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A G E N D A

Meeting Title	Governing Body Meeting	Date	Wednesday 8 July 2020
Chair	Dr Julian Povey	Time	1.00pm
Minute Taker	Mrs Sandra Stackhouse	Venue / Location	Via Teleconference

Due to the COVID-19 pandemic, we are following Government advice on self-isolation, therefore members of the public will be unable to observe this meeting, Draft minutes of the meeting and questions and answers will be available on the CCG's website two weeks following the meeting.

Reference	Agenda Item	Presenter	Time	Paper
GB-2020-07.070	**Apologies**	**Julian Povey**	***1.00***	*verbal*
GB-2020-07.071	**Members' Declaration of Interests**	**Julian Povey**	***1.00***	*verbal*
GB-2020-07.072	**Introductory Comments from the Chair**	**Julian Povey**	***1.05***	*verbal*
GB-2020-07.073	**Minutes of Previous Meeting** Meeting held on 13 May 2020	**Julian Povey**	***1.10***	*enclosure*
GB-2020-07.074	**Matters Arising**	**Julian Povey**	***1.15***	*enclosure*
GB-2020-07.075	**Questions from Members of the Public** Questions from members of the public will be accepted in writing 48 hours prior to the meeting and should be submitted by **12.00 noon** on **Monday 6 July** to: Dr Julian Povey, Clinical Chair, Shropshire CCG, Somerby Suite, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL or via email: SHRCCG.govbody@nhs.net Guidelines on submitting questions can be found at: **http://www.shropshireccg.nhs.uk/get-involved/meetings-and-events/governing-body-meetings/**	**Julian Povey**	***1.20***	*verbal*
GB-2020-07.076	COVID-19 Update	**Sam Tilley**	***1.25***	*presentation (to follow)*
GB-2020-07.077	Shropshire, Telford & Wrekin System Response to COVID-19	**Steve Trenchard**	***1.40***	*enclosure*
GB-2020-07.078	**Corporate Performance Reports** Performance and Quality Report to include integrated, secondary and primary care	**Julie Davies/ Zena Young**	***1.50***	*enclosure*

	Clinical and Financial Reports			
GB-2020-07.079	Finance, Contracting Report incl. Quality, Innovation, Productivity & Prevention (QIPP) schemes	**Claire Skidmore**	***2.10***	*enclosures*
	BREAK		***2.25***	
	Governance & Engagement			
GB-2020-07.080	Governing Body Assurance Framework (GBAF)	**Alison Smith**	***2.35***	*enclosure*
GB-2020-07.081	Update on Temporary Changes to Governance arrangements to support COVID-19 response	**Alison Smith**	***2.40***	*enclosure*
GB-2020-07.082	Strategic Priorities Update	**David Evans**	***2.50***	*enclosure*
GB-2020-07.083	Learning Disabilities and Autism Update LeDeR Annual Report	**Frances Sutherland / Helen Bayley**	***3.00***	*enclosure* *enclosure*
GB-2020-07.084	SEND Inspection Report	**Claire Parker**	***3.15***	
GB-2020-07.085	Audit Committee – 24 June (summary)	**Keith Timmis**	***3.30***	*enclosure*
GB-2020-07.086	Healthwatch Update	**Lynn Cawley**	***3.40***	*verbal*
	For Information Only/Exception Reporting		***3.45***	
GB-2020-07.087	Single Strategic Commissioner Update	**Alison Smith**		*enclosure*
GB-2020-07.088	Finance & Performance Committee – 25 March	**Kevin Morris**		*enclosure*
GB-2020-07.089	Quality Committee – 25 March	**Meredith Vivian**		*enclosure*
GB-2020-07.090	North Locality Board – 27 February	**Mike Matthee**		*enclosure*
GB-2020-07.091	South Locality Board – 5 March	**Matthew Bird**		*enclosure*
GB-2020-07.092	**Any Other Business**	**Julian Povey**	***3.45***	*verbal*
	Date of Next Meeting • Wednesday 9 September 2020 - time and venue to be confirmed			

Dr Julian Povey
Clinical Chair

David Evans
Accountable Officer

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 13 MAY 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
Dr Priya George	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 [Items GB-2020-05.048-057]
Ms Claire Parker	Director of Partnerships for Shropshire and Telford & Wrekin CCGs
Mrs Nicky Wilde	Director of Primary Care [Items GB-2020-05.048-055]
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
Dr Colin Stanford	Lay Member

In Attendance

Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire
Ms Rachel Robinson	Director of Public Health, Shropshire Council [Items GB-2020-05.048-057]
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-2020-05.048 - Apologies

2.1 There were no apologies noted.

Minute No. GB-2020-05.049 - 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 Dr Shepherd advised Members that since the last Governing Body meeting her role had changed and she was also now Interim Medical Director across both Shropshire and Telford & Wrekin CCGs and Locality Chair for the Shrewsbury and Atcham Locality Board.

3.3 Dr Stanford reported that he had a new declaration of interest that as a returning GP he was employed by the South Central Ambulance Service NHS Foundation Trust as part of the NHS111 COVID-19 response.

3.4 There were no further conflicts of interest declared.

Minute No. GB-2020-05.050 - Introductory Comments from the Chair

4.1 Dr Povey explained the use of the Zoom video conferencing system for this meeting, which would facilitate the chairing of the meeting as all participants would be shown on screen. Dr Povey requested Members to use the raised hand feature in Zoom to indicate if they would like to ask a question during the meeting. Those present were also reminded that it would be helpful to select mute on their microphones when not speaking.

Minute No. GB-2020-05.051 – Minutes of the Previous Meeting – 11 March 2020

5.1 The minutes of the previous meeting held on 11 March 2020 were presented and approved as a true and accurate record of the meeting following one amendment on: page 11, paragraph 14.11, line 2: change 'aesthetic' to 'anaesthetic'.

RESOLVE: MEMBERS FORMALLY RECEIVED AND APPROVED as an accurate record the minutes of the meeting of Shropshire Clinical Commissioning Group (CCG) held on 11 March 2020.

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

Minute No. GB-2020-05.052 – 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-2020-01.010 – Shropshire CCG Strategic Priorities – Dr Davies reported that she had passed over the action to Steve Trenchard, in his new role of Interim Executive Director of Transformation, to bring back an update on the Alliance Agreement with providers for the new model of care for the integrated provision of Musculoskeletal (MSK) services across Shropshire, Telford and Wrekin. The implementation of the integrated service was on hold at the present time but the CCG was continuing to progress the Alliance Agreement and a detailed update would be presented at the next meeting.

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

b) GB-2020-03.034 – Maternity Update – Dr Povey referred to the Governing Body Part 2 Confidential meeting held earlier that day, which had discussed the action for the CCG to write a letter to NHS England and NHS Innovation (NHSE/I) expressing its frustration about the lack of further information on the proposals for Transforming Midwifery Care. It had been agreed that it was not the right time to pursue this with the on-going challenges following the COVID-19 response in the region and so had been deferred but was something the CCG would considering doing following the recovery phase.

ACTION: Following the recovery phase of COVID-19, the Governing Body to consider whether Dr Povey/Mr Evans should write a 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.

Minute No. GB-2020-05.053 – Public Questions

7.1 Dr Povey advised the meeting that no new written questions had been received from the public. It was noted that there had been a late submission of two questions that had been carried forward from the last meeting and the questions and answers would be available on the CCG's website.

Minute No. GB-2020-05.054 – COVID-19 Update

8.1 Shropshire Telford and Wrekin (STW) CCGs' Response to COVID-19 - Mrs Tilley presented the COVID-19 Update using PowerPoint slides, which focussed on the response structure and the key elements of the incident response arrangements, which included: Critical Care Capacity; Community Capacity; Staff Testing; Patient Testing; Personal Protective Equipment (PPE); and Restoration.

8.2 On behalf of the Governing Body, Dr Povey expressed his appreciation of the work of all staff and thanked Mrs Tilley in particular for the huge amount of work she had undertaken as the Lead on the emergency response, which he appreciated, must have been very challenging work.

8.3 Ms Robinson supported the appreciation of the work that Mrs Tilley had undertaken leading the emergency response. Ms Robinson highlighted that the structures within the local response had been dynamic to reflect the requirements that had been constantly changing as new guidelines and needs had arisen. The involvement of system partners had been a phenomenal effort and leadership to the common goal, which had resulted in the actions and the speed at which decisions could be made and changes put into place.

8.4 From Public Health England's (PHE) point of view, the next phases would be about refocusing and remodelling. As Mrs Tilley had highlighted, the curve was very different in Shropshire compared to other areas, such as London and to a certain extent to the West Midlands, and it was important for Shropshire to be careful and cautious in the next phase not to forget this and to look at things differently. Work in care homes and in the community needed to be closely monitored and to ensure the correct systems were in place. It was emphasised that there should be a real increase in refocusing attention from the rescue phase into the next phase and to ensure that lessons learnt were not disregarded.

8.5 Dr Pepper expressed his appreciation of the excellent communication received from the Primary Care Team during the COVID-19 response period. It was acknowledged that there was a huge amount of work being carried out by members across the CCG responding to the incredibly challenging situation that COVID-19 had presented to the health system. The speed, efficiency and quality of the communication had been really excellent and it was a credit to those CCG staff that had facilitated that response.

8.6 Dr Leaman raised that it was now fairly clear which groups of people who do not do well if they contracted COVID-19 and asked if the CCG was actively identifying healthcare workers with those characteristics to remove them from frontline work.

8.7 Mrs Tilley confirmed that a risk assessment around protective characteristics groups of staff was being undertaken. The output of this risk assessment would help to inform how to protect the workforce better and to best deploy staff. Mrs Young added that a risk assessment had been undertaken for every person included on the redeployment list, and as a result, some staff had been identified as better placed remaining in the CCG to work or to work at home. Those staff were under active review and the CCG was refreshing those in light of the system approach to risk-assessing individuals. However, the CCG had very clear engagement with all its staff to ask them to highlight any concerns about protective characteristics for themselves, their families and the homes that they live in as well if there were any other considerations. The CCG was mindful that it was a changing picture nationally and was very much in line with the guidance and was waiting to see how that might change.

8.8 Dr Leaman said he was particularly concerned about secondary care staff and asked if it was right that people had been left to decide for themselves if there were any risks. Dr Leaman's concern was that many of those staff would put their duty ahead of their own well-being and suggested that the CCG should be actively identifying those people who should not be working in PPE-type situations.

8.9 Mrs Young considered that the work in progress was a wider piece of work in that it did not just include assessing and excluding people from certain duties, it was making sure that if they were in the situation that they might be of increased risk, staff had the appropriate protection in order to undertake that work. It may be a case of ensuring that staff had enhanced PPE in accordance with the guidance. If any of the front line work of staff that could not be avoided, in particular, those medical staff with a skill set that cannot easily be transferred in the secondary care setting; for example, there was a high black, Asian and minority ethnic (BAME) population in the clinicians working in some of the provider organisations; each provider organisation was undertaking a similar piece of work to scope out the extent of the protective characteristics of most concern related to COVID-19 and would be in line with the system approach to how they are going to take that forward.

