Foundations Trusts will not be required for the remainder of 2020/21. Collaborative work has commenced with our 4 main providers on the development of a new type of contract and payment approach for 2021/22 and beyond. Initial discussions have identified that all partners are in agreement that a new approach should be developed and system Directors of Finance have approved that work will progress towards an Aligned Incentive Contract.

20. Independent Hospitals continue to be contracted directly by NHSEI although this is expected to change by October/November with a re-procured national framework agreement within which local contracting will resume.

21. Smaller community based independent sector providers are providing their plans for re-opening services via the System Restore Process and we continue to work with them to reflect the outcome in their contracts. We have started to review Open Book submissions from providers detailing their income and spend for the first 3 months of 2020/21, queries or concerns have been raised with some providers and the aim is finalise the review over the next month and confirm a payment structure for the remainder of the year.

QIPP

22. This month, the QIPP PMO has performed a stocktake of the previous QIPP plan for the year in order to assess what might be refreshed and delivered in year. In particular, conversations with project managers in the Medicines Management and CHC/Individual Commissioning teams have been held in order to commence a redraft of plans for the year (where required) and the DoF has met with Director leads to restart regular dialogue on project progress. We are seeking to restore the QIPP Programme Board from September in order to allow scrutiny of progress and

are currently working with system colleagues to review how we best capture the work of the Programme Boards in order to be able to report on any system driven savings.

Risks and Mitigations (High Level)

23. The financial position reported is not without risk. These are unprecedented times which means that, for some spend areas, accruing year to date expenditure is difficult given that historic trends do not always give a true reflection of the current situation. This is particularly pronounced in areas such as prescribing and CHC. We are working hard to track our spend patterns, encouraging our budget managers to monitor spend carefully, and as our recovery and restoration activity scenarios develop we will refine our financial modelling accordingly. We will ensure, where appropriate, that we align our estimates with our system partners.

24. The current financial position is predicated on the fact that block payment arrangements are in place with providers. We assume that this arrangement will stay in place for 2020/21 and do not yet know what contracting arrangements for 2021/22 will be. To mitigate against the risk that this poses a sub group of the system DoF meeting, chaired by the CCG DoF, is now meeting regularly to develop new contract arrangements from 2021/22.

25. Since 19th March, Individual Commissioning assessments have been suspended to accelerate discharge from hospital. Funding for these has been through the COVID reimbursement route. However, a backlog of assessments is now building up as all cases accepted since then will require a review. The Individual Commissioning team are currently collating data to explore the additional cost and expected time to work through this backlog and are trialling a 'return to normal' assessment protocol and checklist.

26. Prior to the COVID-19 pandemic the CCG had incorporated significant risk into the submitted financial plan based on a judgement of the deliverability of the QIPP schemes. The majority of this work is now paused and there is risk currently present around the potential increased costs in relation to the system COVID response.

27. The system restoration and recovery process has highlighted significant capital and revenue requirements to enable the system to return to full capacity. Any additional investment associated with this is not built into the CCG financial position and the CCG does not currently have any investment budgets available.

28. To mitigate against some of these risks, finance staff are now embedded in each of the restoration/recovery groups in order to model the impact of system plans. The CCG PMO are also working with budget managers to review internal CCG QIPP schemes in Individual Commissioning and Medicines Management and assess what might be delivered in-year. Further, all directors are given regular updates on the finance position and reminded to seek areas for reducing expenditure during 2020-21 where possible.

Conclusion

29. At Month 4 the CCGs are collectively £7.1m over budget. If the anticipated retrospective allocation adjustment for COVID costs is applied, this becomes a £4.6m overspend. This is not unexpected given the level of expenditure that was submitted in CCG financial plans. The key variances to budget have been mapped out throughout the report.

30. At present NHSEI are funding 'COVID' spend and have requested further information on the reasons behind other variances to budget. The guidance suggests that as long as NHSEI are content with our explanation for variances then we can expect further retrospective allocation adjustments from NHSEI so that both CCGs will report break even up to month 4. So far we have received a contribution towards cost pressures of £950k which is factored into our position.

31. It is extremely difficult to predict what/how financial reporting will look like in the coming months due to the level of uncertainty currently surrounding the COVID-19 pandemic. We await national guidance to inform Month 5 onwards and we will respond appropriately as soon as it becomes available. Current high level risks and mitigations within the position are highlighted above.

NHS Telford and Wrekin, Shropshire CCGs

Summary of Covid Costs for April 20 - July 20

	Non ISFE category	TWCCG £	SCCG £	Total £
A	**Acute Services**			
	Local Maternity Services	7,500	-	**7,500**
	Recovery Beds	-	82,891	**82,891**
B	**Mental Health Services**	33,085	-	**33,085**
C	**Community Health Services**	-	-	**-**
D	**Continuing Care Services**			
	Other Programme services	1,708,516	1,848,376	**3,556,892**
	CCG directly commissioned	1,091,588	1,153,510	**2,245,098**
E	**Primary Care Services**			
	Prescribing	-	-	**-**
	General Practice - Community base services	272,716	852,593	**1,125,308**
	General Practice - IT	21,923	12,315	**34,238**
	Hot Sites - Infrastructure	-	295,315	**295,315**
	Hot Sites - Staffing		324,106	**324,106**
	Care Home Support (CHAS)	29,520	86,000	**115,520**
	Phlebotomy	65,254	65,254	**130,508**
	Patient Transport		7,082	**7,082**
	Other	14,564	33,716	**48,280**
F	**Running Costs**	15,786	108,874	**124,659**
	Total	**3,260,452**	**4,870,030**	**8,130,482**

Note that from Month 3 the guidance does not allow prescribing cost pressures to be included as part of the 'COVID' reimbursement process.

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 9 September 2020**

Item Number:	Agenda Item:
GB-20-09.105	Joint Governing Body Report: Strategic Risk Update - Shropshire CCG Board Assurance Framework (GBAF) and Telford and Wrekin CCG Board Assurance Framework (BAF)

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

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Shropshire GBAF reported to Governing Body	8th July 2020	S
Telford and Wrekin BAF reported to Governing Body	12th May 2020	S

Executive Summary (key points in the report):

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 2020/2021 Board Assurance Frameworks for each CCG and provide assurance that the risks are effectively identified and mitigated.

The report provides a position statement on each risk and highlights any changes to the risk rating where applicable. Attached to both BAF is the risk matrix for information.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	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
- note the planned development of a joint Board Assurance Framework for both CCGs.

NHS Telford and Wrekin CCG Governing body is recommended to:

- accept and note the content of this report and supporting appendix B 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
- note the planned development of a joint Board Assurance Framework for both CCGs.

Item Number:	Agenda Item:
GB-20-09.105	Joint Governing Body Report: Strategic Risk Update - Shropshire CCG Board Assurance Framework (GBAF) and Telford and Wrekin CCG Board Assurance Framework (BAF)

1. Introduction

1.1 The Governing Bodies of both CCGs have a responsibility to maintain an on-going risk profile of their respective CCG through the Board Assurance Framework (BAF). Accountability for each of the strategic risks recorded on the BAF is assigned to an Executive Lead. The BAF provides evidence and ensures that a systematic process for identifying the CCG's strategic objectives as well as its associated strategic risks, towards the achievement of the objectives, is in place. It is a key document for both Governing Bodies and should be used to monitor key risks and to assure itself that the risks are being mitigated. The Governing Bodies should:

- challenge the risk ratings and target risk scores
- assess the robustness of the controls and actions plans identified
- ensure that progress is made to reduce the gap between the current risk rating and the target score.

1.2 The Committees of the respective Governing Bodies of both CCGs have oversight of individual risks recorded on the BAF, in accordance with the terms of reference of each Committee. The Audit Committees of both CCGs are responsible for oversight of the risk management processes and to satisfy itself that sufficient assurance is in place to demonstrate risks identified on the BAF are being managed and monitored effectively.

2. Risk Update - NHS Shropshire CCG

2.1 The updated BAF is attached as appendix A to this report.

2.2 No new risks have been added since last reported to the Governing Body and none have been removed.

2.3 The following risk numbers have been reviewed and amended: 1, 3, 10, 11 and 12. There has been no change in the risk levels previously reported.

3. Risk Update – NHS Telford and Wrekin CCG

3.1 The updated BAF is attached as appendix B to this report.

3.2 No new risks have been added since last reported to the Governing Body and none have been removed.

3.3 The following risk numbers have been reviewed and amended: 1, 2, 7, 8, 9,10, 13, 14 and 15. There has been no change in the risk levels previously reported.

4. Creation of a Joint Board Assurance Framework

4.1 Both Governing Bodies have expressed a desire to develop a joint Board Assurance Framework during the Autumn of 2020 in preparation for the planned creation of a single CCG from April 2021 onwards. The creation of a joint BAF is dependent on agreement on joint objectives by both CCGs that strategic risks can then be identified from. Since appointing and electing joint Governing Body members an Organisational Development Plan for the Joint Governing Body members has started to be delivered which will include

facilitated discussions on developing joint objectives in workshop 2 and 3. On this basis it is expected that a Joint BAF would be able to be developed from November/December onwards.

4.2 At the last Shropshire CCG Governing Body meeting the executive team were asked to consider if original risk information could be included within the BAF. The Executive Team believe that inclusion of information which shows the last reported risk level position to indicate overall movement would be more beneficial and this will be incorporated as part of the development of the new joint BAF.

4.3 Governing body members of both CCGs are asked to consider in preparation for the development of a joint BAF, any further amendments that should be considered to the presentation of the information going forward and to communicate this to the Director of Corporate Affairs.

5. Recommendations

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
- note the planned development of a joint Board Assurance Framework for both CCGs.

NHS Telford and Wrekin CCG Governing body is recommended to:

- accept and note the content of this report and supporting appendix B 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
- note the planned development of a joint Board Assurance Framework for both CCGs.

Shropshire CCG Governing Body Assurance Framework Version 19.0 Governing Body Meeting September 2020 - Appendix A

Risk ID	Opened by/ when	Map to key Principle	Summary title of risk and fuller description of risk	Key Controls Summary of existing controls / systems in place to manage the risk	Source of Assurance Summary of existing assurances that provide confidence that the existing controls relied upon are operating effectively and that action plans to address weaknesses are implemented.	Gaps in Controls/Assurances Summary of gaps in existing controls or assurances at the time the risk is identified or subsequently updated.	Assessment of risk level - Low / Medium / High / Extreme Risk /Movement of risk rating	Action / Lead Name / Timescale Identify what actions can be taken to fill gaps in controls and assurances and to also assist in achieving the residual target risk rating by the end of the financial year	post mitigation Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Owner	Amend/ Review: name and date
	Key Principle 1 - Deliver a continually improving Healthcare and Patient Experience **Key Principle 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation)** **Key Principle 3 - Achieve Financial sustainability for future investment** **Key Principle 4 - Visible leadership of the local health economy through behaviour and action** **Key Principle 5 - Grow the leaders for tomorrow (Business Continuity)**										
1/20	CS	Key Principle 3	**1. Underlying Financial Position** There is a risk that the CCG fails to deliver its financial plan for 2020/21 and that the underlying position going forward will significantly deteriorate. This is now further impacted by the uncertainty to the financial position due to the impact of the COVID-19 pandemic.	Robust financial model with sufficient detail to model growth, inflation and QIPP sensitivities Comprehensive QIPP Programme in place; overseen by Finance and Performance Committee ~~Joint QIPP Programme Board (meets monthly)~~: QIPP PMO in place. Business case challenge/due diligence on schemes Constitution, Standing Orders, Prime Financial Policies and Scheme of Reservation and Delegation Suite of financial policies and procedures (supported by AGC 27.6.18) Robust contract challenge mechanisms with major providers. Finance and contract reports to Finance and Performance Committee and Governing Body, highlighting risks and mitigating actions Regular GB consideration of the finance position and oversight of management actions Disinvestment Process	Lead Committee - Finance and Performance Committee Regular reporting of Finance, QIPP, Contracting and Performance position to Finance and Performance Committee and Governing Body Completion of internal audit recommendations; outstanding audit actions reviewed at Audit Committee. Assurance gained through seeing improving internal audit ratings for finance and QIPP Action Trackers for Contract Management Meetings with Providers and escalation where required through exec level Strategic Commissioning meetings NHSE escalation meetings in place Budget Manager handbook and training programme in place	**Gaps in control** GC1: Development of robust financial recovery plan GC2: Absence of formal signed off 2020/21 plan with NHSEI due to pause in planning due to COVID-19 GC3: Absence of signed contracts due to pause in planning and contracting due to COVID-19 GC4: Impact of COVID-19 on financial position currently uncertain GC5: CHC process issues remain **Gaps in Assurance - None**	Extreme Likelihood 5 x Impact 5 = 25	GC1: Financial Recovery plan in development and being discussed with NHSE/I on a regular basis. Draft plan submitted as part of application to become a Single Strategic Commissioning organisation. Plan to continue to be refined and aligned with Clinical Commissioning strategy. However, awaiting NHSEI ~~instruction~~ /planning guidance on the impact of COVID-19. Revised draft of plan to be worked up for September submission and to include the impact of restoration/recovery modelling Financial recovery processes implemented including enhanced governance and increased grip and control. Executive team to continue to develop actions to reduce expenditure. Current QIPP plans are hindered by the impact on provider capacity due to COVID-19. GC2: For 2020/21 budgets for Months 1-4 have now been issued by NHSEI based on 2019/20 Month 11 expenditure and a system of retrospective allocation adjustments is underway. Confirmation is awaited but it is now likely that a similar arrangement will continue throughout 2020-21. Therefore, we await NHSEI planning guidance in terms of submitting a plan for 2021/22. ~~Regular discussion with NHSEI on next steps in agreeing a plan/revising plan for impact of COVID-19. Awaiting further guidance/instruction from NHSEI.~~ Finance team have submitted the Month 2 position and a Month 1-4 forecast based on the known impact of COVID-19 and other issues compared to issued budgets. ~~currently working up Month 1- 4 forecast snapshot based on the known impact of COVID-19. To be presented to PPQ in May 2020.~~ GC3: - The contract and planning round has been paused. The CCG was in final stages of negotiation with providers for 2020/21 contracts and therefore final contract values have not been agreed. In the meantime we have secured agreement that all parties still wish to operate block contracts once we resume usual activities. New contract arrangements for the future including risk shares are in discussion as part of the system restoration/recovery plan. GC4:Organisations have stepped away from their original operating plans in order to support our response to COVID-19 and we are awaiting guidance on what is expected of systems with regard to financial modelling and targets for the rest of this financial year. A snapshot of the current financial ~~potential~~ implications has been presented to NHSEI and execs as at Month 2. ~~on the financial position for Months 1-4 is currently being worked up to be presented to Finance and Performance Committee in May.~~ GC5: Joint working across CHC and finance teams with a focus on sharing good practice and harmonising procedures. Financial forecasting methodology bedded in; finance focus is on robust information to support forecasting and QIPP delivery. Weekly CHC team meetings (with finance in attendance) held which incorporate review of QIPP activities. Impact will be tested through monthly review of the finance position. New Executive Director now in post. Director of Finance to meet with them and review elements of current CHC action plan related to finance process and governance areas (to include process for payments to the LA).	Likelihood 4 x impact 4 = 16	Claire Skidmore	17.6.20
2/20	AS 20/09/16	Key Principle 1	**2. Quality and Safety** There is a risk that the CCG fails to commission safe, quality services for its population	CQRM meetings with providers Quality and Safety visits Triangulation of information and exception and escalation reporting to Quality Committee National and local reporting Healthwatch CQC QSG NHSE Joint Commissioning Serious Incident Panel Quality Strategy and Delivery Plan including achievable milestones included. SaTH: • The CQC has taken urgent enforcement action where deemed necessary and this remains subject to legal process. • Weekly Regulation 31 audit submissions to CQC received by CCG • 'Safe today' calls continue with Trust Executive Clinicians • Daily and monthly quality indicators and outcomes work continues- Trusts IMT remains a barrier • Unannounced site visits undertaken Quality controls other providers: Restructure of quality team priorities to ensure alignment of new leads against other competing priorities QIPP Quality impact assessments, procurement and contracting requirements etc. Workforce lead in place Delivery Plan will be monitored bi-monthly at Quality Committee New SI policy and process to be shared with Quality Committee	**Lead Committee - Quality Committee** CQRM meetings with providers which feed into the Quality Committee. Minutes of QC meeting and Chairs report presented monthly to QC, Public Governing body Executive team meetings, reports, escalation Clinical Commissioning Meeting WMQRS Formative Review of Quality, Patient Safety and Experience Function, Structure, systems & process and assurance report received June 2019. WMQRS review of Quality, Patient Safety and Experience Structure, systems & process and assurance February 2019. Quality strategy and operational delivery plan signed off at September's Quality Commitee WMQR Review of Critically Ill and Injured Children at SaTH with action plan in place NHSE&I chaired Safety Oversight and Assurance membership to monitor the SATH quality improvment plan delivery. Senior CCG lead for strategic system working group now in place along with Chief Nurse on LWAB .	**Gaps in Controls (GC):** GC1: Workforce issues in health and social care economy increasing and increased quality risks in system mean that capacity in team to effectively monitor and manage the escalating risks is compromised. This is compounded by need to ensure the increased number of QIPPs, reprocurement and contracting requirements are met. Existing system wide workforce groups not impacting as quickly as the service provision requires it to manage risk **Gaps in Assurance (GA):** GA1: Sufficient business intelligence support to provide up to date quality data and benchmarking information from which to highlight and focus on concerns. GA2:Reporting to the Quality Committee requires a review on level of detail provided to provide correct level of assurance to the governing body, refer to WMQR of SCCG Quality comittee as aprt of wider review GA3: Limited assurance on management of SI process as detailed by internal Audit report. Revised policy and process in place and signed off at September Quality Committee and Audit Committee	Likely x Major = 16	GC1: Workforce oversight of providers via CQRMs, STP Stratgeic Workforce Group and LWAB continues Sytemwide People Plan in development to align with NHSE People Plan. GA3: Procurement for serious incidents and mortality review complete. Review to be timetabled to comence and be completed by late 2020 GA3: Action plan to address the limited assurance in place. New SI policy and process to be shared with Quality Committee in September 2019. Revised Quality Strategy produced awating sign off from NHEI	Possible x Moderate = High 12	Zena Young	6.1.20