8.10 Mr Evans completely understood the points made but highlighted that the local health economy did have a workforce issue. The CCG was doing everything that it could for its own staff. Mr Evans was confident that every organisation within the local system was doing everything that it could to protect their staff within the parameters and that included making sure that there was the right PPE available for the frontline staff if they were required to continue working in a setting where they might be of increased risk.

8.11 Mrs Young referred to slide 3 of the presentation and highlighted as a point of accuracy that she was now leading the Infection Prevention Control (IPC) group and not Maggie Bayley, who was no longer working for the CCG.

8.12 Dr Stanford raised a word of caution, particularly in relation to the discharge of hospital patients to care homes, because of the reliability of testing and the role of immunity, recovering patients and what the cause of the condition is. It was highlighted that some people seemed to have got better and then had become worse again and it was not known what this meant in terms of their risk to others.

8.13 Dr Stanford had also been pleased to see in the 60 page Government document circulated that week, that there was a section on care homes suggesting that it would be wise for staff not to travel between care homes. This particularly raised two concerns, which were: 1) about many care homes who used agency staff to supplement their own workforce; and 2) of agency staff working in hospitals who may also be working in other organisations.

8.14 Dr Stanford raised that there was a lot of misunderstanding about testing and for the CCG not to under-estimate the huge public expectation there was now around testing and what testing means to individuals.

8.15 Dr Povey sought clarification of the current block to testing. Mrs Tilley explained that there were a number of factors that included the interface between patient testing and other testing. There was the requirement for the local laboratory patient testing to be prioritised to ensure there was sufficient capacity to keep the flow through of local services running. The additional local capacity was then used for staff testing. This was supplemented by the testing carried out by the Ministry of Defence (MOD) that provided up to 300 additional tests per day and did not use local lab capacity or the local swab supply, which helped significantly to preserve the local capacity and supply. It was thought that the way that testing had increased and had been rolled out had been very challenging in that there had been confusing messages about who could get tested, where, when and how the results would be received. A People Workstream had been formed that was managing this to ensure the best impact locally in terms of what services were available.

8.16 In answer to Dr Stanford's second question, Mrs Tilley advised that there was a Care Sector Working Group that was working through all of the issues. This was part of the Care Home Action Plan that had been developed to support care homes in the utilisation of staff, how NHS staff can be redeployed to work in care homes, and where that might support them. As testing is rolled out there would be an impact on the availability of staff, which the working group would be reviewing.

8.17 Ms Robinson supported the comments made about agency staff moving between care homes, which had been recognised as an issue, and was included on the action plan that was being reviewed. A group had been set up that was looking at care homes both across the whole system and then within each local authority that linked into the Care Sector Working Group. Both local authorities were conducting weekly welfare calls to all the care homes, and making further calls if they required additional support from PHE and the local authority.

8.18 To reiterate Mrs Tilley's comments, Ms Robinson considered that there had been a huge amount of work carried out on testing. One of the issues had been the confusion, particularly amongst the public and staff because of the range of options that had made available, particularly nationally. It was thought that there was a robust testing process in place locally on which to move forward with the national testing but this would require clear communication to ensure that the test results were processed through the local labs and returned to the correct patients in a timely manner.

8.19 Dr Leaman said that he had heard that antibody testing might become available in a few weeks' time and sought further information on this. Mrs Tilley and Ms Robinson confirmed that they currently had no further information on this in terms of the timescale when antibody testing would become available.

RESOLVE: The Governing Body NOTED the contents of the report.

8.20 Shropshire Telford and Wrekin (STW) Sustainability Transformation Partnership (STP) Moving from Restoration to System Recovery & New Norm – Mr Trenchard presented a verbal update, using PowerPoint presentation slides, which covered the following areas:

- Framework for planning and managing the stages of the pandemic
- Making Visible System Changes: Transformation Oversight During COVID-19
- The 8 Tests STW Must Meet: 1) COVID-19 Treatment Infrastructure; 2) Non-COVID-19 Urgent Care; 3) Elective Care; 4) Public Health burden of pandemic response; 5) Staff and Carer well-being; 6) Innovation; 7) Equality; and 8) The new Health & Care landscape
- STW ICS System Principles & Expectations
- STW Vision
- Restoration Governance Structure (Now)
- Recovery & New Normal Governance Structure (Future)

8.21 Dr Pepper noted that there had been a lot of points raised in the presentation, which had commenced with the phrase, “We need to think about...” Dr Pepper asked if the framework had been progressed locally and what were the practical steps, processes and systems that would enable the CCG to do the work so that it was realised and would not simply be an aspiration.

8.22 Mr Trenchard confirmed that there was a significant amount of work underway on practical steps and changes around modelling and thinking about the baseline. There were practical steps around supporting staff to change their behaviours and to consider new ways of working and practical processes were in place around the supply of PPE equipment, etc. At a high level some of the work did look aspirational. The engine room for most of the work at present was going through Silver Command, the Care Pathways Group and other associated groups. The whole system had shifted its rhythms and had gone from a process of monthly meetings, preparing long papers, committees and sometimes unwieldy governance to Gold and Silver Commands meeting daily, the Care Pathways Group meeting twice a week and various sub groups and decisions were being presented. Solutions were being found very quickly. In the future, it was envisaged that the Transformation Oversight and Delivery Group would be the engine room, which would bring all the programme of work into one place that would report into the Chief Executives Group and the CCGs.

8.23 Ms Robinson explained that there was a lot of work that needed to take stock of where the system was with the process, where it could involve people, and how far had the work been signed off. For Ms Robinson, one of the lessons learned was the really valuable role that other partners had to play in the system, particularly in the care homes and other areas, and so it was how to include some of that work and reference that in the structure. The PHE section appeared in one section but it felt it covered a wider area than was currently shown.

8.24 Mr Trenchard agreed this was an important point, which had been discussed at Gold Command on a call earlier that day. The governance chart that had been discussed did not reflect the current position. The Public Health and prevention aspect was considered the core element which sat in acute, community, mental health and throughout the system. The position at present was that the process was at the beginning of the restoration and recovery period. A restore template needed to be submitted to NHSE/I the next day, which did not capture all the areas but was bringing work together. It had been recognised that at present the focus was on the acute work. There was a Care Pathways Group meeting scheduled to take place on Friday at which Ms Robinson would be invited to attend. It had been acknowledged that the work needed to include community, primary care and all other elements and so the care pathways structure needed to be reset, which had not yet been agreed.

8.25 Dr Stanford commented that it was a very comprehensive if short plan but it was encapsulating everything in health and social care. However, the plan was very aspirational and described a future health care system which many had tried to achieve for a very long time.

8.26 Dr Stanford considered that whilst the system tried to retain the innovations that were currently happening it needed to be done at the right pace because some innovations come by necessity as they do in a pandemic and others even if they are the same ones have to follow cultural, professional, organisational change. The CCG needed to be mindful that it would be wrong to expect the pace of change to follow through in all of the recovery phases of the system plan.

8.27 Dr Stanford raised concern about the workforce situation in the area in particular and suggested that the CCG should be mindful that the confidence in the workforce may be less than it was before the COVUID-19 pandemic. There may be more bureaucracy surrounding COVID-19 and how the system worked in the future and there would be training needs which would need addressing. Also public expectation would be very high and so all of these things may present obstacles to progress.

8.28 Dr Stanford applauded the vision for collaboration but considered that it was very ambitious. For example, reference to ‘PCNs [Primary Care Networks], care homes and MDTs [multi-disciplinary teams]’ felt this was a major task. Dr Stanford considered it was right to try to achieve this but it was considered that this was a big piece of work, which would require a lot of time to complete.

8.29 Dr Stanford felt that the use of: ‘virtual by default’ was too strong an expression to use. Dr Stanford considered that the work should be conducted virtually where it could be, when it was practical to do so. The good innovations needed to be brought in at the right pace and in the right way.

8.30 Dr Stanford further raised that there was a huge number of volunteers who would be willing to help in different ways in the communities in the future but this would need to be properly co-ordinated with a directory of services available.

8.31 Dr Pepper worried that there were many assumptions for primary care, as for social care and the acute trusts, that the work that had happened during the pandemic would be regarded as best practice going forward and would be based on a false pretence. The system needed to be fair across all spheres and not to rush through systems that at the present time there was no actual evidence that they were part of the solution for the future.

8.32 Dr James agreed with Dr Stanford's and Dr Povey's comments about the digitalisation of systems and the pace of change and the CCG not getting ahead of itself. Dr James made the point that there had been more progress seen in the last 7 weeks than in the last 5 years. The CCG should not completely lose this and should build upon the impetus by implementing the right changes, however, at the same time being careful how this was done and at the right pace.

8.33 Dr Pepper noted Mr Trenchard's comments about a new baseline and considered that the baseline was where it was before the response to the pandemic. It was not to reset the baseline but to approve the new practice seen through the recent changes upon the previous baseline.

8.34 Dr George supported Dr James' and Dr Pepper's comments and considered the progress that had been made during the last 7 weeks had been tremendous. Lessons learnt from the experience should be carried forward where appropriate.

8.35 In answer to further questions raised, Mr Trenchard explained that work by the Transformation Team had begun on capturing: service changes on the service log, capturing quality and impact assessments in terms of those changes so that there was appropriate governance and understanding of the pause position. A process had been identified and approved through the Chief Executives meeting around how to use the soft information through interviews, focus groups and Healthwatch surveys and use some of the hard data in metrics. As a consequence of some of the changes seen, the CCG needed to work with colleagues to review the impact of changes seen in the pathways to gauge which previous systems were kept or improved upon and whether the changes were made for a longer period of time. The work behind the scenes was complex in capturing all of the learning and to evaluate across all elements.

8.36 Mr Trenchard said that he liked the use of the softer language of virtual rather than 'virtual by default' and explained the later phrase had arisen as a result of concerns raised about how to retain the swiftness in some of the clinical work seen and not go back to the previous system. The Outpatients Anywhere software was being implemented by Shropshire Community Health Trust (SCHT), Robert Jones and Agnes Orthopaedic Hospital FD Trust (RJAH) and Shrewsbury and Telford Hospital NHS Trust (SaTH). The evaluation of this system needed to be captured and importantly from the experience of people who are using that methodology for accessing healthcare to see what it is like so that it can be understood what conditions the system might be good for.

8.37 Ms Parker reported that a piece of work had commenced looking at best practice that was in place in primary care before COVID-19 to ensure that this was not disregarded and to also capture the innovations that had arisen since then. The CCG sought feedback from primary care about what systems and processes had worked well and had not worked well. This work was feeding into Mr Trenchard's piece of work which was discussed weekly. For example, Dr James had discussed the IT and the digital infrastructure at the last meeting, which would be taken forward on a weekly basis.

8.38 Mrs Tilley considered that it was really important to balance between working at pace as currently and whether this was sustainable going forward in the long term. However, this would be caveated that there seemed to be a real keenness not to revert back to the pace that there was before and that there was a sense of invigoration from quick decision-making balanced with permission to act and being very solution-focussed. For example, this had been experienced by the task and finish groups who had been faced with challenges to find solutions and escalate where they needed to achieve a rapid response. This process had been very positive for staff. The CCG needed to be mindful about what pace is agreed going forward because staff preferred not to revert back to the previous cycle of waiting a month for a meeting to take place and writing lots of papers, which were scrutinised in detail. There was a place for this but the CCG needed to be clear about where that was and what it could do quicker because this was considered a key reason how the CCG had managed to move work forward in the way that it had. Ms Porter confirmed that she fully supported Mrs Tilley's comment on the pace issue.

8.39 Mr Vivian said that he had been struck by the point made that as a system Shropshire had done very well in terms of integration and wondered if that was because the CCG was currently focussed on public health and effective health care for its patients rather than fighting for limited funds with its partners.

8.40 It was considered that the report contained too many words, which made it difficult to understand. Mr Vivian asked if material like this was going to be presented in the future could it be presented in a way that enabled the reader to make more sense of it. Mr Vivian admitted that following Mr Trenchard's verbal presentation it was beginning to make more sense of what was being conveyed.

8.41 Mr Vivian pointed out that the information presented appeared to set out a strategy for healthcare in Shropshire, Telford and Wrekin for the next 2-3 or 5 years and stressed that the CCG would also need to find a way of involving some effective and meaningful engagement into that process.

8.42 Dr Matthee considered that although he was pleased that staff had been allowed to make quick decisions he voiced concern about the pace. Dr Matthee's particular concern was about the baseline, which at the present time, general practice had been pushing though a lot of work because patients had been very accepting of the health response to COVID-19 and that they were not to attend the practice. As time had passed, patients had now started asking when they could return to the surgery. The issue about change was very difficult therefore without patient involvement. Dr Matthee did not wish to revert back to the previous situation but did feel consideration was required on where to lay the foundations for the new norm because the present situation was slightly false because of the COVID-19 emergency response.

8.43 Ms Cawley commented that Healthwatch Shropshire (HWS) was aligning its priorities for 2020/21 with the STP clusters and HWS was keen to get involved in speaking with staff and hearing their perspectives and experiences. HWS felt that staff may be more honest with them than through the provider staff survey process about their experience of working through COVID-19 and views of services design going forward.

8.44 In summary, Mr Evans echoed some of the comments made. The CCG had found itself in a very unique set of circumstances over the last two months. Undoubtedly despite the awfulness of it for families and those people that had died, there had been some real changes both in terms of how the system works but also in terms of how care was being delivered. It was evident that a significant number of patients had chosen not to access healthcare during this time and the level of activities shown now were not going to be the new normal position. Nonetheless, the emergency response had enabled staff to make decisions quickly and enabled things to change and it was about achieving the right balance between those moving forward.

8.45 The report presented was for the Governing Body to note and particular attention was drawn to the new governance slide that would be circulated when finalised. Mr Evans emphasised that the sovereignty and accountability was retained to the CCG or a respective employing organisation. For every other part, the accountability flowed into the Chief Executives Group who would then be responsible for delivery to the ICS Shadow Board.

RESOLVE: The Governing Body NOTED the contents of the report.

ACTION: Mr Trenchard to provide revised slides to Mrs Stackhouse for circulation to the Governing Body Members for information.

CORPORATE PERFORMANCE REPORTS

Minute No. GB-2020-05.055 – Performance and Quality Report including integrated, secondary and primary care

9.1 Performance - Dr Davies reported that because of the impact of the COVID-19 pandemic the report presented reflected the pre and the early stages of COVID-19 and all of the contracting levers and the formal performance monitoring had been suspended.

9.2 Dr Davies presented the CCG's integrated Performance and Quality Report, which contained the CCG's performance against all its key performance and quality indicators for Months 11 and 12 where available for 2019/20. The key standards that were not met year to date for the CCG were in the following areas:

62 day Referral to Treatment (RTT)
31 day where subsequent treatment is surgery or radiotherapy
A&E 4hr target
Ambulance handovers >30mins and >1hr

RTT
Diagnostic waits

9.3 Cancer – There had been continued improvement in cancer performance, particularly on the 2wk performance. The improvement in performance would take time to flow into the subsequent measures and particularly the 62 day Referral to Treatment (RTT) target. There had subsequently been some challenges as a result of the COVID-19 response; however, a lot of the cancer surgery had been maintained either at SaTH or by the Nuffield Hospital. It was of concern that there had been a considerable fall in demand for cancer services, which was very much in line with the region and nationally in terms of an approximate two-thirds reduction in demand for cancer services. This needed to be considered when planning for the future.

9.4 A&E performance – A positive outcome of the COVID-19 emergency response was that attendance at the Emergency Departments (EDs) had decreased which had seen an improvement in ED performance. The performance was not at the level required but this was continuing to be raised and challenged through Gold Command. Levels close to 95% were achieved during in-hours but owing to the workforce challenges, the performance had decreased to an overall level equal to the mid-range of 80%.

9.5 The Emergency Care Intensive Support Team (ECIST) had returned to work with SaTH on some of the continuing issues around the internal systems and processes and professional standards within the Trust.

9.6 Elective Care, Referral To Treatment and Diagnostics – These services had been considerably affected following the impact of the COVID-19 pandemic. There would be a consolidated position of the waiting lists during the next phase of restoration and recovery moving to prioritising activity by clinical priority and urgency. This would be brought forward through the Silver and Gold Command structures and the Governing Bodies. Performance metrics would be used to measure improvement and how that clinical priority activity was managed. At the same time, focus needed to be maintained on the level of backlog work and overall waiting lists. The performance metrics needed to be moved forward to ensure that the right patients were treated with the capacity available. Notwithstanding that on-going capacity needed to be maintained to treat COVID-19 patients and any subsequent peaks that may arise over the coming weeks and months.

9.7 Quality – Mrs Young presented her report with the caveat that whilst the report reflected the period January-March, owing to the present situation, the mechanisms for taking forward the quality agenda had changed. Quality visits were still being maintained with each of the trusts bi-monthly, SaTH's monthly Maternity Quality meeting, and also a general meeting, in addition to other forums for engagement with SaTH specifically.

9.8 Mrs Young highlighted the following points from the Care Quality Commission (CQC) report for SaTH that was published on 8 April 2020:

- The CQC had inspected SaTH again in November 2019 and had some real concerns about safety, particularly urgent care and the Emergency Department (ED) service. SaTH had received a draft report in March for factual accuracy, following which responses were sent, and the report was published on the CQC's website on 8 April 2020.
- The report showed that a number of areas had not improved and that some areas had deteriorated.
  Maternity had improved across a number of domains and whilst it had been rated as 'Requires Improvement' overall it received an improved 'Requires Improvement' rating.
  The Princess Royal Hospital (PRH) had retained the same 'Inadequate' rating.
  The Royal Shrewsbury Hospital (RSH) had shown an improvement and had been rated 'Requires Improvement' overall.
  Urgent and emergency services remained 'Inadequate' overall with Caring domain deteriorated to 'Requires Improvement and all domains for UEC remaining 'Inadequate' or had deteriorated to 'Inadequate' which was the main area of concern.
  Medical care at PRH had deteriorated to 'Inadequate' and the Children and Young People's service at PRH had deteriorated across all areas.
  Overall Caring as an organisation had deteriorated to 'Requires Improvement' compared to the majority of trusts nationally that would be rated as 'Good' or 'Outstanding'.

9.9 The CQC issued new and revised notices which now total 21 conditions applied to their registration, which included themes around governance, safe care and treatment, and workforce. Since November to early 2020, there had been a number of Risk Summits and Risk Review meetings, which NHSE/I continued to chair. NHSE/I also chaired the Safety Oversight and Assurance Group (SOAG), with a reduced membership owing to the COVID-19 situation. The last SOAG meeting held on 23 April had

discussed an update on governance, leadership, progress with the Section 31 concerns regarding sepsis, children's staffing, and the urgent care treatment pathways and risks, which had recently been changed to address the COVID-19 pandemic.

9.10 SaTH had reported that there had been an increased focus both at Board level and a refresh of its governance, patient safety arrangements and a specific focus on ED governance, which would be formally presented at the next SOAG meeting scheduled to take place the following week. The CCG has continued to chair the weekly oversight and assurance meetings and is copied into the returns that are submitted to CQC, which record progress and achievements on a weekly basis.

9.11 SaTH was required to submit an Improvement Plan associated with the report being published, which had been submitted to CQC earlier in the week and would be available for wider viewing in due course.

9.12 Regarding leadership, Maggie Bayley was now Interim Chief Nurse at SaTH and a number of senior nursing posts had been made, including a new Matron and a new Head of Nursing, which would be instrumental to achieving the improvements and to strengthen the ED leadership. ECIST had returned with a clear brief. The emphasis at SOAG and the message from CQC and the partners to the Trust was that many of the issues were for the Trust to resolve as they were not system business.

9.13 The SOAG meeting had also discussed the clinical care and safety in pathways and the improvements, particularly around the triage times that SaTH had reported. It was understood that that work had been sustained however; the activity had been reduced because of COVID-19. There had also been improvements with documentation completion. It had been reiterated to SaTH, and they were very much aware of the expectation, that more pace was required around the improvements for sepsis care and consistency of achieving all of the standards overall all of the time.

9.14 The CCG continue to hold Quality Review meetings, weekly assurance calls and are engaging with a number of other forums to gain a line of sight into how SaTH are challenging the progress and improvements. In particular, there is an ED operational group, which will give a line of sight into how SaTH are challenging the progress with the improvements and will be involved in moving that forward.

9.15 Regarding workforce issues, SaTH had reported how COVID-19 had impacted on their ability to recruit international staff because of the current travel restrictions, which was a key part of their improvement plan. There was very little mitigation for that, which was a national issue. However, SaTH had recruited two more consultants; one substantive and one locum, which it was understood would not be affected by COVID-19.

9.16 The CCG had deployed staff into front line services and into some back office functions, such as serious incident (SI) reporting of patient safety, which was helping to gain a clearer understanding of how the Trust conducts its business in this area and for the CCG to make any suggestions to move work forward.