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72/16	AS 20/09/16	Key Principle 1	**3. NHS Constitution** There is a risk that the CCG fails to meet its NHS Constitution targets either fully or sustainably	Planned Care Working Groups for Cancer and Referal to Treatment Times (RTT) in place	**Lead Comittee: Finance and Performance Committee** Provider Remedial Actions report via the Monthly Contract meetings . Updates from A&E Delivery Group & Board included in the monthly performance reports to Finance & Performance Committee and bi-monthly to Governing Body. Monthly contractual performance data	Gaps in Assurance (GA): GA1: Lack of SaTH medical /surgical representation at the PCWG	Likely x Major = Extreme 16	GC1: UEC (formerly A&E) Delivery Group now includes clinical input (both SaTH and CCG) and focuses on actions to improve ED systems and processes, Same Day Emergency Care (SDEC), Frailty, Ambulance Demand and for the back door Home First. - Pathway Zero and Integrated discharge teams. The two latter schemes are to ensure the system remains one of the best in the region for DTOC which remains <2%. MFFD is varying from 0-30. Now UEC Delivery Group focusing on demand managment with emphasis on avoiding admissions (Shrewsbury pilot and working with WMAS on providing alternative clincial advice for Care Homes). Performance has improved to >85%, key is to maintain that as activity restores post COVID. UEC delivery group now being re-instigated to lead the work necessary to maintain this performance. Work has begun on integrated system performance reporting and dashboard to give earlier view of issues and better highlight system interdependancies. It will also enable us to be more proactive take appropriate action earlier. GC2: SaTH have committed to a significant investment in both nursing and medical staffing for ED to improve performance and improvements are being seen in middle grades and nursing but will not have a significant impact this winter. System wide demand and capacity planning remains a key enabler. The in-hospital element has been refreshed to include the short stay capacity requirements but this now needs refining to take into account the impact of adopting the Same Day Emergency Care principles as part of the NHS long term plan. Further detailed work on the system wide demand and capacity has been delayed due to no system owner being identified despite escalation to the UEC Delivery Board. RTT having been impacted by SATH being permanently escalated into both DSUs, has worsened further due to the pandemic halting all routine elective treatment and OP. Only clinically urgent caticity has been taking place based on the national priorities. Tis is now subject to detailed recovery planning as part of the system wide Restore and Reccovery Work. Bids have been made to NHSE/I for additional capacity to help recover the position (beds,thetares and diagnostics). A detailed recovery/mobilisation plan will only be possible when the extent of the addtional capacity available is confirmed. GC4: Cancer performance has improved in Q4 and breast symptoms and 2wk are now achieving. 2wk demand fell by ~30% during the pandemic and as this demand returns performance will be impacted by the limitations to capacity in diagnostics/theatres etc due to new IPC arrangements. Additional capacity has been requested via NHSE/I to support the recovery phase post COVID. Capacity has and continues to be used at the local Nuffield for cancer treatment. The 62 day target cannot be delivered until wider capacity issues resolved for Urology. Progess has been made in this area with SaTH agreeing a formal parnership arrangement with UHNM which will see increased access to robotic surgery from February 2020. GC3: The gaps in controls and assurance have been escalated with SATH via the System Urgent Care Director. GA1 - clinical representation for planned care now through the system recovery structure.	Possible x Moderate = High 9	Julie Davies	19.6.20
76/16	AS 20/09/16	Key Principle 5	**6. CCG Workforce Resilience and trust** There is a risk that the current financial situation impacts negatively on existing CCG staff resilience and retention levels and prevents successful recruitment in the future.	Clear staffing structure which meets the needs of the organisation Executive team prioritising key workstreams. Sickness absence data Statutory and Mandatory Training Staff newsletter Staff survey Staff appraisals and one to ones Staff Hero Awards Procurement of dedicated Organisational Development and Human Resource to support transition to a single strategic commissioning organisation Utilisation of ESR system to manage mandatory training As part of single startegic commissioner CCG has provided CV and Interview training sessions. Staff Singel Staregic Commissiner MOC timeline in place and shared with staff. Clear structred OD plan for moving to single startegic commissioner now in place.	**Lead Committee - All** Line management 1:1 with staff Training reports reviewed by Directors Staff Survey results Staff briefings CCG workforce data reviewed by Governing Body and Executive Team regularly Joint Executive Team meetings Weekly Single Strategic Commissioning Organisation update Reports Single Strategic Commissioner - reporting to each Board on progress which includes a section on HR/OD workstream oversight and delivery of this part of programme.	**Gaps in controls (GC):** GC1: : Maintenance of Statutory and Mandatory Training targets **Gaps in assurances (GA):**	Likely x Major = Extreme 16	GC1: The CCG's statutory and mandatory training compliance is being moritored and reminders have been given to staff in this regard	Possible x Major = High 9	Alison Smith	30.04.20

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77/16	AS 20/09/16 NEW	Key principle 1,2,3 and 5	**7. Sustainability of Provider Workforce** There is a risk that providers ability to deliver services and remain financially viable is not sustainable.	Primary Care Workforce Strategy Primary Care Workforce Group (PCWG) led by NHSE with remit to look at sustainable Primary Care Workforce for the future. Secondary care: Contract monitoring via CQRM, A&E Delivery Board, QSG, and external reviews - CQC WMQRS LHE Clinical Sustainability Group Provider has key processes for managing staff shortages to minimise risk STP Workforce Group and Local Workforce Action Board (SLWAB) in place with remit to support the implementation of robust workforce strategies and sustainable workforce and education plans	**Lead Committees - Quality Committee, Primary Care Committee** <u>Primary Care</u>: Individual GP practice visits Reporting to PCC and Governing Body. PCWG reporting into PCC GPFV workforce section assured by NHSE Primary Care workforce survey Staffordshire/ Shropshire Primary Care Programme Management Office for GP Forward View oversees delivery of the GPFV plan which includes Primary Care Workforce <u>Secondary Care</u>: Reporting from CQRM to QC and then onto Governing body Regular updates shared by commissioners at North Midlands Quality Surveillance Group (QSG) chaired by NHS England. SWLAB reporting into QC NHSI supporting acute trust with recruiting from overseas. Modernisation of services includes review of traditional stffing arrangements to encourage grester felxibility and wider skill mix.	**Gaps in controls (GC):** GC1: Workforce issues in health and social care economy increasing and increased quality risks in system mean that capacity in team to effectively monitor and manage the escalating risks is compromised. This is compounded by need to ensure the increased number of QIPPs, procuremnet and contracting requirements are met High agency use still reported by providers. GC2: Gaps in terms of mechanisms for effectively working together across the system to address this issue . GC3: Need more effective local system wide (health, social care and private industry) approach to recruitment and retention to bridge gap and support long term planning. Providers often appointing from same pool of candidates GC4: Full analysis of Acute Trusts position and options for business continuity GC5: long term workforce planning via Future Fit and STP workforce workstream **Gaps in assurances (GA):**	Like x catastrophic = Extreme 20	**GC1:** Workforce oversight of providers via CQRMs, STP Stratgeic Workforce Group and LWAB continues Sytemwide People PLan in development to align with NHSE People Plan. **GC2 & GC3**:STP workforce group and LWAB in place which coordinates apprenticeship schemes/staffing passport and back office functions to maximise staff flow and competencies. STP workstream to realign as part of system savings plan. STP workforce proceses in place. **GC4**: Oversight of SATH Trust workforce improvement plan monthly via the NHSEI Safety Oversight Assurance Group. Workforcce deep dive planned for 22/10/19 **GC5:**Full Business Case for Future Fit will be prepaered in November 2019 for future acute trust workforce plan to be reviewed. Awaiting sight of this formally.	Possible x Major = High 16	Zena Young	6.1.20
61/15	Accountable Officer / Chair	Key principle 1, 2,3 and 4	**8. Stakeholder and Patient support and trust** Failure to maintain stakeholder (including membership) and Patient/Public trust and support leading to negative organisational reputation because of the following reasons-: - Financial performance challenges - Leadership challenges - Organisational culture challenges - NHSE CCG Assurance - 'needs improvement'	Annual Stakeholder 360 degree survey Patient engagement programmes associated with key workstreams Quality Impact Assessments Equality Impact Assessments Patient Insight service Patient Experience service Patricipation in STP workstreams Better Care Fund Communications and Engagement Plan in relation to transition to a Single Strategic Commissioning Organisation Programme of Line Manager Training in place	**Lead Committee - Governing Body** Results of 360 degree stateholder survey Patient Insight reporting Patient Experience reporting Commuications and Engagement Plan Communications and engagement planning for each work programme Joint Executive Team	**Gaps in controls (GC):** GC1: capacity within the organisation and the Communications and Engagement team to meet the communications and engagement requirements GC2: Gaps in staff training opportunities **Gaps in assurances (GA):**	Like x catastrophic = Extreme 20	GC1: The volume of transformation work being undertaken by the CCG is significant and capacity remains an issue. Current demands are enhanced due to supporting major programmes of transformation and redesign and forthcoming consultations in relation to MLU and Care Closer to Home, as well as an increased level of public and press interest regarding the CQC interventions regarding maternity and A&E services at SaTH. Work plans and priorities are kept under continuous review and adjustments made where necessary to maximise capacity and responsiveness. Working arrangements with T&WCCG have been reviewed and a joint interim structure is now in place to ensure capacity is maximised and duplication reduced, along with work to maximise communication and engagment capacity and expertise in the Future Fit/ STP team GC2: Staff training opportunities being continuosly monitored. Mental Health Awareness training planned for staff	Possible x Major = High 9	Alison Smith	30.04.20
71/16	GB 8.2.17	Key Principles 1, 3	**9. Impact of Social Care Funding Challenges** Risk of individuals escalating into acute hospital care or not being able to be discharged from acute hospital care thus impacting adversely on the capacity and capability of health services	BCF plan and development of associated Partnership Agreement Joint Commissioning Board ToR Sustainability and Transformation Plan approved by NHS England Performance data DTOC performance reported monthly BCF Partnership Agreement and Joint Commissioning Board ToR to be completed	**Lead Committee - Clinical Commissioning Committee** Clinical Commissioning Committee Health and Wellbeing Board Regular reporting regarding hospital and community service performance DTOC data	**Gaps in controls (GC):** GC1: Full implementaiton of Care Closer to Home Programme GC2: Lack of impact assessments in relation to cessation of services by Local Authority **Gaps in Assurances (GA)** : GA1: Fully formed STP governance structure	Almost certain x Major - Extreme 20	GC1: Delivering care Closer to Home to reduce demand failure in the acute setting. Demonstrator site procurement for admission avoidance in Shrewsbury area in progress. GC2: On going dialogue with Shropshire Council regarding service cessation impacts GA1: The STP governance structure has been agreed and a Shadow ICS Board is being put in place from February 2020	Possible x Major = High 9	David Evans	6.1.20
78/16	GB 10.10.18	Key Principle 1	**10. Management of 0-25 Health & Wellbeing Service.** Risk of lack of assurance of quality and safety of current service, in particlular for a number of legacy patients	Additional capacity in SCCG through MH Programe Director System Action Plan System Communication plan Contractual levers where required NHSE oversight	Lead Committee CQRM T & F Group H&W Board overview NHSE executive assurance process	**Gaps in controls (GC):** GC1: Workforce plan in delivery; poor data sources remain a concern; **Gaps in Assurances (GA):** GA1: Lack of pace in improvements has been resolved with the delivery of the recovery action plan more effective than the previous RAP	Major x Possible = High 12	GC/GA1:Concerns raised by visit of the Intensive Support Team , a comprehensive action, communication and governance plan was developed by the contract lead provider and has now been delivered. A new model of service delivery has been agreed a to deliver this service in the future within appropriate waiting times. The ASD pathway is an outstanding action that has been developed and agreed by all system partners, the funding to implement to Assessment and Daignositic Pathway has been impacted upon by COVID and investement planning. The issues has been esculated to NHSEI by DOF as NHSE have to approve any new investment.	Possible x Major = High 9	Julie Davies	23.06.20

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3/20	23/03/20 AS	Key Principle 1	**11. Single Strategic Commissioner** Failure to create a single strategic commissioner by April 2021	Change Management Policy already in existence PMO support via CSU in place from 01/07/19 HR support via CSU in place from 01/07/19 OD partner support in place form 08/08/19 Joint Project created with joint SRO in place Governance for project in place - workstreams and oversight group Deliverables and programme plan Communications and Engagement Project Plan in place New application deadline agreed with NHSE of 30 April 2020 Action plan for addressing panel application feedback submitted Nov 2019 to NHSE Further work undertaken on scoping operating model to help inform director's design of staffing structures Membership agreement to new inetrim constitution to allow jointly appointed governing body members on both CCG Boards. Consultation with existing governing body members completed.. Clearer operating model developed at high level which is informing design of staff structure. Application submitted 30 April 2020 Clearer alignment of ICS development with Single Strategic Commissioner timeline Governing Bodies - Joint Chair and GP/Healthcare Professionals now elected.	Informal and formal Board discussions and update papers Board paper to March meeting. Board paper and agreement at May Board meeting Briefing papers presented at JHOSC and HWBBs for both local authorities during June 2019 Project reporting weekly to Joint Executive Group Weekly teleconference update on project status with both Accountable Officers and Chairs of both CCGs Weekly progress reports to Joint Executive Group acting as project oversight group Submission of application completed and panel presentation to NHSE/I on 3 June 2020 completed. Positive informal feedback received. Recommendation to approve application with conditions forwarded to national committee	**Gaps in controls (GC):** No agreement on final form to date to describe operating model and eventual release 20% savings on administration costs Finance plan and commissioning strategy missing key information that will be produced from further modelling and discussions at a system level Successful recruitment to joint vacancies on both Governing Bodies during July 2020. Final Ratification of the new Constitutions by NHSE/I by 31st July 2020. **Gaps in Assurances (GA):** Successful application submission to NHSE/I	Possible x Major = 12 High	Further detailed clarity on Operating Model particularly at place level is being worked through staff management of change/staffing design and in discussions with local authority partners. DE/ST Oct 2020 New Directors to design new staffing structure in preparation for staff management of change which will clarify operating model but will be subject to staff consultation and therefore may change. Sep 2020 (AS) Further information to be added to the Commissioning Strategy post application May/Jun 2020 ready for next submission to NHSE/I on 30 September 2020 ST/AP Timeline for additional modelling to inform Finance plan agreed with NHSE/I post application Sep - Dec 2020 CS Awaiting National Committee outcome follwoing recommendation to approve application with conditions made by regional panel.	Unlikely x major = moderate 8	Alison Smith	28.06.20
4/20	23/03/20 AS	Key Principle 1	**12. Covid 19 response** Failure to manage with partners the local health system response to Covid 19 pandemic	EPRR processes in place and tested National and regional daily Covid 19 calls involving SRO and AO Business Continuity plans in place and have been enacted Critical services identified, non critical scaled down CCG SRO dedicated to leading CCG response – internal and external, with partners in local authority Redeployment of clinical staff to front line NHS services enacted Most staff apart from critical services that must be on site working from home. Financial accounting of Covid 19 additional cost incurred. Staff in on site critical services are cmplinat with government guidance on safe distances.	Briefings to Board members and Executive team National guidance continues to be issued which is being enacted by CCG Gold Command Group Silver Command Group Theme specific Task & Finish Groups Gold Command Risk Register in place Gold Command decision log shared with Committee Chairs/Lay members	Gaps in controls (GC): Ability for national PPE supply chain to keep pace with demand Lack of clarity regarding release of guidance and its implementaition Gaps in Assurances (GA): Governance Board and Committee meetings will be scaled back, so regular informal briefing of Board members required. Impact on populationb as lockdown eases are currently unknown therefore CCG response may be inadequate.	Almost Certain x Catastrophic = 25 Extreme	Incident response structure now well bedded in with good enagement from all system partners. System has been able to respond well to all COVID19 related tasks and has managed its response well. Critical Care and Death Management capacity created for the response phase has been sufficient and the system has not been overwhelmed. System now focusing in tandem on Restoration phase whilst maintaining ability to respond to a further surge in COVID19 activity should it occur. Response remains resource intensive and the systems ability to maintain this when managing restoration in tandem will require continual monitoring Silver and Gold Command regaularly review the PPE issues and a dedicated PPE supply chain cell has brought together the system to manage the supply chain locally. This has been of great benefit in mitigating risk as far as is possible. System approach through Silver command to implementation of national guidance as proved beneficial in addressing the requirements. Governance Board and Committee meetings will be scaled back, so regular informal briefing of Board members required. Agreement to provide Committee Chairs and Lay members with the Gold Command decision log on a fortnightly basis	Likely x Catastrophic = 20 Extreme	Sam Tilley	11.06.20 ST

NHS Telford and Wrekin CCG - Board Assurance Framework (BAF) 2020/21 - Governing Body meeting September 2020

CCG Objective 1: To improve commissioning of effective, safe and sustainable services, which deliver the best possible outcomes, based upon best available evidence.

CCG Objective 2: To increase life expectancy and reduce health inequalities.

CCG Objective 3: To encourage healthier lifestyles

CCG Objective 4: To support vulnerable people

CCG Objective 5: In meeting the objectives above, to exercise CCG functions effectively, efficiently and economically, and in accordance with generally accepted principles of good governance and as an employer of choice.

1	2	3	4	5	6	7	8	9	10	11	12	13
Risk ID	**Objective**	**Opened / added by/ ref to provider BAF**	**Risk and description**	**Opportunity**	**Existing key controls**	**Existing sources of assurance**	Gaps in controls or assurances	**Risk score (consequences x likelihood)**	**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	2 & 3 & 4	Board 30/05/17	**Risk is that the organisation is distracted from addressing the health inequalities needs of the population as identified by the JSNA** The risk of distraction will be higher during Q4 20/21 as the CCG works to align structures/organisations with SCCG	The opportunity is to improve the health of our population which historically is typical of the socio-economic disadvantaged groups. AND to reduce CCG spend as healthier people will require fewer planned or urgent interventions. A virtuous circle will then enable the CCG to invest in more health promotion activities instead. The current opportunity provides far greater scope to reduce health inequalities by ensuring the new joint arrangments prioritise Population Health Management across the whole system.	STP priority - Managing Director of the Council chairing the local neighbourhood Board CCG operational plan JSNA Additional project management support, Undertaking modelling of left shift of activity from acute setting to community, Paper on Right Care approach regarding diabetes to PPQ (Aug 2017) and also STP Board Board meetings have gone to bi-monthly to allow greater strategic discussion and oversight. More detailed modelling and analysis was completed at the end of October 2019 for the Future Fit DMBC. Realignment of portfolios has created a dedicated Deputy Exec role to focus on Neighbourhood Development and Rightcare to ensure delivery of CCG priorities. T&W Council leading on improving Healthy Lifestyles. NHS Improvement Oversight meeting. Safe Today process in place.	T&W Neighbourhood Board STP Board PPQ Health Wellbeing Board	Gaps in controls: Insufficient synergy between STP Population Health Management Group, CCG Care Closer to Home schemes and all other schemes designed to reduce prevalence of diseases linked with disadvantage and poor lifestyle. Failure to meet some IAF targets associated with particular area of health inequalities. Gaps in Assurance: Lack of clarity between existing governance arrangements and STP Board An additional risk is imminent with the departure of the current Deputy Exec Lead for Neighbourhood Development who leaves the CCG at the end of October 2018	16 High - major 4 x likely 4	Greater focus on reporting on CCG priorities to **PPQ and** CCG Board - via performance reports - ongoing Neighbourhood development now a greater priority for the Future Fit Programme Board given the mutual dependencies of the hospital reconfiguration and diversion of activity into the community - both self help and interdisciplinary working. FB/TJ Feb 19 This is being strengthened with revisions to the STP Board and work programme CCG and T&W Council are creating a joint team to increase pace of change for Neighbourhood development in line with creation of Primary Care Networks. New team will focus on risk stratisfication/identification/better care of patients with high risk of diagnosis/diagnosis through improved primary care activities. Realign enhanced payments to focus on CCG/Rightcare Priorities. JS/RT completed Mar 2019 Telford Health Hearts initiative JS/TJ Mar 19 - work programme now being implemented. June 20 Jt programme of work continues with the Local Authority. although at reduced levels due to impact of redirection of community staff to address covid. The use of buisness continuity which include EQIA processes undertaken by provider will assist in highlighting inequalities of accesss . Restore templates for services require equalities inpact considered at overacrhing care pathway group (ST)	Moderate 9 - moderate 3 x possible 3	ST TJ	FB 15/06/17 AS 10/07/18 FB 01/03/18 FB 04/09/18 FB 19/12/18 FB 14/03/19 FB 07/01/20 TJ 05/05/20 TJ 15/06/20
2	1 & 4	Board 30/05/17	**Risk that SaTH is unable to provide good quality sustainable services**	The opportunity is to improve quality of care, ensure patient experience and safety are paramount. Plus to minimise avoidable costs of doing the wrong things and putting mistakes right i.e. quality drives financial improvement. NHS constitutional targets will be met for planned, cancer and urgent care. Sustainability will be delivered via Future Fit reconfiguration of both hospital and community services. Plus closer collaboration through STP and System Sustainability	Contract mechanisms - CQRM, SPF Escalation processes embedded in the contract governance processes. NHSE Assurance meetings Joint Commissioning Board with SCCG Activity and finance meetings Cancer Assurance Board Executive team - reporting weekly Regulators - NHSI/E and CQC Plans in place within the Trust to manage these risks	PPQ Board A&E Delivery Board and ED Group Future Fit Programme QSG Planned Care Working Group Regional QSG receives regular updates on quality and safety risks.	Gaps in controls: Workforce challenges and inability to recruit in ED and several challenged specialities. Increasing concern that the Trust is not working quickly enough to adopt new models of care to address workforce challenges. Workforce strategies STP wide to promote recruitment and retention of staff. Gaps in Assurance: Sustainability of current mitigating actions. CCG receives short term solutions but not assurance that the short term arrangements are sustainable.	20 high- almost certain x major	CCG working jointly to commission different service models to ensure sustainability and good quality care AP Sep 20 Review transformation implemented as part of Covid-19 response to implement those that support sustainable services AP Sep 20 STP workforce focus VR Work has begun on integrated system performance reporting and dashboard to give earlier view of issues and better highlight system interdependancies. It will also enable us to be more proactive take appropriate action earlier.	High 16 - likely x major	JD AP	FB 22/06/17 FB 27/07/17 CM 02/11/17 FB 04/09/18 FB 19/12/18 FB 07/01/20 AP 05/05/20 JD 19/06/20
3	RISK REMOVED 02/07/18											
4	1 & 4	Board 30/05/17	**Risk that strategic proposals are not viable**	To ensure commissioned services provide consistently high quality services to patients.	STP Plan STP governance Structure Board reporting STP plan predicated on each individual NHS organisation's medium term financial plan. STP Director appointed and PMO resource in place Prevention and self management now forms part of neighbourhoods NHS England assured by Future Fit process to date. Independent STP Chair appointed.	Board reporting STP Board Future Fit Board T&W Neighbourhood Board	Gaps in controls: Financial modelling completed at moment in time and requires constant review and monitoring. Individual organisation plans do not deliver long term financial sustainability. Gaps in Assurance: None identified	20 Extreme = Catastrophic 5 x Likely 4	STP Finance Workstream undertaking ongoing review of activity modelling. Further CCG financial assurance will be required at the point of decision on Future fit following consultation. JC 31/01/19 Independent STP Chair is undertaking a review of STP structure/governance/vision and there is now an Accountable Officers meeting once a fortnight.	10 Moderate = Catastrophic 5 x unlikely 2	DE	DE 26/06/17 DE 10/11/17 DE 23/02/18 AS 10/07/18 DE 28/08/18 AS 02/01/19 JC 22/08/19 DE 07/01/20
5	RISK REMOVED 02/07/18											

6	1, 2, 3, 4 & 5	Board 30/05/17	**Risk that external factors may influence the CCG's ability to deliver its core objectives.**	To ensure commissioned services provide consistently high quality services to patients.	CCG commissioning and Medium Term Financial Plans scrutinised by NHS E STP scrutinised by NHSI Single Strategic Commissioner (SCC)Transition programme set up with SRO and workstreams and a programme plan	PPQ reporting Board reporting NHS E Assurance Meetings STP Board SSC reporting weekly to programme board and weekly calls to NHSE and regular reporting to Board	Gaps in controls: Current political instability may affect NHS policy. Brexit - uncertainty of workforce planning and impact on public finances. CCG financial position 2018/19 - do not yet have a balanced finance plan Requirement for CCGs to make 20% administration savings by 2021. LTP - move to single startegic commissioner - delivery of the programme plan Gaps in Assurances: None identified	High 16 = major 4 x likely 4	Monitor of key objectives including finance - regular updates to Board. Although initial review of disinvestment opportunities has ben completed, and work is continuing, at this stage there is no single project plan or programme of actions to deliver. ongoing Programme plan delivery is ongoing	Moderate 8 = major 4 x unlikely 2	DE	DE 26/06/17 DE 23/02/18 DE 10/11/17 DE 23/02/18 DE 28/08/18 AS 02/01/19 JC 22/08/19 AS 29/08/19 DE 07/01/20
7	1&4	Board 30/05/17	**Risk of failure of CCG commissioner quality systems to either predict or identify quality failure by providers.**	To ensure commissioned services provide consistently high quality services to patients.	Contractual processes CQRM for all providers Announced and unannounced visits Joint CCG and Trust Exemplar visits Triangulation of soft intelligence with complaints information Review of external inspections/assessments - WMQRS, CQC and Healthwatch NHS E Quality Surveillance Group Dedicated quality resource Established working with coordinating commissioner to triangulate information Dedicated resource for infection control and safeguarding Oversight of serious incidents NHS to NHS Concerns Infection controls and systems Safeguarding Board for Adults and Children Safeguarding leads across all commissioner areas. Weekly CQC Reports and action plans shared by SaTH to CCG NHSEI Improvement Oversight meeting for SaTH Weekly assurance calls between CCG, Sath and NHSEI	Board reporting Safeguarding Boards External reviews - WMCQRS, CQC QSG PPQ/ QC reporting Monthly CQRM meetings NHSE assurance meetings Actions from WMQRS review completed and presented to PPQ in September 2019 Monitoring of Serious Incidents and action plans across the system Monitoring of workforce -recruitment and retention plans	Gaps in controls: Lack of transparency from all providers in relation to reporting failure of quality systems Lack of pace to implement changes required. Unknown unintended consequences of Covid - impact on waiting list/ unidentified harm Gaps in Assurances: Reliance on provider assurance systems	High 12 possible 3 x major 4	Escalating when we have gaps in assurance using escalation processes to seek further assurances. Ongoing CM SaTH remain on enhanced rating at QSG and within the local system. CQC carried out unannounced and announced visits into SaTH including ED and Maternity Services Risk Summit held by NHSE/I with actions for the system to deliver. Follow up Risk Summit in January / April 2020 to reveiw actions. CEO discussion with NHSE/I regarding working together as regulators - January 2020. Action plans for improvement shared with quality leads and tested via Safe Today Process - still not providing sufficient assurance. Raised with NHSE/I Sath CQC report was published in April 2020. Maternity services showed signs of improvement. The overall Trust CQC rating stayed the same at 'inadequate'. CQC imposed the powers of Section 31 of the Health and Social Care Act (2008). In total there are currently 21 conditions in place. The CCG is working closely with the Trust, NHSEI, ECIST and partners to provide support and challenge in driving forward the measures required to improve. SaTH CQC action plan is shared weekly with CCG and the information informs the weekly assurance calls. Capacity within the patient safety team in Sath is causing significant delay in the completion of RCA's for the Serious Incidents being reported. The CCG quality team are working with the Trust to gather information for the chronology sections of the reports.	High 12 possible 3 x major 4	ZY HB	CM 23/06/17 CM 02/11/17 CM 31/08/18 CM 18/12/18 HB 25/05/19 CM 22/08/19 CM 12/11/19 CM 07/01/20 HB 16/06/20