9.17 Mrs Young reported on the changes on the Urgent Care Pathways that had been implemented through the Gold Command, which was the system approvals process for making such service changes and endorsed by NHSE at the time. Two Urgent Care Centres (UCCs) had moved from Shrewsbury and Telford to the Minor Injuries Units (MIUs) at Bridgnorth and Whitchurch, which had enabled capacity to be created in the EDs. It had been reported that the number of patients presenting through those new routes were low, however, there were patients still attending the EDs with conditions that could be treated through the UCCs, which needed to be reviewed. Also of particular interest and concern was whether or not patients had received any detriment as a result of the changes to the pathways. From the information received, there were no reports that would give rise to concern but workforce remained a risk.

9.18 Pace and achieving the embedded changes through ECIST were not yet certain, however, there was intent through the SOAG to develop a System Improvement Board (SIB) when key personnel were available. A key part of the work of the SIB would be to produce a system improvement plan that would involve partners and their role in the wider patient flow and the Care Closer to Home work.

9.19 In summary, the last SOAG meeting had concluded that SaTH continues to demonstrate improved transparency and collaboration with regulators and partners. System partners were encouraged by the commitment of the Trust to strengthen their ED leadership and also their wider governance arrangements. The ECIST work was felt to be a significant vehicle for improvements but the sustainability needs to be proven.

9.20 Mrs Young noted two errors in the report, which required amendments: On page 1 of the cover sheet: Mrs Young's title was Director of Quality and not Chief Nurse. On the last line on page 10 of the report, the correct overall rating for Maternity Services should read 'Requires Improvement' and not 'Inadequate'.

9.21 Dr Leaman noted that the response to the COVID-19 pandemic had shown that if the workload was taken out of the EDs then the ED performance improved and if this was sustained, the CCG should ensure that the workload was permanently redirected away from the ED and into alternative assessment areas.

9.22 Dr Davies responded that some level of improvement had been shown but not as much as the CCG had hoped for given the level of reduction in activity that had been seen. Mrs Young added that there had been a reduction in the number of 12 hour trolley breaches, which had seen a material improvement but it remained to be seen whether or not this level can be sustained when activity started to increase. Moreover, it was also trying to manage patients' expectations also and encouraging them to access the right services.

9.23 Dr Povey understood Dr Leaman's point but understood the redirection of patients had not improved the performance but had improved the flow of individual patients.

9.24 Dr Leaman clarified that if SaTH was to avoid achieving its past performance percentages of 50%-60%, it was essential that it redirected large numbers of major cases away from the ED into separate assessment areas.

9.25 Dr Pepper highlighted SaTH's poor RTT performance ratings prior to the COVID-19 pandemic and pointed out that the CCG should be mindful of not just recovery but also improving upon the original baseline.

9.26 Dr Davies clarified that recovery did mean reverting back to achieving the constitutional standards. It was acknowledged that there had been a performance issue with the RTT target ratings before the COVID-19 pandemic with there being a backlog, which would now have increased. Implementing the social distancing requirements would impact on capacity and it may result in approximately 25% reduction in bed capacity in the acute hospitals. Work would progress clearing the backlog of referrals in an incremental stage based on clinical priority. However, capacity solutions needed to be found for clearing the backlogs and the CCG was keen to provide evidence to escalate through NHSE/I to maintain the access to the independent sector capacity, particularly at the Nuffield Hospital; otherwise it would be hard to achieve a recovery position.

9.27 Ms Cawley reported that Healthwatch Shropshire had received complaints through its independent health complaints advocacy service, largely with the issue of communication within the Trust not just between staff but also communication with patients and their families. People had reported that when they had spoken to staff on the ward they knew nothing about the patient, including their pre-existing health conditions. It was appreciated that staff were under an enormous amount of pressure at the present time but the situation was exacerbated by the fact that families were unable to visit patients and it was hard to communicate with them. Healthwatch Shropshire had received some difficult feedback and requests for help to the point that on two occasions Ms Cawley had been required to intervene. Ms Cawley reported that she had commenced a piece of work before COVID 19 with SaTH to try to limit the number of complaints received about communication with patients, which also included SIs and hoped to continue with this work. It was agreed that Mrs Young would meet separately with Ms Cawley to discuss further and Mrs Young would request SaTH to urgently look into the issues raised.

9.28 Dr George referred to the workforce issues and suggested that efforts should be made to go over and beyond other areas in terms of sending out the right gestures to the staff at this time, which might help in recruitment and retention.

9.29 Mrs Young agreed with this point and reported that SaTH had been asked to do some work on retention rates. SaTH had reported that its turnover rate was not unusual compared with national benchmarking. However, the turnover rate for staff that have been employed there for a year or less was high and was an outlier so the Trust needed to understand why staff were joining and leaving so quickly afterwards.

9.30 Dr Povey enquired if information was available on whether SaTH had accepted all the returning medical staff that had been offered to them.

9.31 Mrs Young reported that each of the providers was working hard to best utilise the returning staff. A number of the returning staff were in place with the same number, which were being processed. It was understood that from the perspective of the Regional Chief Nurse, it was seen as a priority to place

returning staff in post. It had also been seen as the right match for some returning staff to be deployed to work in care homes.

9.32 Mr Timmis felt it was of particular concern that the CQC report had stated that SaTH's management could not trust its own systems because the data quality was unreliable and governance systems were poor. If the same logic was applied to the information received by the CCG's Quality Team and Quality Committee from SaTH, Mr Timmis asked how this would work with taking information through forums such as the Clinical Quality Review Meeting (CQRM).

9.33 Mrs Young advised that the CCG needed to be mindful that in the past anecdotal data had been shared or in different versions, which had not been helpful. The CCG had now restricted to only accepting data from Trust Board papers or official returns.

9.34 Dr Davies added that there had been issues with specific elements of data quality regarding performance metrics. Fortunately these issues had been resolved but the CCG did rely heavily on NHSE/I central reporting and then being able to flag an issue that it was then able to follow up. This was an area that was being raised with SaTH prior to the COVID-19 pandemic as it was understood that SaTH had inadequate informatics resource. Dr Davies considered it was a fundamental part of the restoration and recovery phase because there needed to be confidence in the data that would give an accurate position both in terms in real time and in historic reporting of really critical measures. Moving forward, as noted earlier, clearing the backlog by the clinical priority of treatments was going to take a length of time because of the lack of capacity to treat all patients. The accuracy of the data would be even more critical to minimise patients coming to harm as the system worked through the recovery phase. The CCG should support SaTH but SaTH needed to put significant investment in terms of capacity and systems in order to give the CCG that assurance.

9.35 Dr Leaman voiced concern that he had not seen any performance data on Maternity services for some time and asked if there had been any information received on stillbirths, neonatal deaths, maternal deaths, caesarean section rates, and asked how these compared with the national data.

9.36 Mrs Young reassured Dr Leaman that a dashboard of information was received and considered by the Maternity Quality Review meetings and that there was a Maternity Update report due to be presented to the Quality Committee at its meeting in two weeks' time, which would be received by the Governing Body at its next formal meeting. Caesarean rates were an area of concern which was being reviewed. The new Director of Midwifery at SaTH intended to run Statistical Process Control (SPC) charts showing the significance of any variance. The information needed triangulating with other data in that if the caesarean section rate was low, it could mean that there were more instrumental deliveries and potential more risk so it was always balancing a range of possibilities and outcomes.

9.37 Dr James commented that there was a danger of inaccurate data being provided and if there was more data and more timely data, it would make work on areas such as predictive work on capacity a lot easier. At the present time, it was understood that SaTH relied on collecting data through paper trails and then transferring the information on to spreadsheets rather than automatically capturing the information electronically. It was therefore difficult for SaTH to provide the data that was needed to help run the system. SaTH was aware that it needed to update its infrastructure.

9.38 Dr Povey referred to Ms Cawley's comments about patient experience feedback received and the quality of services in the period of when services had been stepped down. It was reported that similar feedback had been received in general practice in that it felt that some patients had received sub-optimal care compared to 6 months-1 year ago and these issues needed to be investigated. The quality and performance of the two week wait referrals also required monitoring because although SaTH had reported it had stepped up its non-coronavirus urgent services there had been anecdotal evidence that two week referrals had been returned. The CCG needed to be mindful of this and ensure it reviewed the quality of care and patient experience over the last few weeks and as it moved forward.

9.39 Mr Evans agreed that SaTH was aware that the organisation was data poor because its infrastructure was so poor. The Trust had had significant governance challenges over an extended period of time. The CCG could not be assured that it was receiving accurate data and it was felt that SaTH's Board had not been assured either to enable it to make the right decisions. The new Chief Executive of SaTH and her team were aware of the extent of the governance challenge and it was hoped that there would be some improvements in that moving forward in the coming months.

<u>RESOLVE</u>: 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: Mrs Young and Ms Cawley to discuss the further detail of cases raised by Ms Cawley.

Mrs Young to escalate the complaints received from Ms Cawley to SaTH with the request to urgently address the concerns raised.

Amendments to be made to the report as noted in paragraph 9.20 above.

CLINICAL AND FINANCE REPORTS

Minute No. GB-2020-05.056 – Finance, Contracting Report including Quality, Innovation, Productivity & Prevention (QIPP) schemes

10.1 Mrs Skidmore noted that for this meeting there were two reports presented: one report on the final 2019/20 year end position to 31 March 2020 (Month 12); and a report on the 2020/21 Budgets.

10.2 Final 2019/20 year end position (Month 12) - As noted in the report, the 2019/20 year end financial position was subject to external audit but at this stage the numbers were not expected to change. It was highlighted that although it was not good for the CCG to be in deficit position, Mrs Skidmore was pleased to report that the CCG had achieved its financial position that had been agreed with NHSE/I.

10.3 The summary page of the report contained further detail of the CCG's Month 12 financial year-end position. Although the forecast had not changed overall, there had been movements in expenditure categories but there had been no substantial shifts in expenditure that gave cause for concern. The QIPP position was what had been expected in that the final year end QIPP position showed delivery of £16m of QIPP against a target of £19.8m (81% delivery).

10.4 Shropshire CCG had incurred some COVID-19 related costs up to 31 March 2020 of approximately £193K. These costs had been included in the position but alongside that there was an assumption of income from NHSE/I, which had been fully reimbursed. Members were reminded that the external auditors were working with the CCG at the present time but it was not expected there would be any difficulties with the process.

10.5 Dr Povey thanked Mrs Skidmore and the work of her team and recognised that it was really positive for the CCG to hold firmly to an agreed financial position over the last three months. It was hoped that this would give NHSE/I the confidence that the CCG had the capability to deliver an agreed financial position.

10.6 A short conversation took place about the increase in activity in Prescribing and in Prescription Ordering Direct (POD) during the period covering the response to COVID-19. Mrs Skidmore advised that no data had been available as yet. It was thought that the national view was that there was a timing issue and unfortunately, the response to COVID-19 had happened at the year-end and every CCG was in a similar position. Mr Evans added that he understood that Shropshire CCG's prescribing costs had increased by 25% in April.