8	1, 2, 3, 4 and 5	Board 30/05/17	**Risk that CCG leadership fails to influence Local Health Economy**	To ensure commissioned services provide consistently high quality services to patients.	A&E Delivery Board representation STP representation Deputy AO on STP Leadership Programme Leadership Courses Clinical leadership - Paean Succession planning STP OD support arranged for December 2017and two more in 2018 facilitated by the Kings Fund Internal OD support for Board has been ongoing from February - September 2018. 4 elected GP/Primary Care Health Professional Board members in place. Deloitte Single Strategic Commissioner OD plan in place includes engagement with ICS partners. Joint Executive weekly meeting between TW and SCCG also acts as programme board for Single Strategic Commissioner scrutinising progress against plan and OD plan. 1 single AO covering TWCCG and SCCG 1 single Director structure across both CCGs Joint Governing body Members elected and appointed for August 2020. Govenring body meetings in common begin Septmeber 2020. Governing body OD plan agreed with Deloitte as delivery partner and communicated to GB memebrs in first workshop.	OD work at Board Development Days -as part of single strategic commissioner transition and creation of joint Board roles. OD work with staff has started as part of single strategic commissioner transition although paused due to Covid.	Gap in control: Strengthen partnership working with other parts of provider health economy Need to talent spot next leaders - clinical and non clinical. Currently staff OD work in abeyence due to Covid 19 response. Gaps in assurance: Board reporting of OD Plan	High 12 = major 4 x possible 3	STP will be transitioning into CCGs scope and timeline is still being agreed but this may be latter as a result of Covid 19 response. October 2020 (DE) ~~Governing Body alignment – Paper to Boards Jan 2020 outlining proposed transition to a new shared Constitution that memberships will be required to approve that will then lead to management of change process for existing governing body members and recruitment/election to shared roles on both governing bodies.~~ ~~**Work progressing as per programme plan which is shared with Board . AS Sep 2020**~~ Staff Management of change now programmed for end of Septmeber which will then lead to staff OD beginning earliest December/January follwoing the end of management of change process. Delivery of Staff OD plan is currently being discussed with CSU as delivery partner. Once full OD plan is agreed this will be reported to Govenring bodies. Nov 2020 AS	Moderate 8 = major 4 x unlikely 2	DE AS	DE AS 26/06/17 DE 10/11/17 DE 23/02/18 AS 10/07/18 AS 31/08/18 AS 19/12/18 AS 14/03/19 AS 29/08/19 DE/AS 11/11/19 AS 07/01/20 AS 30/04/20 AS 15/08/20

9 (To replace Risk 5)	5	JC 26/06/18	**Underlying Financial Position** There is a risk that the CCG fails to deliver its financial plan for 2020/21 and that the underlying position going forward will significantly deteriorate. This is now further impacted by the uncertainty to the financial position due to the impact of the COVID-19 pandemic.	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	Robust financial model with sufficient detail to model growth, inflation and QIPP sensitivities. Comprehensive QIPP programme in place: overseen by PPQ, ~~Joint QIPP Board (meets monthly),~~ QIPP, PMO. Business case challenge/due diligence on schemes. Constitution, Standing Orders, Prime Financial Policies and Schemes of Reservation and Delegation. Suite of financial policies and procedures. Robust contract challenge mechanisms with main providers. Finance and contract reports to PPQ and CCG Board, highlighting risks and mitigating actions. Regular budget manager meetings in order to identify early deviation from plan and agree mitigating actions. Regular CCG Board consideration of the financial position and oversight of management actions.	Lead Committee - PPQ Regular reporting of finance, QIPP, contracting and performance position to PPQ and CCG Governing body. Completion of internal audit recommendations; outstanding audit actions reviewed at Audit Committee, assurance gained through seeing maintained internal audit ratings for finance and QIPP. Action Trackers for Contract Management Meetings with providers and escalation where required through executive level Strategic Commissioning meetings. NHSE/I escalation meetings in place.	GC1: Development of robust financial recovery plan GC2: Absence of formal signed off 2020/21 plan with NHSEI due to pause in planning due to COVID-19 GC3: Absence of signed contracts due to pause in planning and contracting due to COVID-19 GC4: Impact of COVID-19 on financial position currently uncertain	Extreme x Major = 25 High	GC1: Financial Recovery plan in development and being discussed with NHSE/I on a regular basis. Draft plan submitted as part of application to become a Single Strategic Commissioning organisation. Plan to continue to be refined and aligned with Clinical Commissioning strategy. However, awaiting NHSEI ~~instruction /~~ planning guidance on the impact of COVID-19. Revised draft of plan to be worked up for September submission and to include the impact of Resoration/Recovery modelling. Financial recovery processes implemented including enhanced governance and increased grip and control. Executive team to continue to develop actions to reduce expenditure. Current QIPP plans are hindered by the impact on provider capacity due to COVID-19. GC2: For 2020/21 budgets for Months 1-4 have now been issued by NHSEI based on 2019/20 Month 11 expenditure and a system of retrospective allocation adjustments is underway. Confirmation is awaited but it is now likely that a similar arrangement will continue throughout 2020-21. Therefore, we await NHSEI planning guidance in terms of submitting a plan for 2021/22. ~~Regular discussion with NHSEI on next steps in agreeing a plan/revising plan for impact of COVID-19. Awaiting further guidance/instruction from NHSEI.~~ Finance team have submitted the Month 2 position and a Month 1-4 forecast based on the known impact of COVID-19 and other issues compared to issued budgets. ~~currently working up Month 1- 4 forecast snapshot based on the known impact of COVID-19. To be presented to PPQ in May 2020.~~ GC3: - The contract and planning round has been paused. The CCG was in final stages of negotiation with providers for 2020/21 contracts and therefore final contract values have not been agreed. In the meantime we have secured agreement that all parties still wish to operate block contracts once we resume usual activities. New contract arrangements for the future including risk shares are in discussion as part of the system restoration/recovery plan. GC4:Organisations have stepped away from their original operating plans in order to support our response to COVID-19 and we are awaiting guidance on what is expected of systems with regard to financial modelling and targets for the rest of this financial year. A snapshot of the ~~potential~~ current financial implications on the financial position has been presented to NHSEI and Execs for Month 2. ~~for Months 1-4 is currently being worked up to be presented to Finance and Performance Committee in May.~~	Likely major=16	CS LC	JC 28/06/18 JC 28/08/18 JC 18/12/18 JC 22/08/19 CS 07/01/20 LC 03/03/20 LC 05/05/20 LC 17/06/20
10	1&4	FB 2/11/18	**Meeting ED target** Risk that the performance meeting the ED target of 95% of patients being discharged in 4 hours is not met and continues to worsen.	Opportunity to redesign Urgent Care by improving alternatives to ED attendances and Emergency admissions	Dedicated Urgent Care Director with strong ECIST links. ED Delivery Board and ED Delivery Group include all partners ensuring a system wide approach to mitigating the risk. CCG provides significant resource to managing flow on a daily basis to ensure Complex patients are discharged within 48 hours and on the most appropriate pathway. The ED Board has approved a Recovery Plan which the ED Group monitors. Regulators are heavily involved in supporting/challenging SaTH and our system. Practices have improved urgent care and extended hours access. CCG has commissioned a streaming service to divert patients with minor injuries/illnesses from the ED Demand and capacity modelling better than in previous years in Winter Plan ECIP support via Urgent Care Director Excellent community collaboration resulting in target for Fit to Transfer largely being met and DTOC amongst lowest in the	ED Delivery Board ED Delivery Group Regional Escalation Group (led by NHSI) PPQ performance reports A range of workstream project Boards and steering groups that report to EDDB and/or STP e.g. Frailty Board, Integrated Discharge Group etc	Risk averse culture and lack of understanding of the disadvantages of hospital based care for many older frail patients Workforce capacity and reliance on traditional models of care No current trajectory for when the ED Target will be met Significant distraction at present while focus is on the closure overnight of PRH ED Insufficient traction in delivering the Recovery Plan Capacity challenges in Domiciliary Care in T&W Resistance from ambulance service to use community alternatives to attendance/admissions New focus on top three priorities included in revised STP Plan:- 1. Acute Processes 2. ED Processes 3. Acute workforce. New trajectory to achieve 80% by March 2020. T&W Council now able to maintain Saturday Social Worker input to PRH all year long	Likely x Major = 16 High	Alternative secondary care dispositions being explored and implemented e.g. Urgent Treatment Centres, SDEC - Action owned by A&E Delivery Group. Review transformation implemented as part of Covid-19 response to implement those that support hospital flow - Action owned by A&E Delivery group. Performance has improved to >85%, key is to maintain that as activity restores post COVID. UEC delivery group now being re-instigated to lead the work necessary to maintain this performance. Work has begun on integrated system performance reporting and dashboard to give earlier view of issues and better highlight system interdependancies. It will also enable us to be more proactive take appropriate action earlier.	Possible x moderate = moderate 9	JD AP	FB 19/12/18 FB 15/03/19 AP 06/05/20 FB 07/01/20 JD 19/06/20
11	1&4	FB 2/11/18	**0-25 Emotional Wellbeing Service** Risk that the implementation of the new 0-25 service model for Children and Young People is delayed.	Opportunity to provide the model envisaged when the CCGs procured the new service. This will address the emotional and mental health needs of a wider group of our population more effectively through a partnership with a range of voluntary organisations.	Dedicated contract monitoring of the 0-25 service. Joint Recovery Action Plan based on recommendations from a recent IST review has been agreed and is being implemented.	PPQ Board New STP Partnership Board (under development) NHSE performance meetings	Gaps in controls: Current workforce skill mix is still too medically biased and pathways with voluntary organisations need more development. MPFT has been proactive in reducing waiting times, but more to do. Similarly the change to move from medical models to more socio/psychological models is ongoing but ideally would be faster. Gaps in assurance: CCG requires more granular analysis on progress implementing changes - these will be provided as part of the Joint Action Plan monitoring.	Likely x Major = 16 High	Wider cultural changes are needed across the system in schools, primary care etc to ensure partners make appropriate contributions to the support of CYP with emotional/behavioural challenges. FB/FS Feb 2019	Possible x moderate = moderate 9	ST FS	FB 19/12/18 FB 15/03/19 FB 07/01/20

13	1,2,3,4,5	AS 20/08/19	**Failure to create a single strategic commissioner by April 2021**	Opportunity to work more collaboratively with partners and across the health and social care system to deliver the objectives of the NHS Long Term Plan and the requirements to reduce administration costs by 20%	Change Management Policy already in existence PMO support via CSU in place from 01/07/19 HR support via CSU in place from 01/07/19 OD partner support in place form 08/08/19 Joint Project created with joint SRO in place Governance for project in place - workstreams and oversight group Deliverables and programme plan Communications and Engagement Project Plan in place New application deadline agreed with NHSE of 30 April 2020 Action plan for addressing panel application **fee**dback submitted Nov 2019 to NHSE Further work undertaken on scoping operating model to help inform director's design of staffing structures Membership agreement to new interim constitution to allow jointly appointed governing body members on both CCG Boards. Consultation with existing governing body members completed.. Clearer operating model developed at high level which is informing design of staff structure. Application submitted 30 April 2020 Clearer alignment of ICS development with Single Startegic Commissioner timeline Governing Bodies - Joint Chair and CPH Healthcare Professionals now elected	Informal and formal Board discussions and update papers Board paper to March meeting. Board paper and agreement at May Board meeting Briefing papers presented at JHOSC and HWBBs for both local authorities during June 2019 Project reporting weekly to Joint Executive Group Weekly teleconference update on project status with both Accountable Officers and Chairs of both CCGs Weekly progress reports to Joint Executive Group acting as project oversight group Submission of application completed and panel presentation to NHSE/I on 3 June 2020 completed. Positive informal feedback received. Recommendation to approve application with conditions forwarded to national committee	Gaps in controls: No agreement on final form to date to describe operating model and eventual release 20% savings on administration costs Finance plan and commissioning strategy missing key information that will be produced from further modelling and discussions at a system level Gaps in Assurances: Successful application submission to NHSE/I	Possible x Major = 12 High	Further detailed clarity on Operating Model particularly at place level is being worked through staff management of change/staffing design and in discussions with local authority partners. DE/ST Oct 2020 New Directors to design new staffing structure in preparation for staff management of change which will clarify operating model but will be subject to staff consultation and therefore may change. Sep 2020 (AS) Further information to be added to the Commissioning Strategy post application May/Jun 2020 ready for next submission to NHSE/I on 30 September 2020 ST/AP Timeline for additional modelling to inform Finance plan agreed with NHSE/I post application Sep - Dec 2020 CS ~~Submission of application completed and work continues on prep for panel presentation to NHSE/I on 3 June 2020 AS June 2020~~	Unlikely x major = moderate 8	DE /AS	AS 20/08/19 AS 11/11/19 AS 07/01/20 AS 30/04/20 AS 03/08/20
14	1,2,3,4,5	AS 19/03/20	**Failure to manage with partners the local health system response to Covid 19 pandemic**	Opportunity to work using remote technology across a broader spectrum of staff and other partner organisations/primary care across the health and social care system.	EPRR processes in place and tested National and regional daily Covid 19 calls involving SRO and AO Business Continuity plans in place and have been enacted Critical services identified, non critical scaled down CCG SRO dedicated to leading CCG response – internal and external, with partners in local authority Redeployment of clinical staff to front line NHS services enacted Most staff apart from critical services that must be on site working from home. Financial accounting of Covid 19 additional cost incurred. Staff in on site critical services are cmplinat with government guidance on safe distances.	Briefings to Board members and Executive team National guidance continues to be issued which is being enacted by CCG Gold Command Group Silver Command Group Theme specific Task & Finish Groups Gold Command Risk Register in place Gold Command decision log shared with Committee Chairs/Lay members	Gaps in controls: Ability for national PPE supply chain to keep pace with demand Lack of clarity regarding release of guidance and its implementaition Gaps in Assurances: To comply with NHSE guidance on decision making ad assurance functions during Covid 19 response, Governance Board and Committee meetings will be scaled back Impact on population as lockdown eases are currently unknown therefore CCG response may be inadequate.	Possible x Catastrophic = 15 High	Incident response structure now well bedded in with good enagement from all system partners. System has been able to respond well to all COVID19 related tasks and has managed its response well. Critical Care and Death Management capacity created for the response phase has been sufficient and the system has not been overwhelmed. System now focusing in tandem on Restoration phase whilst maintaining ability to respond to a further surge in COVID19 activity should it occur. Response remains resource intensive and the systems ability to maintain this when managing restoration in tandem will require continual monitoring Silver and Gold Command regaularly review the PPE issues and a dedicated PPE supply chain cell has brought together the system to manage the supply chain locally. This has been of great benefit in mitigating risk as far as is possible. System approach through Silver command to implementation of national guidance as proved beneficial in addressing the requirements Governance Board and Committee meetings will be scaled back in line with a proposal that was briefed to Board members at an informal Board on 9th April. Regular informal briefing of Board members will be held remotely to supplement formal mechanisms being scaled back. Agreement to provide Committee Chairs and Lay members with the Gold Command decision log on a fortnightly basis	Possible x Major = 12 High	DE/ST	AS 19/03/20 ST 11/06/20
15	1,2,3,4,5	ST 05/05/20	**Failure to capture and act on learning from local system responses to Covid19 poses a risk to longer term system recovery plans**	Opportunity to 'lock in' beneficial changes that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations			Gaps in controls: Insufficient synergy between STP PMO , CCG PMO and Provider PMO Gaps in Assurances: No one consistent programme approach to changes in the system Absence of complete and consistent data sources across system Potential for immediate service/ response needs to detract from medium to longer term system planning and to impact on cross system working	Possible and Major=12 High	Implementation of whole system governance established as part of COVID 19 response will be furhter developed to governance structure post Covid (ST May 2020) LHRP subgroups structure to be transformed into the mechanism to co-ordinate and capture learning going forward (ST May 2020) Cross system working to be the focus of methodology of addresseing restore and recover as per Simon Stevens letter 29 April (ST May - June 2020) Increased Clinical leadership visable in response work will be being uitlised in Restore and Recover ST (May 2020) Programme of work to be co-ordinated around learning from both qualiaitive and quantitative data sets . (ST TJ / LC April-June) 2020) Implemention of a transformation oversight group (ST May 2020) Development of a refreshed System LTP (To be co-ordinated by STP Lead date TBC) Creation of System Evalaution HUB (ST July 2019)	**Possible x moderate = moderate 9**	ST TJ	TJ 05/05/20 TJ 16/06/20