RESOLVE: The Governing Body NOTED the unaudited financial position at Month 12.

10.7 2020/21 Budgets – Mrs Skidmore reported that the Finance and Performance Committee had discussed an operational budget that managers would recognise despite the CCG not currently having a plan that has been signed off by NHSE/I. It was reported that it was a similar position nationally in that organisations' plans had been paused because they had been written based on a world position that looked differently now following the COVID-19 pandemic. Whilst the budgets had not been grounded in any operational delivery in moving forward there was the additional complexity because the CCG had not had its Financial Plan agreed and signed off by NHSE/I.

10.8 Whilst the report was being presented for governance purposes to ensure that there was a firm baseline to refer back to, Mrs Skidmore assured the Governing Body that she was cognizant that it was a snapshot of a plan that had been produced was at a point in time before the response to the COVID-19 pandemic. Guidance was awaited on what is expected of systems with regard to financial modelling and targets for the remainder of this financial year. This would also have implications for other work, including the preparation of the finance strategy for the new single strategic commissioner.

10.9 The block contract arrangements with the main trusts were likely to continue well beyond the summer. There would still continue to be, at least for the next few months, a system of reimbursement for direct related costs for COVID-19. There were certain areas of the CCG's spend that would make it difficult for

the CCG to provide longer range forecasts for at least for the next two months because of the unknown environment in which the CCG would be operating. Therefore, the Finance Team had been asked to focus on the run-rate for the CCG's spend so that the managers could be provided with the best information as possible to maintain oversight of grip and control and, more importantly for the Governing Body to achieve the best value for money in terms of the CCG's expenditure.

10.10 Dr Povey referred to the monthly payments made to SaTH and asked if the block contracts had not been fixed how would the CCG agree the amount paid to SaTH.

10.11 Mrs Skidmore explained that nationally the level of the block payments to the trusts were worked out based on a representative month taken from late last year. As a result, all CCGs were issued with a spreadsheet of who they should pay and how much they should pay.

10.12 Dr Povey further asked if the CCG was aware of the amount it was expected to pay SaTH and was the amount above or below the amount that had been planned for the new commissioning organisation.

10.13 Mrs Skidmore advised that the amount varied per trust and was very much a cost based system. The Finance Team was currently undertaking work reviewing the run rate for April compared to what would have been expected based on a similar month last year. Each of the trusts were receiving fixed block payments from each of the CCGs that have larger contracts with them and then also receiving a top-up payment from NHSE/I each month based on the difference between the block income that they were receiving and the costs that they were spending for that month.

10.14 The Governing Body was advised that a set of planning guidance was expected in December. It was anticipated that at a point in time, the CCG would be expected to build a finance model based on the demand and capacity of the restore and recovery work.

10.15 In answer to Dr Povey's question about the Trust's debt, Mrs Skidmore reported that there was a plan to write off Trust debt. There was a short Briefing Paper that Mrs Skidmore would arrange to be forwarded to Members for information. The Trust would not see a cash benefit because where it has had its debt written off, NHSE/I would be adjusting any plans that they have for the extent of the gain that that might have created. The amount of SaTH's write off was £83m which in comparison had been a smaller amount than those paid to some other trusts.

10.16 In answer to Dr Povey's second question about Hospice finance, Mrs Skidmore advised that the national guidance about Hospice finance was that any contract or grant arrangements the CCG holds with the hospice would need to continue at the levels already committed to. There had been an announcement that a central payment would be made to hospices to ensure they were not disadvantaged if charitable income dramatically reduced as seen in some areas. Certainly for 4 months, the hospices would receive the contributions from the CCGs and a commitment through national funding.

10.17 Mr Morris asked how the CCG was anticipating to structure in QIPP targets in the budgets at such a difficult time. Mrs Skidmore confirmed that a national instruction had been given to ignore developing QIPP in terms of finance reporting. It was being assumed that CCGs would need to write off QIPP for April and May due to the system having to support the emergency response to COVID-19. There would be an opportunity to review the QIPP plan through the work of Mr Trenchard and the various teams. Members would remember that at a point in time the CCG still had unallocated QIPP but there were areas to consider, such as accelerating the Outpatient work. An updated project list had just been received from the Project Management Office (PMO) and it was Mrs Skidmore's intention to meet with each of the Executive Directors to review their areas.

10.18 Mr Timmis confirmed that he supported Mrs Skidmore's operating budget and agreed with Mr Morris' concerns about achieving the QIPP target. It had already been highlighted that the CCG was in a weaker position than earlier years before the COVID-19 pandemic. It was a cause for concern when the CCG would review the QIPP targets as this was a big challenge and it was already well into the current financial year.

10.19 Mr Timmis also highlighted the fact that there was uncertainty on so many areas, such as contracts, and there was unlikely to be certainty for some time, which would mean that it was going to be even more difficult for the CCG this year to try and deliver its financial target. Whilst it was good that the CCG delivered the revised target at the end of the last financial year, it was of concern how the CCG would set and manage a budget in a situation where there was a much greater level of uncertainty.

RESOLVE: The Governing Body:

- ***APPROVED the current 2020/21 financial plan submission and budgets to be used as the CCG's baseline operational plan pending the receipt of further guidance/instruction from NHSE/I.***
- ***NOTED the impact on the CCG finances of COVID-19 and NOTED that the CCG awaits national guidance on any updated financial requirements for 2020/21.***

ACTION: Mrs Skidmore to forward the Briefing Paper to Mrs Stackhouse for circulation to the Members and attach to the draft minutes.

GOVERNANCE & ENGAGEMENT

Minute No. GB-2020-05.057 – Governing Body Assurance Framework (GBAF)

11.1 Miss Smith presented the GBAF and highlighted that there were two new risks, numbers 12 and 13, as a result of COVID-19. There were also three new issues that had been added to the log and some content changes, all of which had been highlighted in red.

11.2 Dr Povey queried the first risk under ID No 1/18 for the Underlying Financial Position and noted that it had the same number as the previous risk listed. Mrs Skidmore explained that the risks were usually framed for a specific financial year and the risk in question had been brought forward and re-framed for the new financial year. It was agreed that Mrs Skidmore would arrange for the risk to be re-numbered.

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: Mrs Skidmore to arrange for the renumbering of the first risk under Risk ID No 1/18.

Minute No. GB-2020-05.058 – Single Strategic Commissioner Update

12.1 Miss Smith presented the Single Strategic Commissioner Update for Shropshire & Telford & Wrekin Update Report. The application for the dissolution of the two existing CCGs and proposal to create a single CCG from April 2021 had been made on 30 April 2020. At present, the regional panel was scheduled to take place on 3 June 2020 and the CCG had until 20 May 2020 to resubmit any documents it may need to amend, such as the Financial Plan or the Commissioning Strategy.

12.2 The engagement report on the feedback from the public and stakeholders was currently in draft form. Feedback from Healthwatch Shropshire had been received but feedback from Healthwatch Telford and Wrekin was still awaited. It was expected that the engagement report would be formally released into the public domain very soon.

12.3 Dr Povey requested a note of an action point from the Part 2 meeting for the formal minutes. Miss Smith had been asked to consult with NHSE/I about the transitional period between the two CCGs' Governing Bodies ending on 26 July 2020 and the creation of the new joint Governing Body on 1 August 2020. Confirmation was required from NHSE/I to confirm whether or not special arrangements needed to be in place during this period to achieve full quoracy and possibly not having the full complement of Governing Body Members in post on 1 August 2020.

RESOLVE: The Governing Body NOTED the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin.

ACTION: Miss Smith to consult with NHSE/I about the transitional arrangements between the two CCGs' Governing Bodies ending on 26 July 2020 and the new joint Governing Body on 1 August 2020.

Minute No. GB-2020-05.059 – Temporary Changes to Governance arrangements to support COVID-19 response

13.1 Miss Smith updated Members on the temporary changes to governance arrangements to support COVID-19. A letter had been received from Sir Simon Stevens, Chief Executive Officer of the NHS, containing guidance regarding the governance arrangements during the COVID-19 response period. This contained an overview of the CCG's decision-making but also to make it expeditious and not to create any unnecessary barriers to managing the response over the health system. Miss Smith explained that the

paper presented contained the content of discussions previously held and was for any further discussion, clarity or amendments that Members may wish to make.

13.2 Dr Pepper noted that the Primary Care Commissioning Committee (PCCC) had been stood down and convened only as required and asked if it was felt that standing down the PCCC was the right decision.

13.3 Miss Smith explained that in a previous Governing Body discussion there had been an acknowledgement that the standing reports that are normally presented to the PCCC would probably cease naturally as a result of the CCG's Primary Care Team's need to focus on supporting primary care through the COVID-19 response. Therefore it was proposed that PCCC is stood down for the time being given the likelihood of decisions needing to be made will be very limited and to create capacity in the Primary Care Team to provide the support for colleagues in primary care that was currently required.

13.4 It was explained that the decision to stand down the PCCC was on the understanding that if there were exceptional circumstances where a decision needed to be taken by that committee then there remained the ability to call a meeting at very short notice. This would probably be based on the least number of members in attendance to achieve quoracy but still within the rules to make decisions. At the time of the discussion it had been considered that the work in hand was not of a sufficiently urgent nature that the CCG would continue with the standing meetings. As the situation changed and moved forward, the CCG would need to keep reviewing the frequency of the committee meetings in relation to whether there was a need for some issues to be reinstated on the agenda for decisions and discussions to be made.

13.5 Dr Pepper referred to the frequency of committee meetings during the COVID-19 period and noted in particular that the Finance and Performance Committee and Quality Committee were to be held bi-monthly. Dr Pepper asked if there was anything specific that would be lost with the reduction in the frequency of meetings and asked what mitigations were in place.

13.6 Miss Smith confirmed that in the months where the committees did not meet, the respective Executive Director and Chair of the committees would hold a briefing meeting to discuss upcoming issues and whether or not they required an urgent meeting. Miss Smith understood that these meetings had now been diarised by the Executive Directors' PAs.

13.7 Referring to the committee meetings that were to be held bi-monthly, Dr Pepper asked what form of reviewing mechanism would there be to determine whether the frequency of the committee meetings was still appropriate.

13.8 Miss Smith suggested that the Governing Body should review this at the next formal meeting in July. A paper would be prepared by Miss Smith which would set out the current position, feedback from the Chairs of the committees and the Executive Directors, and whether the schedule of meetings should revert back to its previous regularity of meetings or adopt a different schedule.

13.9 Dr Povey pointed out that the report stated that there would be an informal joint briefing meeting held in August when there would be a new Constitution and different committee structure.

13.10 Miss Smith advised that the functions might be in a different combination of committees but would still be the same, ie Quality Committee would continue to review and assess the same quality data. The Governing Body would need to consider whether it needed to reinstate the regularity of the meetings to meet the CCG's normal statutory duties or whether developments in the COVID-19 response meant that the CCG still needed to take that as the urgent focus at that time. It was difficult to predict now what the situation would be at that time until the system had gone through the first phase of the immediate incident management and into a different phase.