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 9 September 2020**

Item Number:	Agenda Item:
GB-20-09.106	Proposed changes to the Constitutions and Governance Handbooks of NHS Shropshire CCG and NHS Telford and Wrekin CCG

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

Action Required (please select):									
A=Approval	X	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)**
None to date		

Executive Summary (key points in the report):

Both Shropshire and Telford and Wrekin CCGs have submitted and had changes to their Constitutions ratified by NHS England/Improvement that came into effect on 10th August 2020. These changes were to facilitate the joint appointments of Governing body members to both CCGs and the alignment of the CCGs Committee structures to make decision making more effective and efficient during the interim period leading up to the creation of a single CCG.

The time the approval and ratification process has taken from approval by both memberships through to ratification by NHS England/Improvement has been lengthy and during this time changes to roles and responsibilities have taken place that require the Constitutions and Governance Handbooks of both CCGs to be amended to reflect these.

The report outlines the proposed changes to both the Constitutions and Governance Handbooks and summaries of specific pages are attached as appendices. As the full Constitution documents and Governance Handbooks showing proposed changes are lengthy these are not attached to the papers but can be accessed by requesting electronic copies from the Director of Corporate Affairs.

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

7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Recommendations/Actions Required:

NHS Shropshire CCG Governing Body is recommended to:

- Note the changes being proposed to both the Constitution and the Governance Handbook as outlined in the report and appendices; and
- Approve the proposed amendments to the Constitution under clause 1.4.2 of the Constitution that the changes are not material and do not require approval by the membership of the CCG; and
- Approve the proposed amendments to the Governance Handbook.

NHS Telford and Wrekin CCG Governing Body is recommended to:

- Note the changes being proposed to both the Constitution and the Governance Handbook as outlined in the report and appendices; and
- Approve the proposed amendments to the Constitution under clause 1.4.2 of the Constitution that the changes are not material and do not require approval by the membership of the CCG; and
- Approve the proposed amendments to the Governance Handbook.

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1. Introduction

Both Shropshire and Telford and Wrekin CCGs have submitted and had changes to their Constitutions ratified by NHS England/Improvement that came into effect on 10th August 2020. These changes were to facilitate the joint appointments of Governing Body members to both CCGs and the alignment of the CCGs Committee structures to make decision making more effective and efficient during the interim period leading up to the creation of a single CCG.

The time the approval and ratification process has taken from approval by both memberships through to ratification by NHS England/Improvement has been lengthy and during this time changes to roles and responsibilities have taken place that require the Constitutions and Governance Handbooks of both CCGs to be amended to reflect these.

The report outlines the proposed changes to both the Constitutions and Governance Handbooks and summaries of specific pages are attached as appendices. Full copies of the Constitutions and Governance Handbooks showing the proposed changes can be requested from the Director of Corporate Affairs:

2. Report

2.1 Constitutions

For ease of reference the proposed changes are documented below and shown in red text on the attached appendices to this report:

Appendix 1 – Page 22 section 5.6.2 and 5.6.3 – inclusion of the new roles of Medical Director and Associate Lay Member PPI – Equality, Diversity and Inclusion

Appendix 2 – Page 34 & 37 (Shropshire) and page 35 & 38 (Telford and Wrekin) appendix 1 – inclusion of definitions for the roles of Medical Director and Associate Lay Member PPI – Equality, Diversity and Inclusion

Appendix 3 – Page 40 (Shropshire) and page 42 (Telford and Wrekin) section 2.1 inclusion of the Associate Lay Member PPI – Equality, Diversity and Inclusion in the membership of Audit Committee

Appendix 4 – Page 52 (Shropshire) and Page 54 (Telford and Wrekin) section 5.2 Attendees at Primary Care Commissioning Committee - inclusion of the Medical Director and Director of Performance.

Under the Constitution the membership of both CCGs has to approve any changes to it. However, under clause 1.4.2 of both Constitutions in certain circumstances the Accountable Officer may propose amendments to be approved by the Governing Bodies only:

1.4.2 *The Accountable Officer may periodically propose amendments to the Constitution which shall be considered and approved by the CCG Governing Body unless:*

a) changes are thought to have a material impact;

b) changes proposed to the reserved powers of the members;

c) at least half (50%) of the Governing Body Members formally request that the amendments be put before the membership for approval.

Following advice from the Director of Corporate Governance, the Accountable Officer is proposing that these amendments are approved by the Governing Bodies of both CCGs and not the memberships, as the changes do not have a material impact and are not changing the reserved powers of the membership. The Governing Body members are asked to consider approving these changes on this basis, noting that the Governing Bodies can reserve the right to request the amendments are put before the membership if they feel this is necessary in this instance.

2.2 Governance Handbooks

For ease of reference the proposed changes are documented below and shown in red text on the attached appendices to this report:

Appendix 5 – Page 41 (Shropshire) and page 42 (Telford and Wrekin) Quality and Performance Committee Terms of Reference section 2.1 and 2.3 – membership and attendees – increase in number of lay members on the committee given the CCGs have appointed the Associate Lay Member PPI – Equality, Diversity and Inclusion which has increased the lay member capacity. Also inclusion of the Medical Director as an attendee.

Appendix 6 – pages 48/49 (Shropshire) and pages 49/50 (Telford and Wrekin) Joint Strategic Commissioning committee Terms of Reference sections:

5.1 - change to membership from Lay Member Governance to Lay Member PPI – Equality, Diversity and Inclusion
5.2 - change of chair from Lay Member Primary Care to Lay member PPI – Equality, Diversity and Inclusion
5.3 - change of Vice Chair from Lay Member Governance to Lay Member Primary Care
5.4 - inclusion of the Medical Director as an attendee.

Appendix 7 – page 52 (Shropshire) and page 53 (Telford and Wrekin) Joint Individual Funding Committee – inclusion of the titles of both Director's of public Health for both Shropshire and Telford and Wrekin for clarity.

Changes to the Governance Handbooks can be approved by the Governing Bodies as set out in the Scheme of Reservation and Delegation. The Governing Bodies are asked to approve these proposed amendments.

3. Recommendations

NHS Shropshire CCG Governing Body is recommended to:

- Note the changes being proposed to both the Constitution and the Governance Handbook as outlined in the report and appendices; and
- Approve the proposed amendments to the Constitution under clause 1.4.2 of the Constitution that the changes are not material and do not require approval by the membership of the CCG; and
- Approve the proposed amendments to the Governance Handbook.

NHS Telford and Wrekin CCG Governing Body is recommended to:

- Note the changes being proposed to both the Constitution and the Governance Handbook as outlined in the report and appendices; and
- Approve the proposed amendments to the Constitution under clause 1.4.2 of the Constitution that the changes are not material and do not require approval by the membership of the CCG; and
- Approve the proposed amendments to the Governance Handbook.

APPENDIX 1

1.1 Additional Attendees at the Governing Body Meetings

5.6.1 The CCG Governing Body may invite other person(s) to attend all or any of its meetings, or part(s) of a meeting, in order to assist it in its decision-making and in its discharge of its functions as it sees fit. Any such person may be invited by the chair to speak and participate in debate, but may not vote.

5.6.2 The CCG Governing Body will regularly invite the following individuals to attend its meetings held in public as attendees:

a) Associate Lay Member Patient and Public Involvement – Equality, Diversity and Inclusion

b)The Director of Corporate Affairs;

c) The Director of Partnerships;

d) The Director of Performance;

e) The Director of Planning;

f) The Medical Director

e) Director Public Health for Shropshire;

f) Director of Public Health for Telford and Wrekin;

g) Representative of Shropshire Healthwatch; and

h) Representative of Telford and Wrekin Healthwatch.

5.6.3 The CCG Governing Body will regularly invite the following individuals to attend its meetings held where circumstances require the Governing Body to transact business in private as set out in Standing Order 3.13.1:

a) Associate Lay Member Patient and Public Involvement – Equality, Diversity and Inclusion

b) The Director of Corporate Affairs;

c) The Director of Partnerships;

d) The Director of Performance;

e) The Director of Planning;

f) The Medical Director.

APPENDIX 2

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006
Accountable Officer (AO)	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act, appointed by NHS England/Improvement, with responsibility for ensuring the Group: complies with its obligations under: sections 14Q and 14R of the 2006 Act, sections 223H to 223J of the 2006 Act, paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006, and any other provision of the 2006 Act specified in a document published by the Board for that purpose; exercises its functions in a way which provides good value for money.
Area	The geographical area that the CCG has responsibility for, as defined in part 2 of this constitution
Associate Lay Member Patient and Public Involvement (PPI) – Equality, Diversity and Inclusion	A lay Member who is appointed by the CCG and attends, but is not a member of the CCG Governing Body. A lay Member is an individual who is not a Member of the CCG or a healthcare professional (as defined above). This Lay Member is one with knowledge about the CCG area enabling them to advise on patient and public involvement matters with a particular focus on equality, diversity and inclusion matters.
Chair of the CCG Governing Body	The individual appointed by the CCG to act as chair of the Governing Body and who is usually either a GP member or a lay member of the Governing Body.
Chief Finance Officer (CFO)	A qualified accountant employed by the Group with responsibility for financial strategy, financial management and financial governance and who is a member of the Governing Body and described as Executive Director of Finance.
Clinical Commissioning Groups (CCG)	A body corporate established by NHS England/Improvement in accordance with Chapter A2 of Part 2 of the 2006 Act.
Clinically Qualified Independent Members	Those Governing Body Members described as the Secondary Care Doctor and Registered Nurse.
Committee	A Committee created and appointed by the membership of the CCG or the Governing Body.
Committees in Common	A mechanism for similar committees of two statutory bodies to meet at the same time and place and to consider them same items of business.

Director	A member of the employed senior executive team of the CCG, who do not have a vote on the Governing body but attend the meetings.
Deputy Chair	This person is appointed from the Lay Members to deputise for the CCG Chair and chair Governing Body meetings when the Chair is unable to attend the Governing Body meeting.
Executive Directors	A member of the employed senior executive team of the CCG, who is a member and has a vote on the Governing Body.
Governing Body	The body appointed under section 14L of the NHS Act 2006, with the main function of ensuring that a Clinical Commissioning Group has made appropriate arrangements for ensuring that it complies with its obligations under section 14Q under the NHS Act 2006, and such generally accepted principles of good governance as are relevant to it.
Governing Body Member	Any individual appointed to the Governing Body of the CCG
Healthcare Professional	A Member of a profession that is regulated by one of the following bodies: the General Medical Council (GMC) the General Dental Council (GDC) the General Optical Council; the General Osteopathic Council the General Chiropractic Council the General Pharmaceutical Council the Pharmaceutical Society of Northern Ireland the Nursing and Midwifery Council the Health and Care Professions Council any other regulatory body established by an Order in Council under Section 60 of the Health Act 1999
Joint Committee	Committees from two or more organisations that work together with delegated authority from both organisations to enable joint decision-making
Independent Governing body Member who is clinically qualified	This is the Secondary Care Doctor Governing Body Member and the Registered Nurse Governing Body Member.
Independent GP Representative	That individual appointed to the Primary Care Commissioning committee who is a practising GP in another CCG area or a retired GP from Shropshire and Telford and Wrekin area.
Lay Member Governance	A lay Member of the CCG Governing Body, appointed by the CCG. A lay Member is an individual who is not a Member of the CCG or a healthcare professional (as defined above) or as otherwise defined in law. This Lay Member will lead on audit, conflicts of interest and to undertake the role of Conflicts of Interest Guardian and Freedom to Speak Up Guardian to be

	known as the Lay Member for Governance.
Lay Member Public Patient Involvement (PPI)	A lay Member of the CCG Governing Body, appointed by the CCG. A lay Member is an individual who is not a Member of the CCG or a healthcare professional (as defined above) or as otherwise defined in law. one with knowledge about the CCG area enabling them to lead on patient and public involvement matters to be known as the Lay Member for PPI.
Lay Member Primary Care	A lay Member of the CCG Governing Body, appointed by the CCG. A lay Member is an individual who is not a Member of the CCG or a healthcare professional (as defined above) or as otherwise defined in law. This role is to provide a sound understanding of the challenges and opportunities which face primary care. This individual will also chair the Primary Care Commissioning Committee
Medical Director	A member of the employed senior executive team of the CCG and a GP, who does not have a vote on the Governing body but attends the meetings.
Membership Forum	The mechanism for the CCG membership to meet, discuss and approve decisions where necessary, either face to face or by virtual or electronic means via practice representatives.
Member/ Member Practice	A provider of primary medical services to a registered patient list, who is a Member of this CCG.
Member practice representative	Member practices appoint a healthcare professional to act as their practice representative in dealings between it and the CCG, under regulations made under section 89 or 94 of the 2006 Act or directions under section 98A of the 2006 Act.
Primary Care Commissioning Committee	A Committee required by the terms of the delegation from NHS England/Improvement in relation to primary care commissioning functions. The Primary Care Commissioning Committee reports to NHS England/Improvement and the Governing Body
Professional Standards Authority	An independent body accountable to the UK Parliament which help Parliament monitor and improve the protection of the public. Published *Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England* in 2013
NHS England/Improvement	The operational name for the National Health Service Commissioning Board.
Registers of interests	Registers a Group is required to maintain and make publicly available under section 14O of the 2006 Act and the statutory guidance issues by NHS England/Improvement, of the interests of: the Members of the Group; the Members of its CCG Governing Body;

	the Members of its Committees or Sub-Committees and Committees or Sub-Committees of its CCG Governing Body; and Its employees.
Sub-Committee	A Committee created by and reporting to a Committee.
Vice Clinical Chair	A GP/Health Professional elected to the Governing Body who deputises for the CCG Chair for clinical matters.

APPENDIX 3

Audit Committee

Terms of Reference

1. Introduction

1.1 The Audit Committee (the committee) is established by The Governing Body in accordance with the CCG's Constitution, standing orders and scheme of reservation and delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the constitution.

1.2 The Audit Committee (the Committee) is responsible for supporting the CCG in the delivery of its statutory duties and to provide assurance to the Governing Body in relation to the delivery of these duties. It shall advise and provide assurance to the Governing Body on:

- The strategic processes for risk, control and governance and the Governance Statement;
- The accounting policies, accounts and annual report of the CCG;
- Planned activity and results of both internal and external audit;
- Adequacy of response to issues identified by audit activity, including external audit management letter;
- Management of risk and corporate governance requirements of the CCG; and
- Anti-fraud policies, raising concerns at work processes and conflicts of interest.

1.3 The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by the Committee.

1.4 It is authorised by the Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of external representation with relevant experience or expertise if it considers necessary.

1.5 The Committee is authorised to create working Groups or task and finish Groups in order to take forward specific programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such working Groups or task and finish Groups. The minutes of such Groups will be presented to the committee.

1.6 The Audit Committee may meet 'in-common' with the Audit Committee of NHS Shropshire CCG.

1.7 The Committee has authority to make the following decisions on behalf of the Governing Body as set out in the Scheme of Reservation and Delegation:

- To approve policies and procedures specific to the Committee's remit which include, but are not limited to:
    - Risk Management
    - Conflicts of Interest management
    - Health and Safety
    - Human Resources
    - Security Management
    - Counter Fraud
    - Financial Policies

2. Membership

2.1 The membership of the Committee will be as follows:

- Governing Body lay members for Governance, PPI, Primary Care and PPI – Equality, Diversity and Inclusion

Deputies:

- Independent Governing Body member who is clinically qualified

2.2 All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Committee Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified.

2.3 In addition meetings will be attended by the following (non-voting):

- Executive Director of Finance (Chief Finance Officer)
- Director of Corporate Affairs
- Internal Audit Manager
- External Audit Manager
- Counter Fraud Specialist

2.4 Other members of staff and CCG members will be invited to attend at the committee's discretion.

2.5 The external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the committee and its Chair.

APPENDIX 4

Primary Care Commissioning Committee (PCC)

Terms of Reference

1. **Introduction**

1.1 Simon Stevens, the Chief Executive of NHS England/Improvement, announced on 1 May 2014 that NHS England/Improvement was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England/Improvement would delegate the exercise of certain specified primary care commissioning functions to a CCG.

1.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England/Improvement has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Telford and Wrekin CCG.

The delegation is set out in Schedule 1.

1.3 The CCG has established the NHS Telford and Wrekin CCG Primary Care Commissioning Committee (PCC) ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

1.4 It is a committee comprising representatives of the following organisations:

- NHS Telford and Wrekin CCG

2 Statutory Framework

2.1 NHS England/Improvement has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

2.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England/Improvement for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England/Improvement, exercise those set out below:

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

2.5 The Committee is established as a committee of the NHS Telford and Wrekin CCG Governing Body in accordance with Schedule 1A of the "NHS Act".

2.6 The members acknowledge that the Committee is subject to any directions made by NHS England/Improvement or by the Secretary of State.

3 Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Telford and Wrekin, under delegated authority from NHS England/Improvement.

3.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England/Improvement and NHS Telford and Wrekin CCG, which will sit alongside the delegation and terms of reference.

3.3 The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

3.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

3.5 This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

3.6 The CCG will also carry out the following activities:

a) To plan, including needs assessment, primary care services in Telford and Wrekin;

b) To undertake reviews of primary care services in Telford and Wrekin;

c) To co-ordinate a common approach to the commissioning of primary care services generally;

d) To manage the budget for commissioning of primary care services in Telford and Wrekin.

4 Geographical Coverage

4.1 The Committee will comprise the NHS Telford and Wrekin CCG area.

5 Membership

5.1 The Committee shall be constituted in accordance with the following:

Voting members:

- Lay Member for Patient and Public Involvement
- A second lay member (who is the chair of the Primary Care Commissioning Committee)
- Independent GP Representative
- Accountable Officer
- Executive Director of Finance (Chief Finance Officer) (or deputy)
- Executive Director of Transformation (or deputy)
- Executive Director of Quality (or deputy)
- Director Of Partnerships (or Deputy)

5.2 Attendees:

- 2 GP/Primary Care Health Professional Governing Body Members (one the CCG Chair and one another GP/Primary Care Health Professionals, and of these, one should be drawn from those GP/Primary Care Health Professionals on the Governing Body elected by NHS Shropshire CCG membership and one should be drawn from those GP/Primary Care Health Professionals on the Governing Body elected by NHS Telford and Wrekin membership)
- Director of Performance
- Medical Director
- Telford and Wrekin Healthwatch representative
- Telford and Wrekin Council Health and Wellbeing Board representative

5.3 The Chair of the Committee shall be a Lay Member with responsibility for Primary Care Commissioning appointed by the Governing Body.

5.4 The Vice Chair of the Committee shall be a Lay Member with responsibility for Patient and Public Involvement, appointed by the CCG Governing Body.

APPENDIX 5

Quality and Performance Committee

Terms of Reference

1. Introduction

1.1 The Quality and Performance Committee (the committee) is established by the Governing Body in accordance with NHS Telford and Wrekin Clinical Commissioning Group's Constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee.

1.2 The Quality and Performance Committee (the Committee) is responsible for the oversight and monitoring of:

- the quality of commissioned services including patient experience, safety and clinical effectiveness;
- the effectiveness and performance of commissioned services;
- the performance of the CCG and their delivery of agreed outcomes.

1.3 The committee will support the Governing Body in ensuring the continuous improvement in the quality of services commissioned on behalf of the CCG. The committee aims to ensure that quality sits at the heart of everything the CCG
does, and that evidence from quality assurance processes drives the quality improvement agenda across the Shropshire, Telford and Wrekin healthcare economy.

1.4 The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by the Committee.

1.5 It is authorised by the Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of external representation with relevant experience or expertise if it considers necessary.

1.6 The Committee is authorised to create working Groups or task and finish Groups in order to take forward specific programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such working Groups or task and finish Groups. The minutes of such Groups will be presented to the committee.

1.7 The Quality and Performance Committee may meet 'in-common' with the Quality and Performance Committee of NHS Telford and Wrekin CCG.

1.8 The Committee has authority to make the following decisions on behalf of the Governing Body as set out in the Scheme of Reservation and Delegation:

- To approve policies and procedures to minimise clinical risk, maximise patient safety, support safeguarding of vulnerable adducts and children and to secure continuous improvement in quality and patient outcomes.

- To approve policies and procedures to support delivery of patient engagement and involvement.

- To approve policies and procedures in relation to complaints management.

2 Membership

2.1 The membership of the committee will be as follows:

- ~~1~~ 2 lay members
- 1 GP/Primary Health Care Professional Board member
- Registered Nurse
- Secondary Care Doctor

2.2 All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Committee Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (In the case of clinical members).

2.3 Other directors and senior managers will be invited to attend where appropriate. Expected attendance will include:

- Executive Director of Quality
- Director of Performance
- Director of Corporate Affairs
- Medical Director

3 Chairing arrangements

3.1 The Committee will be chaired by the Lay Member for PPI.

3.2 In the event of the chair of the audit committee being unable to attend all or part of the meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.

3.3 If the Chair is unable o chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.

4 Secretary

4.1 Secretarial support for the panel will be provided by the Corporate PA team. Their role will be to support the chair in the management of committee business.

APPENDIX 6

Joint Strategic Commissioning Committee

Terms of Reference

1. Introduction

1.1 The National Health Service (NHS) faces unprecedented financial and clinical challenges including rising demand for services and a significant financial gap. A system-wide solution is required to address these challenges for the benefits of patients.

1.2 The following organisations have agreed to work together to meet these challenges and jointly commission services where it is appropriate to do so:

NHS Shropshire Clinical Commissioning Group (Shropshire CCG)
NHS Telford and Wrekin Clinical Commissioning Group (Telford and Wrekin CCG)

1.3 The establishment of the Joint Strategic Commissioning Committee will formalise collaborative working between the two CCGs.

2. Purpose

2.1 The NHS Shropshire and NHS Telford and Wrekin CCGs Joint Strategic Commissioning Committee (the Committee) is responsible for discharging functions and powers delegated to it by NHS Shropshire CCG and NHS Telford and Wrekin CCG to jointly commission goods and services for the residents of Shropshire, Telford and Wrekin.

3. Authority

3.1 The Committee is established in accordance with NHS Shropshire and NHS Telford and Wrekin Clinical Commissioning Groups' Constitutions, as a joint committee of, and accountable to, NHS Shropshire Clinical Commissioning Group Governing Body and NHS Telford and Wrekin Clinical Commissioning Group Governing Body.

3.2 The statutory framework that allows a Joint Committee to be created is Section 14Z3 of the Health and Social Care Act 2006 (as amended).

3.3 These terms of reference set out the membership, remit, responsibilities, standing orders and reporting arrangements of the Committee.

3.4 The Committee is authorised to seek any information it requires from any employee of both CCGs and all employees of both CCGs are directed to co-operate with any requests made by the Committee.

3.5 It is authorised to obtain outside legal or other independent professional advice and to secure the attendance of external representation with relevant experience or expertise if it considers necessary.

3.6 The Committee is authorised to create working Groups or task and finish Groups in order to take forward specific programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such working Groups or task and finish Groups. The minutes of such Groups will be presented to the committee.

3.7 The Committee has authority to make commissioning decisions on behalf of NHS Shropshire and NHS Telford and Wrekin CCGs as set out in the respective Schemes of Reservation and Delegation for the following:

- Acute services
- Specialist services
- Community services
- Maternity Services
- Urgent care – 111 services

- Emergency and non emergency Transport services
- Mental Health services
- Prescribing (Strategic)
- Equipment services
- Services commissioned via a Section 75 agreement
- Childrens' Services
- Individuals Commissioning
- Learning disabilities
- Shared grants
- Care closer to home
- Specialised Commissioning

The Committee should recognise that there are large variations in demographics and the need across Shropshire, Telford and Wrekin and that a local understanding is beneficial in designing services to meet that need.

4. Duties

The Committee will be responsible for exercising the following functions with regard to the services outlined in 2.7 above:

4.1 Make commissioning decisions in line with the financial limits delegated by the Governing Body of Shropshire CCG and Governing Body of Telford and Wrekin CCG which will include but not limited to:

- Reviewing and approving business cases and service change requests and redesign
- Reviewing and approving needs assessment and demand and capacity planning
- Overseeing procurement processes and awarding tenders
- Overseeing contract and contract management
- Identifying and approving joint work with local authorities
- Setting outcomes for providers and monitoring outcomes
- Decommissioning services

4.2 When making decisions the Committee will ensure that:

- Appropriate evidence is available to demonstrate clinical and cost effectiveness, including consideration of benchmarking information where available;
- Appropriate Quality, Equality and Data Protection Impact assessments are completed and their findings considered as part of the decision making. This will include consideration of collective impact of previous decisions and current and future proposals.
- Appropriate stakeholder engagement and consultation where appropriate takes place and is considered;
- Appropriate information on wider commissioning decisions and services across the health and social care system is considered.
- Ensure economy, efficiency and effectiveness in the use of CCG resources.

4.3 Oversee development and ongoing review of the CCGs' ethical decision making framework for recommendation to the Governing Bodies for approval.

4.4 Oversee development and ongoing review of the Commissioning Strategy of both CCGs for recommendation to the Governing Bodies for approval.

4.5 Oversee development and ongoing review of strategies of both CCGs for recommendation to the Governing Body of Shropshire CCG and Governing Body of Telford and Wrekin CCG specific to the Committee's remit.

4.6 Review and approve policies specific to the Committee's remit.

4.7 Oversee the identification and management of risks relating to the Committee's remit.

5. Membership

5.1 The membership of the committee will be as follows:

- Lay Member PPI – Equality, Diversity and Inclusion
- Lay member Primary Care
- ~~Lay member Governance~~
- 2 GP/Primary Health Care Professional Board members, 1 elected from Shropshire CCG membership and 1 elected from Telford and Wrekin CCG membership
- Registered Nurse
- Accountable Officer
- Executive Director Finance
- Executive Director Quality
- Executive Director Transformation

5.2 The committee will be chaired by the lay member for ~~Primary Care~~ PPI – Equality, Diversity and Inclusion

5.3 The committee will appoint the Lay Member for ~~Governance~~Primary Care as the Vice Chair.

5.4 Other attendees will be invited to attend where appropriate. Expected attendance will include, but is not limited to:

- Representative of Shropshire Council
- Representative of Telford and Wrekin Council
- Director for Partnerships
- Director for Performance
- Director for Planning
- Director for Corporate Affairs
- Medical Director

APPENDIX 7

Joint Individual Funding Committee

Terms of Reference

1. Introduction

1.1 The Joint Individual Funding Committee (Stage 2) (IFC) is established in accordance with NHS Telford and Wrekin Clinical Commissioning Group's Constitution. These terms of reference set out the membership, remit responsibilities and reporting arrangements of the panel.

1.2 The following organisations have agreed to work together to meet these challenges and jointly commission services where it is appropriate to do so:

NHS Shropshire Clinical Commissioning Group (Shropshire CCG)
NHS Telford and Wrekin Clinical Commissioning Group (Telford and Wrekin CCG)

1.3 The establishment of the Joint Individual Funding Committee will formalise collaborative working between the two CCGs.

2. Membership

2.1 The committee shall be appointed by the Clinical Commissioning Group.

2.2 The following are members of the committee:

- 1 lay member
- Directors of Public Health for Shropshire and for Telford and Wrekin (or deputies)
- 2 CCG GP/Primary Care Health Professional Board members of the CCG Governing Bodies, 1 from Shropshire CCG and 1 from Telford and Wrekin CCG.
- Pharmaceutical Adviser

2.3 The Executive Director of Transformation (or Deputy), Director of Planning (or Deputy) and Executive Director of Quality (or Deputy) will be invited to attend the meetings where their specific knowledge is required to support the Committee to make a decision.

3. Chairing Arrangements

3.1 The Committee will be chaired by the Lay Member.

3.2 In the event of the chair of the Committee being unable to attend all or part of the meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.

3.3 If the Chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 9 September 2020**

Item Number:	Agenda Item:
GB-20-09.107	Appointments to the NHS Shropshire and NHS Telford and Wrekin CCGs and Governing Bodies

Executive Lead (s):	Author(s):
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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)**
Not applicable		

Executive Summary (key points in the report):

The purpose of the report is to:

1) note the recent joint appointments to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG;

2) note the appointment of an Associate Lay Member Public and Patient Involvement (PPI) - Equality, Diversity and Inclusion for both CCGs;

3) note the requirement to appoint the Deputy Chair of the CCGs Governing Bodies to be scheduled for the next meeting of the Governing Body Meetings in Common; and

4) confirm appointment to the joint role of the Vice Clinical Chair of the CCGs.