13.11 Mr Timmis, as Chair of the Audit Committee, said that he was comfortable with the proposals put forward and considered that there was appropriate mitigation in place with the meetings of the committee chairs and the Executive Directors. Mr Timmis thought that the Quality Committee, for example, should only meet bi-monthly on the same basis as the Audit Committee where a certain amount of time was required in between meetings to enable the Executive Directors to undertake the work required. Mr Timmis appreciated that Mr Vivian would not be in agreement with this proposal, particularly given the scale of some of the quality challenges in Shropshire but felt that the CCG had an entirely appropriate set of arrangements for this and strongly supported Miss Smith's paper.

<u>RESOLVE</u>: The Governing Body APPROVED the proposed temporary arrangements to the CCG's Governance processes up to and including 31 July 2020, and NOTED that these arrangements will be reviewed further in the July 2020 Governing Body meeting.

ACTIONS: **Miss Smith to present a review report on Governance arrangements for COVID-19 at the next formal meeting.**

Mrs Stackhouse to include an item on Temporary Changes to Governance arrangements to support COVID-19 response on the next meeting's agenda.

Minute No. GB-2020-05.060 – Temporary Changes to Commissioning Intentions and Contract to support COVID-19

14.1 Mr Trenchard presented the paper on the Temporary Changes to Commissioning Intentions and Contract to support COVID-19 and assumed the paper as read. There were no comments received.

RESOLVE: The Governing Body RECEIVED and DISCUSSED the report presented.

Minute No. GB-2020-05.061 – Audit Committee – 29 April (summary)

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

- A big thank you was extended from the Audit Committee to all the staff who had exceeded expectations in preparing and submitting the series of national returns well in advance of their original deadlines even though the CCG had been granted permission for later submissions. This was to the credit of the whole range of CCG staff and the Audit Committee was very grateful.
- The Audit Committee had discussed the progress for the preparation and audit of the CCG's Annual Report and accounts, which was further ahead this year compared to previous years. The Committee had been pleased with the progress made.
- Internal Audit and the Head of Internal Audit Opinion had concluded that the CCG could be given 'Moderate' assurance. A summary of the reports from the year and the comparison with earlier years had been included in an appendix to the report. These reports showed steady improvements in the CCG's arrangements although the Audit Committee had confirmed the aim it had previously expressed that it wanted to see 'Significant' assurance as the CCG's target for all reviews.
- External Audit was in progress and it had been reported that there had been no problems with the remote working of the two auditors in Finance and no significant issues had been reported to date.

15.2 Reference was made to the summary of reports, from which Dr Povey noted that two of the areas reviewed from the previous year had achieved a higher rating from 'Moderate' to 'Significant' and asked what further work could the CCG do to achieve an overall audit opinion from 'Moderate' to 'Significant'.

15.3 Mr Timmis considered that the rating was not based on an exact arithmetical assessment; it depended on the nature of some of the areas. If there were problems in particular areas, such as in Financial Reporting and Financial Management, those were such fundamental areas for the CCG, that it would be difficult to achieve a higher than 'Moderate' assurance rating if the CCG was falling short in those areas. It was considered there needed to be a balance with the nature of the reports where the CCG was failing to meet the required expectations.

15.4 Mrs Skidmore added that she considered the CCG still had an opportunity to improve its ratings. The internal audits tended to be based on system and process rather than the state of the CCG's financial position otherwise it would not have been able to improve for a long time. Particular challenges remained around Continuing Healthcare (CHC) and work continued on the CCG's QIPP reporting. Mrs Skidmore's view was that there was still opportunity to improve. The CCG had seen more improvements this year and would continue to work on achieving the best scores it could.

15.5 Dr Povey queried the delay in the release of the Mental Health Investment Standard Report. Mr Timmis advised that the delay was a national issue, which was frustrating. It had been reported that there had been issues at some CCGs where auditors had requested further information. The CCG had completed its return and there had been no significant issues found. The CCG was not permitted to share the formal report from the external auditors pending a national decision on the release of the results of this work.

15.6 Dr Povey thanked Mr Timmis for the work undertaken. From the CCG's point of view, from 2014 there had been steady improvements each year and although there was still work to do, the report was very positive and the Audit Committee was part of the feedback that steered the improvement.

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

FOR INFORMATION ONLY/EXCEPTION REPORTING

Minute No. GB-2020-05.062 – New Constitution and Governance Handbook

16.1 Miss Smith presented the paper previously circulated, the purpose of which was to provide for information only the final version of the new Constitution and Governance Handbook that had been adopted by both Shropshire CCG's membership and Telford and Wrekin CCG's membership. There were no questions raised.

RESOLVE: THE GOVERNING BODY:

- ***NOTED the outcome of the membership vote on adopting the new Constitution and Governance Handbook; and***
- ***NOTED the content of the new Constitution and Governance Handbook presented.***

Minute No. GB-2020-05.063 – Shropshire Telford and Wrekin (STW) Sustainability Transformation Partnership (STP) Primary Care Strategy Report Update

17.1 Mrs Wilde presented the STW STP Primary Care Strategy Report Update, which was provided for Members' information. There were no questions raised.

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

Minute Nos. GB-2020-05.064 to GB-2020-05.068

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

- Clinical Commissioning Committee – 19 February, 18 March
- Finance & Performance Committee – 26 February
- Quality Committee – 29 January, 26 February
- System A&E Delivery Board – 28 January
- South Locality Board – 9 January

18.2 There were no questions raised.

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

Minute No. GB-2020-05.069 – Any Other Business

19.1 Dr Povey asked if Members could provide their feedback to Mrs Stackhouse on whether they thought there was any difference between using Zoom or Microsoft Teams and which video conferencing system they thought would be better to use for the next Governing Body meeting.

19.2 There were no further items raised.

DATE OF NEXT MEETING

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

- Wednesday 8 July 2020 – time and venue to be confirmed.

Dr Povey thanked Members for their attendance and officially closed the meeting at 3.45pm.

SIGNED …….. DATE ……

APPENDIX 1

CCG Briefing Note

Trust Debt Write Off from 1st April 2020

- £13.4bn total national Trust debt to be written off. This is a combination of:
  - revenue debt which would have included working capital loans
  - capital debt.
- Interest on the loans will stop accruing from 31st March '20 and the principal and outstanding interest will be extinguished from balance sheets.
- Provider surplus/deficit positions (via Financial Improvement Trajectories) will be adjusted to ensure a nil impact of this adjustment[1].
- These loans will be converted to equity – 'Public Dividend Capital' (PDC).[2]
- PDC is not a 'loan' (ie the principle is usually not repayable) but Trusts will still have to pay a 'dividend' on the equity (currently 3.5%).

- Of the £13.4bn[3], £3.5bn is attributed to The Midlands (£3.1bn revenue and £0.4bn capital)
- And of this, **SATH have £83m (£81m revenue and £2m capital).**
- **SATH will not take a financial 'gain' from this arrangement** as any net benefit as a result of these changes will be utilised to accelerate the reduction in their deficit.

- From now on, the DoH are looking to encourage Trusts to move away from using interest bearing loans where possible. If Trusts apply for support from the DoH this will be given as equity rather than it being a debt to be repaid.

- Each STP has been issued a Trust capital envelope for the year and our Trusts will be required to manage within the envelope given. (This is a local pot and excludes national funding sources for new hospitals, digital, diagnostics and CCG business as usual/GP IT).

[1] The intent is that there will be no gain or loss to an individual Trust of this transaction. How this is actually transacted may be different now that planning and reporting has changed due to COVID 19.
[2] PDC is like company share capital for a business. In essence it reflects the tax payer's equity stake in a Trust and generates a dividend payable to the DoH.
[3] A breakdown of this figure can be found at: https://www.gov.uk/government/publications/nhs-debt-write-off-regional-breakdown

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Submitted Questions by Members of the Public
for the Governing Body meeting 13 May 2020

Name Date & Time	Submitted Questions	CCG Summary Response
Marilyn Gaunt	**1 Care Closer to Home** The minutes of the Finance and Performance Committee note: *Regarding Care Closer to Home there is concern that some of the Providers are not being as supportive as they could be. There had been a good outcome from the recent workshop to support the position and a paper on Admissions Avoidance outlining the phasing will be going to the Joint Exec Meeting next week.* **Which providers were being less supportive than desired? In what way? Has this been overcome? Can the paper on admissions avoidance be placed in the public domain?**	There was an initial lack of understanding of the timings associated with the implementation of the new model. There had also been some difficulties recruiting to the posts to implement the model. These challenges remain given the impact of COVID-19 and the need to temporarily redeploy staff to other posts. The paper on admissions avoidance remains commercially sensitive but we will do an evaluation of the model when it is up and running again, which we will share in the public domain. ***Mr Steve Trenchard, Interim Director for Transformation***
	2 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	

Name Date & Time	Submitted Questions	CCG Summary Response
	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.**	As this service formed part of a main contract it was monitored and reviewed through the monthly contract meetings. The conclusion of these meetings was that generally the service was operating well and within capacity. Bases in Shropshire are to be kept under review but there was no immediate need to make any changes to bases as the planning model used was operating within capacity. Clearly we have seen significant changes to the way services have been accessed and delivered as a result of the current COVID-19 pandemic. As we come out of COVID 19 there will inevitably be a range of amendments to the service to respond to and learn from the current situation so the historic review of the current service provision is now largely redundant. ***Dr Julie Davies, Director of Performance***

Shropshire Clinical Commissioning Group

ACTIONS FROM THE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING – 13 MAY 2020

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2020-05.051 – Minutes of Previous Meeting – 11 March 2020	Mrs Stackhouse to make the agreed amendment to the draft minutes as noted in paragraph 5.1.	Mrs Sandra Stackhouse		Complete 14.06.20
GB-2020-05.052 – Matters Arising [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 meeting. Item to be included on the agenda.	Mr Steve Trenchard Mrs Sandra Stackhouse	Next or following meeting	
[GB-2020-03.034 – Update on Transforming Midwifery Care]	Following the recovery phase of COVID-19, the Governing Body to consider whether Dr Povey/ Mr Evans should write a 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	Next meeting / On-going	
GB-2020-05.054 – COVID-19 Update: STW STP Moving from Restoration to System Recovery & New Norm	Mr Trenchard to provide revised slides to Mrs Stackhouse for circulation to the Governing Body Members for information.	Mr Steve Trenchard Mrs Sandra Stackhouse		Complete 29.05.20