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? Dr Adam Pringle has a conflict of interest in the approval of the appointment of Vice Clinical Chair. This conflict of interest will be managed by Dr Pringle leaving the meeting and taking no part in the discussion or decision.	Yes
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 appointments to both CCG Governing bodies meet the requirements set out in legislation and regulations.	Yes

5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:

NHS Shropshire CCG Governing Body is recommended to:

1. Note the recent joint appointments to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG as set out in full in section 2.1

2. Note the appointment of Mr Astakhar Ahmed as the Joint Associate Lay Member Public and Patient Involvement (PPI) - Equality, Diversity and Inclusion for both CCGs.

3. Note the requirement for the Governing Body of both CCGs to appoint a Joint Deputy Chair of both CCGs at the next Governing Body meetings in Common held in public in November.

4. Approve the proposed appointment by the Governing Bodies of Dr Adam Pringle as the Joint Vice Clinical Chair.

NHS Telford and Wrekin CCG Governing Body is recommended to:

1. Note the recent joint appointments to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG as set out in full in section 2.1

2. Note the appointment of Mr Astakhar Ahmed as the Joint Associate Lay Member Public and Patient Involvement (PPI) - Equality, Diversity and Inclusion for both CCGs.

3. Note the requirement for the Governing Body of both CCGs to appoint a Joint Deputy Chair of both CCGs at the next Governing Body meetings in Common held in public in November.

4. Approve the proposed appointment by the Governing Bodies of Dr Adam Pringle as the Joint Vice Clinical Chair.

Item Number:	Agenda Item:
GB-20-09.107	Appointments to the NHS Shropshire and NHS Telford and Wrekin CCGs and Governing Bodies

1. Introduction

The purpose of the report is to highlight recent appointments for noting and for the selection of an individual to the role of Vice Clinical Chair.

2. Report

2.1 Governing Body appointments

2.1.1. Both CCGs have recently appointed joint Governing Body members via either; an election process for the GP/Health Care Professional and Chair roles or through a recruitment process for the Registered Nurse, Secondary Care Doctor, Lay Member Patient, Public Involvement (PPI) and Lay Member Primary Care. The Governing Bodies of both CCGs are asked to note the following appointments:

- Appointment by an election of the GP/Healthcare Professional Governing body Members of Dr Julian Povey as Joint CCG Chair

- Appointment by election of the Shropshire CCG membership of

    - Dr Michael Matthee as GP/Health Care Professional Governing Body Member
    - Dr John Pepper as GP/Health Care Professional Governing Body Member
    - Dr Julian Povey as GP/Health Care Professional Governing Body Member

- Appointment by election of the Telford and Wrekin Membership of:

    - Mrs Rachael Bryceland – GP/Health Care Professional Governing Body Member
    - Dr Adam Pringle - GP/Health Care Professional Governing Body Member
    - Ms Fiona Smith - GP/Health Care Professional Governing Body Member

- Appointment by an external recruitment process of:

    - Ms Julie McCabe – Registered Nurse Governing Body Member
    - Dr Martin Allen – Secondary Care Doctor Governing Body Member
    - Mr Gary Turner – Lay Member Primary Care Governing Body Member
    - Mr Meredith Vivien – Lay Member Patient and Public Involvement Governing Body Member

2.2 Associate Lay Member Patient and Public Involvement (PPI) – Equality, Diversity and Inclusion

2.2.1 Through the recruitment process for Lay Members to the Governing Bodies of both CCGs, the opportunity has also been taken to appoint to a new role of Associate Lay Member for Patient and Public Involvement (PPI) - Equality, Diversity and Inclusion. This joint role is not a Governing Body Member and therefore does not have a vote, but will attend all Governing body meetings, whether held as meetings in common or separately and all informal meetings of both governing bodies to take part in discussion and debate to support decision making. This role will focus on patient engagement and involvement and particularly, but not exclusively, on issues relating to equality, diversity and inclusion.

2.2.2 The successful appointee is Mr Astakhar Ahmed and the Governing Bodies are asked to note this joint appointment is for a tenure of 4 years, with a view to amending this role to a Governing Body appointment for a single CCG from 1st April 2021 onwards if the application is approved by NHSE/I and the additional role on the Governing Body is approved by both CCG memberships.

2.3 Deputy Chair of the CCG Governing Bodies

2.3.1 The Constitutions of both CCGs state a requirement for the Governing Body to appoint a Deputy Chair of the CCG Governing Body from amongst the Lay Members on the Governing Body at a meeting in public to chair the Governing Body meetings when the Chair is not in attendance.

2.3.2 The Governing Bodies are asked to note the requirement for the Governing Body of both CCGs to appoint a Joint Deputy Chair of both CCGs in a public meeting, which is scheduled to take place at the next Governing Body meetings in Common in November.

2.4 Vice Clinical Chair of the CCGs

2.4.1 The Constitutions of both CCGs also state a requirement for the Governing Body to appoint a Vice Clinical Chair who will deputise for the Chair of the CCG in their absence to undertake the clinical leadership elements of the Chair role and to act within the authority of the Chair as outlined within the Constitution and CCGs Scheme of Reservation and Delegation for clinical matters.

2.4.2 The Vice Clinical Chair must be appointed from one of the GP/Health Care Professionals elected to the Governing Body. Following discussion and agreement, the GP/Health Care Professional Governing Body Members and Chair are proposing the Governing Bodies appoint Dr Adam Pringle to this role for both CCGs.

3. Recommendations

NHS Shropshire CCG Governing Body is recommended to:

1. Note the recent joint appointments to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG as set out in full in section 2.1

2. Note the appointment of Mr Astakhar Ahmed as the Joint Associate Lay Member Public and Patient Involvement (PPI) - Equality, Diversity and Inclusion for both CCGs.

3. Note the requirement for the Governing Body of both CCGs to appoint a Joint Deputy Chair of both CCGs at the next Governing Body meetings in Common held in public in November.

4. Approve the proposed appointment by the Governing Bodies of Dr Adam Pringle as the Joint Vice Clinical Chair.

NHS Telford and Wrekin CCG Governing Body is recommended to:

1. Note the recent joint appointments to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG as set out in full in section 2.1

2. Note the appointment of Mr Astakhar Ahmed as the Joint Associate Lay Member Public and Patient Involvement (PPI) - Equality, Diversity and Inclusion for both CCGs.

3. Note the requirement for the Governing Body of both CCGs to appoint a Joint Deputy Chair of both CCGs at the next Governing Body meetings in Common held in public in November.

4. Approve the proposed appointment by the Governing Bodies of Dr Adam Pringle as the Joint Vice Clinical Chair.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-20-09.108
Shropshire CCG Governing Body meeting: 9.09.20

Committee Meeting Summary Sheet	
Name of Committee:	Finance and Performance Committee
Date of Meeting:	29/7/2020
Chair:	Claire Skidmore, Executive Director Finance

Key issues or points to note:

This paper provides a summary of key areas and issues discussed at the Finance and Performance Committee meeting of Shropshire CCG held on 29th July 2020:

- **Finance, Contracting and QIPP** – Mrs Skidmore outlined the current financial arrangements for CCGs and presented the month 3 finance position. The committee noted the challenges in accurately forecasting annual spend at this stage and the current absence of further guidance on funding from NHSEI. It was also noted that QIPP arrangements were in the process of being reviewed and re-established where possible and that more information on this would be provided to the September committee meeting.
- **Performance** – Dr Davies gave an update to the committee on key areas and described work currently underway to map demand and capacity in the system to inform our response to the COVID19 situation. Actions to restore services were considered and in particular, pace of restoration of diagnostic services was agreed to be a particular risk for the system if capacity could not be found to deliver sufficient levels of service.
- **CHC Action Plan** – an update was provided to the committee on the work of the CHC team and a discussion was held about the impact of COVID19 on delivery of the original planned actions. Assurance was given that the team are working on recovery arrangements in preparation for the issue of national guidance and as part of this work, QIPP delivery potential is being considered.
- **STP Finance** – The STP Director of Finance gave a verbal update on the system finance position and current planning arrangements. She described work underway to secure additional capital funding for provider infrastructure costs and the committee considered some of the potential areas for investment; discussing the important need for any new funding to be targeted at work that would directly improve quality of patient care and experience.

Actions required by Governing Body Members:

- The Governing Body of Shropshire CCG is asked to note this report.

CCG Board Meeting
Agenda Item GB-20-09.108

NHS
Telford and Wrekin
Clinical Commissioning Group

PLANNING, PERFORMANCE AND QUALITY EXTRAORDINARY COMMITTEE MEETING: CHAIRS REPORT

DATE:	9th September 2020
MINUTES OF MEETING	*28th July 2020* - A full copy of the minutes of the above meeting may be obtained from the Director of Corporate Affairs prior to the Board meeting. Email: alison.smith112@nhs.net
CHAIR	Chair's report written on behalf of Mr Maybury, Lay Member by the Director of Corporate Affairs
CHAIRS ASSURANCE TO BOARD	**Quorum – the Teams meeting had the prescribed quorum and no conflicts of interest that required specific management in the meeting were raised.** **Synopsis of matters discussed and delegated decisions made:** **Maternity Update** Continue to develop monitoring of maternity services in relation to benchmarking and targets. The Trust is implementing a new data system which will provide more detailed information. Progress has been made with perinatal mortality albeit further work is required. **LeDer Update** An update on current performance was provided. 16 reviews have been completed in 2019/20 and causes of death have been varied. Shropshire/Telford and Wrekin remain one of the best performing CCG's nationally having a low number of unallocated cases and high number of completed cases. **Annual Safeguarding Children and Adults and Looked After Children (LAC)** The committee received a summary of the report which included an update on Covid 19 response, Local Safeguarding Children's Partnership Board and a GP Safeguarding forum which has recently been established. **Performance and Quality** Cancer performance has improved although some challenges still remain. Urgent care and A&E has seen an improvement in performance but the challenge remains on how to make this sustainable. RRT is in a worse position due to the suspension of elective services which are now slowly coming back on line. The system has performed well over a number of months with no delayed discharges.

	Quality visits are continuing at SaTH and a deep dive exercise has been completed on medical notes which show signs of improvement on end of life care, DoLS and Mental Capacity Act, although some areas of the hospital have significant work still to complete. **Finance** Running costs are overspent by £183K and the forecast for the first four months shows an overspend of £259k which is due to savings expected from single strategic commissioner creation having not yet been achieved. Finance report at month 3 is in place where we have not been notified of full year allocations, forecast position is still only up to month 4. **Children and Young People Update** There are no waits for mental health services over 18 weeks but there are waits over 18 weeks for ADHD and ASD diagnosis. All children and young people in crisis are triaged within 4 hours and seen by crisis home team within 72 hours. During Covid 19 pandemic response services were reduced but not stood down with all children being assessed and given a risk rating to determine next steps. Virtual consultations were used. **West Midlands Ambulance/111 Performance Update** Covid 19 has made assessment of data since the transition of the service problematic with CCGs only receiving monthly situation report. There is some evidence of reduced dispositions to the ambulance service from NHS111 but this is heavily caveated and needs further exploration. **SEND Update** Updated on recent joint SEND CQC and Ofsted Inspection which took place in January 2020. Some good areas of practice were noted and the Committee noted that a Written Statement of Action is required because of the areas of improvement identified for publication by 25th September 2020. **Neurology Service Update** Quality risks in relation to the fragility of the neurology service remain a concern. Previously the CCG had supported Royal Wolverhampton Trust providing the service in a phased way following closure of the SaTH service. However subsequently UHNM have closed their service to out of area new referrals and Royal Wolverhampton have agreed to accept these patients so the Committee have supported movement of patients to Wolverhampton immediately. **Learning Disability and Autism Restoration Plan** A summary of the LD&A restoration plan was presented and support given to development of two strategies; all age learning disabilities and one for all age autism.
RECOMMENDATIONS (requiring Board approval)	The Governing body is asked to note the contents of this report and assurances given, and approve the same.

PLANNED WORK	See above
RISKS (Notification to board)	See above
FINANCIAL IMPLICATIONS	See above
CLINICAL IMPLICATIONS	See above
PATIENT/PUBLIC IMPACT	See above
LEGAL/ GOVERNANCE IMPLICATIONS	None
EQUALITY & HEALTH INEQUALITY IMPLICATIONS	None

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-20-09.109
Shropshire CCG Governing Body meeting: 9.09.2020

Committee Meeting Summary Sheet	
Name of Committee:	Quality Committee
Date of Meeting:	29 July 2020 and 27 May 2020
Chair:	Meredith Vivian, Lay Member, Patient and Public Involvement

Key issues or points to note:

To provide assurance to the Governing Body's Committees in Common that the safety and clinical effectiveness of services commissioned by Shropshire Clinical Commissioning Group, and the experience of patients receiving those services, have been reviewed in accordance with the Quality Committee Terms of Reference.

1) To provide a summary of the main items reviewed at the 29 July 2020 Quality Committee meeting.

- Maggie Bayley, Interim Chief Nurse, SaTH, and Nicola Wenlock, Director of Midwifery, SaTH, attended the meeting to provide an update on progress being made with implementation of the recommendations contained within the CQC Improvement Plan.
- There are 176 'Must Take' actions to be addressed by the Trust. In total, 400 actions were raised by CQC.
- As of 15 July 2020 the organisation has achieved 58% compliance of completed actions. Maternity had carried out 65% of their actions and Medical care 72%. The largest area of focus was the Emergency Department as a result of the visit by the CQC to the Trust in February 2020 and an unannounced inspection on 9th and 10th June.
- New nursing documentation has been rolled out which is now compliant with NICE guidance.
- Funding has been received for an Intensive Support Team and money is now available to fund a Quality Matron on each site who will provide support to Ward Managers.
- Funding has been secured for a Mental Health Matron from MPFT to work with SaTH for six months to specifically target and work on Mental Capacity assessments and training for nursing and medical staff.
- The Committee heard that Shropshire CCG Quality leads were regularly reviewing wards to follow up on the CQC recommendations and requested that this work should extend across the organization to monitor safety, effectiveness and patient experience.
- Upon consideration of Maternity data the Committee queried why numbers for Stillbirths were not included in the data dashboard received from SaTH and requested that this omission be explored and, if possible, rectified.
- The combined annual Safeguarding report for Shropshire and Telford and Wrekin was received and noted.

2) To provide a summary of the main items reviewed at the 27 May 2020 Quality Committee meeting.

- The CCG continues to work closely with providers and colleagues across the system, including Care Homes, in relation to the UK Government's response to COVID-19.

- SaTH CQC report was published in April 2020. Maternity services showed signs of improvement. The overall Trust CQC rating remained as 'Inadequate'. CQC imposed the powers of Section 31 of the Health and Social Care Act (2008). In total there are currently 21 conditions in place. The CCG is working closely with the Trust, NHSEI, ECIST and partners to provide support and challenge in driving forward the measures required to improve. The Committee is not fully assured on the quality and safety position at SaTH but that the progress being made is noted.

- Capacity within the Patient Safety Team in SaTH is causing significant delay in the completion of RCA's for the Serious Incidents being reported. The CCG Quality team is providing additional support and are working with the Trust to gather information for the chronology sections of the reports. Interim CNO Maggie Bayley is carrying out a "deeper dive" to ensure that governance processes are in place.

- In March 2020 all School Nurses and Health Visitors were deployed to support front line clinical teams. Due to these changes, regular face to face contact with children and families has been limited. This increases the risk that children in need of help could be missed. To reduce this service risk, SCHT Health Visitors and School Nurses are to return to their existing roles.

- The number of unexpected deaths reported by MPFT remains a concern. The CCG are working with MPFT, Public Health teams and commissioners to ensure learning is being consistently applied.

- The ASD waiting has again started to increase due to the reduced number of face to face assessments being completed during COVID-19.

- The respective Shropshire CCG and Telford and Wrekin CCG Safeguarding supervision policies were approved and combined.

Actions required by Governing Body Members:

- To note.

CCG Board Meeting
Agenda Item: GB-20-09.109

Telford and Wrekin
Clinical Commissioning Group

AUDIT COMMITTEE: CHAIRS REPORT

DATE:	9th September 2020
MINUTES OF MEETING	21st July 2020 - A full copy of the minutes of the above meeting may be obtained from the Executive Lead Governance and Performance prior to the Board meeting. Email: alison.smith@telfordccg.nhs.uk
CHAIR **Contact Details:**	Geoff Braden Lay Member for Governance Tel: 07376130772 Email: geoff.braden@royalmail.com
CHAIRS ASSURANCE TO BOARD	The audit committee provided scrutiny on a number of areas including: • Internal Audit • External Audit – Annual Audit Letter • Board Assurance Framework and Executive Risk Register • Approval of Annual Report • Review of Register of Interests, Gifts and Hospitality • Review of Losses, Special Payments and Waivers • Review the effectiveness of Audit committee The Audit committee took these reports and accepted the recommended actions. Internal Audit – papers received on Conformance with Public Sector Internal Audit Standards during Coronavirus Pandemic, Primary Care Commissioning (PCC) & Progress report Report accepted from Internal Audit regarding the conformance of audit standards during the pandemic, with confirmation that audit plans would be updated and the committee advised. Audit committee received the final report on progress on the Primary Care Commissioning (PCC) report that was originally received in April 2020. Where possible we have updated the plans in line with Shropshire CGG report. Overall a very positive report highlighting significant assurance for contract oversight and management function. Progress report highlighted that due to the pandemic some internal audit staff had been redeployed with no other issues highlighted. The Annual Audit letter summarised the key findings from work completed by external audit for the year ended 31st March 2020.

	The content of the letter was agreed and followed up on the extensive assurance on other External audit documents and detail presented since year end. Board Assurance Framework & Executive Risk Register. No new risks have been identified since the last review, with no escalation or de-escalation of any risks. Further work on the BAF and ERR will take place once the new board have agreed joint CGG objectives. Best practice is available from other CCG's who have already combined their risk registers. Approval of the Annual Audit Committee report was given. No additional gifts or hospitality were added since the last review by Audit Committee Review of Losses, Special Payments and Waivers with no additions since the last Audit Committee.
RECOMMENDATIONS (requiring Board approval)	The Board is recommended to note the work above and accept the report.
PLANNED WORK	Plan attached that may vary with updates from recommendations received from Internal Audit
RISKS (Notification to board)	None identified
FINANCIAL IMPLICATIONS	None identified
CLINICAL IMPLICATIONS	None identified
PATIENT/PUBLIC IMPACT	None identified
LEGAL/ GOVERNANCE IMPLICATIONS	In line with those good governance standards required with input from External and Internal Audit
EQUALITY & HEALTH INEQUALITY IMPLICATIONS	None identified

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-09.110
Shropshire CCG Governing Body meeting: 09.09.20

Committee Meeting Summary Sheet	
Name of Committee:	Clinical Commissioning Committee
Date of Meeting:	20th May 2020
Chair:	Report written on behalf of Sarah Porter, Lay Member by Alison Smith, Director of Corporate Affairs

Key issues or points to note:

- Covid 19/Demand & Capacity Position update

Committee received an update position on modelling for predicting the impact of Covid 19 on the health system and the assumptions being used to underpin the modelling and the constraints i.e. workforce, social distancing etc.

- Pathway and Service Changes

Pathway Group is now focussing on restoring and recovery process that will include engagement with clinical and multi-professionals.

- Restoration of Services & System Update

The update included an explanation of the key tests being used to identify what “good” looks like, adoption of timely decision making, capturing learning from frontline staff, system strengths and high level risks and mitigation.

- Care Closer to Home Update

Pilots had been paused due to Covid 19 but discussions have begun within the Community and Primary Care Group about starting these again as soon as possible.

- MSK Update

Due to Covid 19 the effective start date for the service to begin had been postponed until December 2020. Discussions are ongoing about restarting the clinical working group.

Actions required by Governing Body Members:
To note.

NHS
Telford and Wrekin
Clinical Commissioning Group

CCG Board Meeting
Agenda Item: GB-20-09.110

CCG PRACTICE FORUM: CHAIRS REPORT

DATE:	9th September 2020
MINUTES OF MEETING	*21st July 2020* - A full copy of the minutes of the above meeting may be obtained from the Executive Lead Governance and Performance prior to the Board meeting. Email: alison.smith112@nhs.net
CHAIR **Contact Details:**	*Dr Ian Chan* Tel: Email:
CHAIRS ASSURANCE TO BOARD	For voting purposes the meeting was quorate. **CCG Chair's report** Dr Leahy informed members as from 1st August there will be a shared Governing Body with Shropshire CCG chaired by Dr Julian Povey. The GP/Primary Care Health Professional Governing Body members representing Telford and Wrekin Practices will be Dr Adam Pringle, Mrs Rachel Bryceland and Mrs Fiona Smith. Dr Leahy expressed her gratitude to all that the GP Practices had done throughout the pandemic and acknowledged what a difficult period it has been. She also informed that this was her last GP Practice Forum. The Forum members expressed their gratitude and sincere thanks for all the contributions Dr Leahy has made to Telford and Wrekin over the years. **Introduction to Dr Julian Povey Joint CCG Chair** Dr Povey introduced himself to the forum and highlighted his previous portfolio of work and his current role in creating a new single strategic commissioning organisation from 1st April 2021. Dr Povey had said he would ensure that the interests of patients and all GP Practices across Telford and Wrekin and Shropshire would be protected. Dr Povey further elaborated on the vision on how the local health economy will work together as a collective system of integrated care provider (ICS) with the new Single Strategic Commissioning Organisation setting high level outcomes. The ICS will be made up of provider organisations including GP Practices and PCNs, who would be involved in redesign work and delivering services in neighbourhoods and across the area. The current reconfiguration of the clinical Boards from both Shropshire and Telford meant there had been a significant reduction in running cost and will exceed the proposed 20%

	target. Clinicians on the Board will not be involved with redesign work but setting strategy and overseeing processes and governance moving forward. This governance and redesign split is an important step to ensure the effectiveness of the prospective ICP and strategic commissioning. **Covid-19 Update** Mr Evans provided verbal updates on the current Covid 19 situation. The restoration/recovery phase will prove to be extremely challenging and complex. An application for additional capital resources to cover temporary wards, theatres and a CT scanner has been submitted. Mr Evans said that the current priority is around cancer and clinical priorities of patients. **GP Patient Survey** Mr Evans noted a dropped in the satisfaction ratings across the Practices when compared to last year but also commented most other CCGs had recorded scores of below averages. Overall GP Practices scored above the national average for support with managing long term conditions, disabilities and illness. There have been some challenges around patient experience that needs to be addressed however; the survey did not cover the period of Covid19. Members of the forum had recognised the limitation to the survey and Mr Evans indicated the survey should not be looked at in isolation as they are snapshots of views from patients who had completed the survey and that the CCG primary care team will offer support to Practices around any issues raised in the survey. **SaTH Update** Mr Evans said that members would be aware of the current media attention of SaTH in relation to the Ockenden Review. 1,862 cases were being looked at; no timeline for this has been specified. Mr Evans commented that the new management team at the Trust were open and transparent. The Trust faces some significant challenges, which would take the management team some time to deal with and require the support of the local healthcare system.
RECOMMENDATIONS (requiring Board approval)	CCG Governing Body members were asked to note the content of the report.
PLANNED WORK	*None identified*
RISKS (Notification to board)	*As outlined above*
FINANCIAL IMPLICATIONS	*As outlined above*
CLINICAL IMPLICATIONS	*As outlined above*
PATIENT/PUBLIC	*As outlined above*

IMPACT	
LEGAL/ GOVERNANCE IMPLICATIONS	*None identified*
EQUALITY & HEALTH INEQUALITY IMPLICATIONS	*As outlined above*

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-20-09.111
Shropshire CCG Governing Body meeting: 9th September 2020

Meeting Summary Sheet	
Name of Committee:	North Shropshire Locality Forum
Date of Meeting:	25 June 2020 and 23 July 2020
Chair:	Dr Katy Lewis

Key issues or points to note:

Update from Meeting held on 25 June 2020

Members received an update from Dr Julian Povey about the governance changes within the CCG from 1 August 2020. He also advised that the current localities would continue as Locality Forums but this could be reviewed if needed. An overview was given of the way that CCGs would become strategic commissioners in the future, working with Integrated Care Providers.

Dr Matthee explained that current Board and Locality Chair roles would finish at the end of July and advised of the new Board Members and CCG Chair appointments. He added that information about expressions of interest for the Locality Chair roles had been sent out to Members and explained the role in further detail.

David Evans gave an update about current work ongoing around COVID-19 within the system. He explained that a plan had been requested from NHSEI around what it would take for the system to reach 100% activity levels pre-covid.

Claire Parker gave an update on the restore programme and the processes in place within the system. Discussion also took place about phlebotomy services; Dr Lewis advised she had been involved in the phlebotomy task and finish group; the group were looking into short and long term options for the community phlebotomy service.

The Medicines Management Team update included a presentation about strong opioids use, outcomes from the Keele University audit and patient engagement campaign planned by the CCG Communications Team. Members gave examples of successful approaches and agreed that ideally a pain management service needed to be commissioned for patients on high dose opiates.

Concern was raised about the podiatry service and low risk diabetic foot screening being managed in practices as they were not aware of this. David Evans advised he would ask the System Restore Group to look into this issue.

Update from Meeting held on 23 July 2020

Dr Povey congratulated Dr Lewis for becoming the North Shropshire Locality Forum Chair. Further information about new Board and Locality Chair appointments would be sent out to Members to provide more detail. It was explained that a new Clinical Lead structure was also being put in place underneath the Medical Director role. Work was continuing towards the two CCGs becoming a single strategic commissioning organisation with governance structures changing from 1 August 2020. The CCGs were still planning to go through a consultation for the structure beneath the Executive Team.

Claire Parker advised that the last few primary care services for restoration would be going to the System Restore Group. The system was now moving into the recovery phase and work would take place through the Primary Care and Community Restore and Recovery Group to look at processes and lessons learned through covid to make improvements. The group would also be discussing phlebotomy and a report was due to be presented to Gold Command about this. Concerns were raised about restoration of secondary care services as practices were still being asked to provide services that had been restored.

The Medicines Management Team gave an update about prescribing for vitamin D and advised that the majority of patients should be buying vitamin D themselves unless they had a bone problem or were taking medication that affected bone. Dr Matthee raised an issue with supply of Ranitidine and the team advised they would look into this. Discussion took place about warfarin monitoring and the issues and work involved in this. The team also advised that a draft flu programme plan was being worked on looking at the potential options for delivery.

Dr Julia Head (Specialty Doctor in Advance Care Planning) and Alison Massey (Programme and Redesign Lead Urgent Care) attended the meeting to give an update on the ACP outreach support in care homes and to gain feedback from Members. Feedback from practices showed they were very pleased with the process and had some good conversations with the doctors and found it very useful. Members suggested that having remote access to EMIS to write notes would be useful – it was confirmed that this option was being explored.

An update was given by Cathy Davis (Commissioning and Redesign Lead for Mental Health) about mental health services and areas that had been affected by the restore and recovery process. Concern was raised by Members about the 24/7 helpline as there had been times that patients were advised there was no clinician available, no answer, or patients were advised that they would be called back and were not. It was confirmed that these issues would be investigated.

Actions required by Governing Body Members:

- No actions required.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-20-09.112
Shropshire CCG Governing Body meeting: 9th September 2020

Meeting Summary Sheet	
Name of Committee:	South Shropshire Locality Forum
Date of Meeting:	2 July 2020
Chair:	Dr Matthew Bird

Key issues or points to note:

Members received an update about the future Locality Forum structure and process for appointing new Locality Forum Chairs. An update was given about the newly appointed CCG Governing Body Members and Chair and role of the CCG moving forwards in regards to having a more strategic role. Discussion took place about PLT (Protected Learning Time) with a suggested session around reflection and feedback on COVID-19.

Dr Nandhra, Dr Head (Specialty Doctors in Advance Care Planning) and Alison Massey (Programme and Redesign Lead Urgent Care) attended the meeting to give an update on the ACP outreach support in care homes and to gain feedback from Members. Members advised it would be good for the team to input information directly into EMIS and it was agreed for this option to be explored.

Claire Parker, Director of Partnerships, gave an update about the work to restore primary care services. The process was explained and how this would be communicated to practices. An update was also given about the work being undertaken to increase phlebotomy capacity in the primary and community care system. Concern was raised by Members about the withdrawal of diabetic low risk foot screening by the Podiatry and Foot Service – Claire Parker agreed to look into this issue.

The Medicines Management Team update included a presentation about strong opioids use, outcomes from the Keele University audit and patient engagement campaign planned by the CCG Communications Team. Discussion took place about examples of practices that had been successful in reducing the number of patients on high doses. Members also agreed that a commissioned service was needed for patients that could not be supported by practices – it was advised that this was also raised by the North Shropshire Locality Forum and was being explored by the CCG.

Actions required by Governing Body Members:

- No actions required.

NHS
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Clinical Commissioning Group

Agenda item: GB-20-09.113
Shropshire CCG Governing Body meeting: 9th September 2020

Meeting Summary Sheet	
Name of Committee:	Shrewsbury and Atcham Locality Forum
Date of Meeting:	30 July 2020
Chair:	Dr Ella Baines

Key issues or points to note:

Dr Julian Povey, CCG Chair, gave an update about the future CCG governance structure and information about the newly appointed CCG Governing Body Members. He advised that the Locality Forum structure would be reviewed in the near future with the Membership. Members were advised that Dr Ella Baines had been appointed at the Locality Forum Chair from 1 August 2020.

Claire Parker, Director of Partnerships, gave an update about the work to restore primary care services. Discussion took place about spirometry guidance for AGPs (Aerosol Generating Procedures) and concerns were raised about the long wait for patient appointments. Dr Povey advised that the system had submitted a bid for funding to increase activity to help restore services. Claire Parker also gave an update about the current plans for the phlebotomy service and advised that the CCG were looking into a more sustainable option for this service from next April.

The Medicines Management Team update included a presentation about strong opioids use, outcomes from the Keele University audit and patient engagement campaign planned by the CCG Communications Team. Guidance was also shared about vitamin D prescribing.

Members spent some time reflecting on issues and lessons learned during the COVID-19 pandemic. Members felt that positives were video calls, e-consults, working together, the hot site and getting the IT infrastructure up and running quickly. One of the suggestions was for there to be a more reliable and robust IT support service in place to support remote working.

Dr Nandhra (Specialty Doctor in Advance Care Planning) and Alison Massey (Programme and Redesign Lead Urgent Care) attended the meeting to give an update on the ACP outreach support in care homes and to gain feedback from Members. Feedback from Members was positive and they stated it was good to have the expertise of Dr Nandhra and Dr Head to help develop plans for patients; overall it was a very good experience.

Actions required by Governing Body Members:

- No actions required.