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2020-05.055 – Performance and Quality Report including integrated, secondary and primary care	Mrs Young and Ms Cawley to discuss further the detail of cases raised by Ms Cawley. Mrs Young to escalate the complaints received from Ms Cawley to SaTH with the request to urgent address the concerns raised. Amendments to be made to the report as noted in paragraph 9.20.	Mrs Zena Young Ms Lynn Cawley Mrs Zena Young Mrs Sandra Stackhouse	As soon as possible As soon as possible	 Complete 14.06.20
GB-2020-05.056 – Finance, Contracting Report including Quality, Innovation, Productivity & Prevention (QIPP) schemes	Mrs Skidmore to forward the Briefing Paper to Mrs Stackhouse for circulation to the Members and attach to the draft minutes.	Mrs Claire Skidmore Mrs Sandra Stackhouse		Complete 18.05.20
GB-2020-05.057 – Governing Body Assurance Framework (GBAF)	Mrs Skidmore to arrange for the renumbering of the first risk under Risk ID No 1/18.	Miss Alison Smith Mrs Claire Skidmore		Complete
GB-2020-05.058 – Single Strategic Commissioner Update	Miss Smith to consult with NHSE/I about the transitional arrangements between the two CCGs' Governing Bodies ending on 26 July 2020 and the new joint Governing Body on 1 August 2020.	Miss Alison Smith	As soon as possible	

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2020-05.059 – Temporary Changes to Governance arrangements to support COVID-19 response	Miss Smith to present a revised report on Governance arrangements for COVID-19 at the next formal meeting. Mrs Stackhouse to include an item on Temporary Changes to Governance arrangements to support COVID-19 response on the next meeting's agenda.	Miss Alison Smith Mrs Sandra Stackhouse	Next meeting – 08.07.20	 Complete – on next agenda

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Agenda item: GB-2020-07.077
Shropshire CCG Governing Body Meeting: 8.07.2020

Title of the report:	Shropshire, Telford & Wrekin System Response to COVID-19
Responsible Director:	Steve Trenchard, Executive Director of Transformation
Author of the report:	Lisa Cliffe, Deputy Director of Performance & Delivery Tracey Jones, Deputy Executive of Integrated Care
Presenter:	Steve Trenchard, Executive Director of Transformation

Purpose of the report: To inform the Board Members of the

- Restore and Recovery phase of the Systems Response to Covid 19
- Processes in place to address this as a system including capturing learning
- Risks and Mitigations as part of Restore Process

Key issues or points to note:

On 30th January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. Then in the light of the latest SAGE advice and Government decisions, further far reaching instructions were given on 17th March to stand down services to ensure the NHS had capacity to cope with Covid 19.

A further letter was sent on 29th April from Simon Stevens which required the NHS to plan to re-instate all non covid 19 related urgent services within a six week time frame and begin to plan for restoration of other services in line with capacity and clinical priority and ensuring that areas of good practice and innovation were captured in re-establishing permanent services.

The changes that were required as part of the instructions on 17th March have had significant impact on our normal operating services and therefore oversight is required as to what the implications have been and what actions need to be taken in the short, medium and longer term for our services based upon both the national guidance as it is being published together with the system strategic requirements.

Commissioners have been working with the system to identify the changes that have occurred and decide where services/changes should:

1) Revert to previous position
2) Maintain current levels
3) Expand to further areas

Guidance for this process has been provided by NHSE/I and the system locally has undertaken a sift and sort exercise to evaluate which elements of service change will be recommended for future adoption as part of the local response to the Long Term Plan .

Locally the restoration services are being assured through a three tier approach of

Bronze : System wide overarching restore and recover group receiving restore requests from system sub groups.
Silver : Restore and Recover Review and Approval Of recommendations from Bronze

Gold : Receives silver recommendations and provides final approval (Gold consists of Chief Officers of Health and Social Care Chaired by Dave Evans (as CO of CCGs and Lead Exec for STW System).

To assist in capturing learning from covid a learning evaluation framework and strategic evaluation hub have been developed. The strategic hub will be instrumental in assisting the system as we enter phase 3/4 of recovery.

In addition to the overarching restore group, a demand and capacity cell has been established to model and predict the impact of reduced services due to social distancing requirements as well as assist in resilience planning for further surges or local outbreaks.

Actions required by Governing Body Members:
To discuss and note the contents of the report

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *There may be future resource implications as services enter restore/recovery* *As part of the Government response to Covid-19, there have been changes in relation to funding mechanisms. These changes are being managed and monitored through the finance teams across the CCGs Contracts til end of month 4 are within block arrangements* *Currently there are no additional investment monies available to the CCG for restore/recovery.*	No *None requested within paper*
2	Health inequalities *If yes, please provide details of the effect upon health inequalities* *There may be equality implications in relation to implementing changes following the pandemic. These will be reviewed for each of the identified service changes to understand the impact. Process includes EQIA as part of restore templates to identify health inequalities. These are reviewed by the CCG quality team and the system restore group ahead of recommendations to silver and gold.*	Yes
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirement* QIAs for service restore require providers to consider all protected characteristics including BAME staff and patients .*Process includes EQIA as part of restore templates to identify health inequalities. These are reviewed by the CCG quality team and the system restore group ahead of recommendations to silver and gold.*	Yes
4	Clinical engagement *If yes, please provide details of the clinical engagement* *The processes for restore and recover have been designed on the principle of clinically led and managerially enabled. Clinicians form members of the sub groups and the overarching bronze system restore group.*	Yes
5	Patient and public engagement *If yes, please provide details of the patient and public engagement* *During restore both CCGs have worked closely with respective Healthwatch groups and HOSC Chairs with the Director of Transformation providing weekly briefings to Joint HOSC Chairs. A series of full meetings to provide greater detailed briefing is planned for July The focus of the messaging has been to reassure people the NHS remains open for business. The Communications and Engagement Task group are currently exploring options for engagement within the constraints of social distancing.* *Both Shropshire and Telford Healthwatches have conducted public surveys on experiences during the covid pandemic and these will be published in the near future.*	Yes
6	Risk to financial and clinical sustainability *If yes how will this be mitigated* *Currently there are block arrangements in place with regard to contractual payments and services are expected to be restored within current block payment value. .*	No/Yes

NHS Shropshire CCG

Shropshire, Telford & Wrekin System Response to Covid19 Update Paper – 8th July 2020

Author: Lisa Cliffe, Deputy Director of Performance & Delivery
Tracey Jones, Deputy Executive of Integrated Care

Introduction

1.0 Following a declaration made by the NHS of a Level 4 National Incident on 30th January 2020, on 19th March a subsequent communication was received from NHS England confirming a rapidly increasing Covid19 pandemic and the requirement to put in place emergency crisis response measures that would transition in time through a number of phases including crisis response and restore & restart of services.

2.0 In order to operationalise this shift and put in place the necessary controls and governance, a standard incident response structure was put in place. Known as the Local Health Resilience Partnership (LHRP) this a nationally mandated serious incident (i.e. pandemic) response which is co-led by Public Health in the Local Authorities (Rachel Robinson) and Clinical Commissioning Group (Sam Tilley). This comprises system CEOs (Gold Command), service leaders from across all services (LA, Health, Community, Powys etc) and task and finish groups with collective approach across the system.

3.0 The Care Pathway Groups working through the detail of service changes and impact were structured so that each one had a specific focus, including in-hospital pathways, community care, emergency care, cancer, planned care services. These groups made recommendations on local implementation of national guidance.

4.0 The crisis response measures being developed, agreed and implemented were to:

- Free-up the maximum possible inpatient and critical care capacity;
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support;
- Support staff, and maximise their availability;
- Play our part in the wider population measures newly announced by Government;
- Stress-test operational readiness;
- Remove routine burdens, so as to facilitate the above.

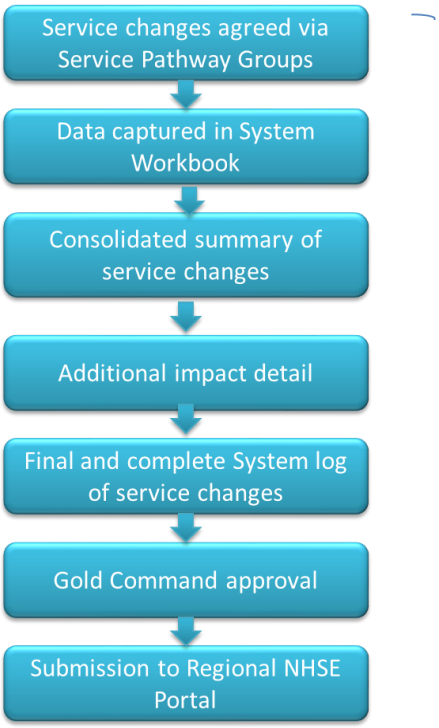
5.0 Further communication was received from NHS England to support this process, by providing guidance on what services should:

- Continue as normal;
- Be reduced;
- Be paused;
- Be enhanced.

6.0 As part of the governance framework overseeing this process, data was collected from a range of sources to gather as much information as possible including:

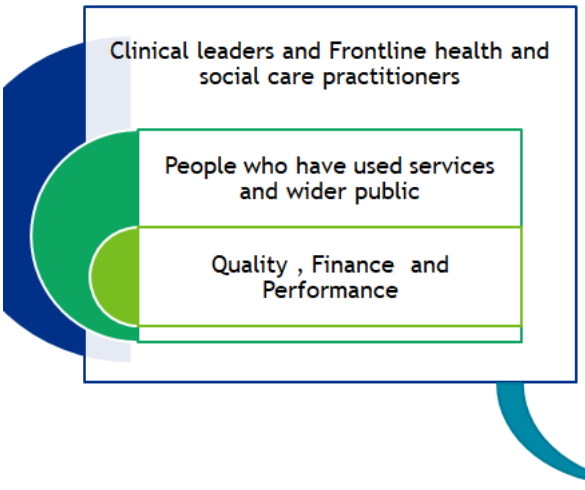
- The status of health services in February prior to the Covid19 changes;
- Status of paused transformation programmes;
- A log of the service changes that were implemented in response to Covid19 including the impact and governance of that decision.

7.0 The governance framework for overseeing this work is illustrated below.



8.0 Whilst an incredibly difficult time, throughout this process much innovation and positive change has been seen including acceleration of the use of digital technologies, collaborative working across the system to the same unified aims & objectives, and reutilisation of a more flexible workforce. These positives, and signs of innovation are also being captured to ensure they are included in the 'lessons learnt' and form part of the eventual plan to return to normal, or a 'new' normal; seizing the opportunity to keep and maintain some of these positive changes.

9.0 To ensure capture of learning across the system and from members of the public, a learning framework has been developed and agreed at a system level by Gold Command. This aims to capture learning through a triple lens of people who use services/ public, front line staff and system leadership perspectives.



Cease Things we implemented during covid response that were just specific to crisis	**Keep and Accelerate** Things we have done during covid response we really want to keep and accelerate
Pause and Evaluate Things we have stopped during covid response that we believe we may be able to stop longer term	**Restore/ Redesign** Things we know we need to restart but Covid experiences suggest a different way

The views of people who have used the services and wider public will be captured through provider feedback mechanisms .Both Healthwatch Telford and Wrekin and Healthwatch Shropshire have been actively involved in collecting public level feedback through on line surveys. The CCG Communication and Engagement team are currently scoping best practice/ public preference options to engage with the public whilst maintaining social distancing.

10.0 On 29th April 2020, further communication was received from NHSE England advising that although the UK remained on a National Incident Level 4, with the impact of Covid19 not quite as severe as anticipated, work must commence on planning how to restart and restore some of the services; and as part of a national planned phased approach, gave guidance on a range of services to plan for restarting.

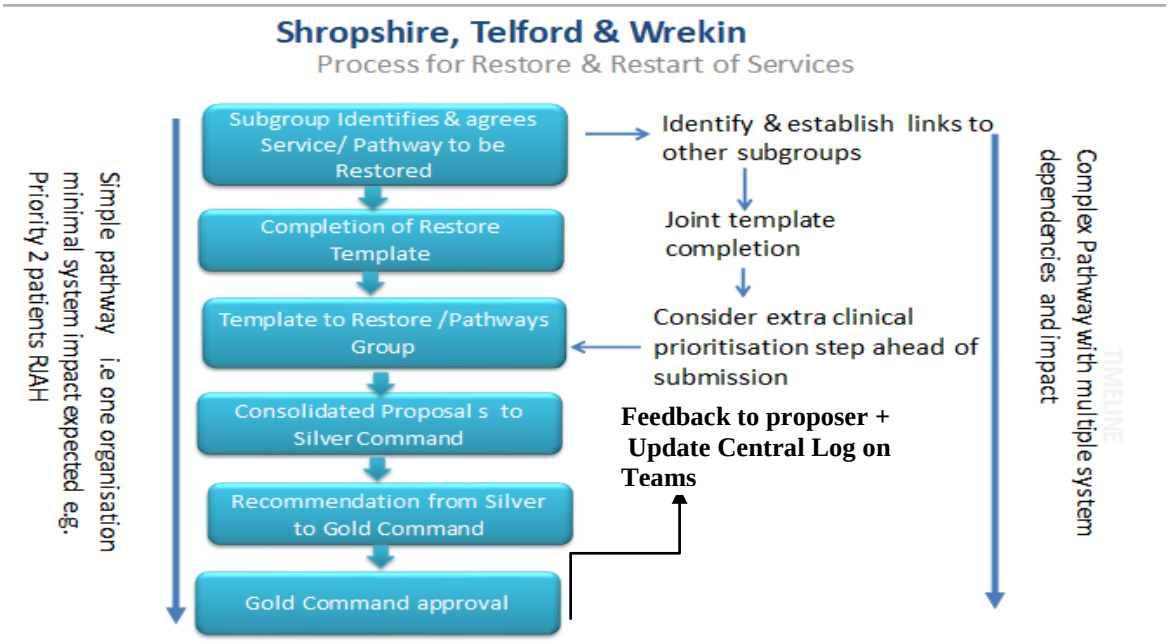
11.0 To supplement this, an impact assessment report had to be completed on the services to be re-started to capture the impact and governance based on national standard key lines of enquiry, and these included numbers of patients potentially affected by the change, waiting list size and assurance on the governance and approval process.

12.0 A supplementary report was also provided to NHS England that captured a complete list of all of the service changes that were implemented, description of the change, and the impact of that change.

13.0 With the system transitioning from crisis response and into a phase of restart & restore, but having to maintain an incident response structure, the governance framework that had been put in place to manage the crisis response has been kept in place but is being redefined. The focus of the refinement is on reviewing all of the information gathered, considering quality impact, waiting lists, potential deterioration of patients who have not presented, and balancing that with learnings captured from the changes seen in responding to Covid19. This will enable the opportunity to develop and plan for the redesign of a new health system.

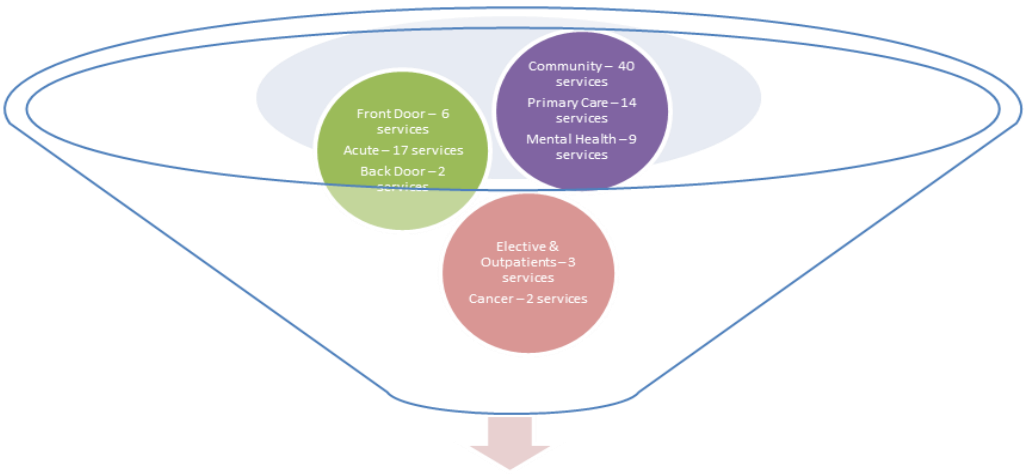
14.0 This would ensure all necessary elements are captured including those services that were paused which must be restore as soon as possible, those that can be stopped or changed permanently, and new methods of delivering services that has been seen during this period that we would prefer to keep and maintain.

15.0 The governance framework overseeing this transition planning work is illustrated below.



The process is shown as linear however if queries are raised the restore template may be returned to the structure below it or clarity sought from the provider /commissioner for resubmission as required.

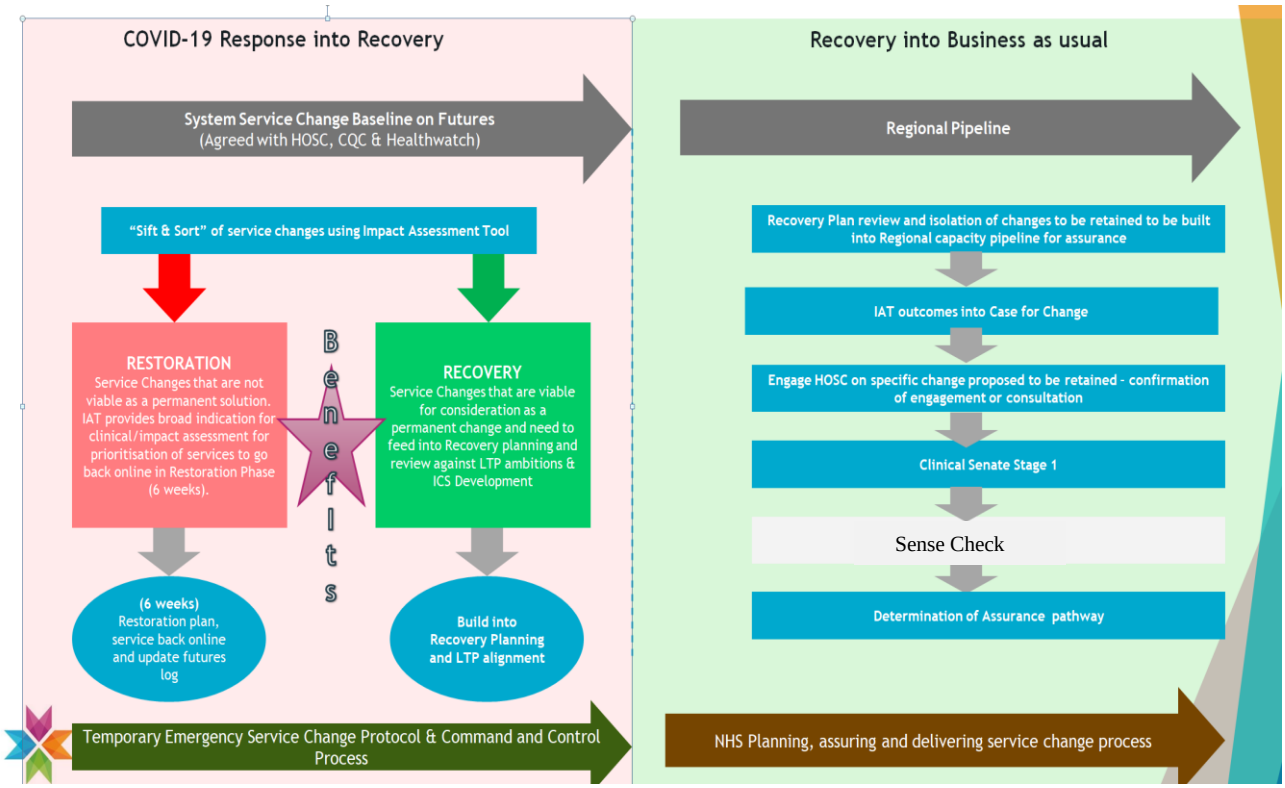
16.0 This next phase of restarting and restoring services is inextricably linked with transformation of services due to the range of opportunities for change, and the need to re-link with the previous transformation programmes that had to be paused, as well as the system Long Term Plan priorities and the strategic aims and objectives for the region.



17.0 The work being undertaken includes

- Recovery of services for health providers;
- Recovery of services for Local Authorities;
- Modelling assumptions to date and next steps to confirm baseline (beds, community, and individual service lines) to reflect reduced capacity due to social distancing and prepare for any further local outbreaks.
- Linking of Capital and Estates, Finances, Digital, PPE, People and Business Intelligence, and Comms & Engagement into restore and recover processes
- Options appraisal for optimal hospital site utilisation;
- Ongoing support to workforce to maintain wellbeing and resilience
- Ensuring local services are restored in line with NHSEI guidelines

18.0 On the 19th June a further submission was provided to NHSEI that categorised the services for restore and for recover using their Impact Assessment Tool. The diagram below details this and provides definitions for restore and recovery.



RESTORATION: Service Changes that are not viable as a permanent solution. Impact assessment tool provides broad indication for clinical/impact assessment for prioritisation of services to go back online in Restoration Phase (6 weeks)

RECOVERY: Service changes that are viable for consideration as a permanent change and need to feed into recovery planning and review against the Long term Plan ambitions and Integrated Care System Development. Locally we have 29 services identified for recovery

19.0 Strategic Evaluation Hub

As part of the learning framework referenced in section 10, system is developing a strategic evaluation hub which has the following aims:

- Provide System oversight into Benefits Realisation;
- Provide an oversight, review and evaluation function to the restore & recovery process based on data, intelligence, modelling and best practice;
- Restore – early identification of system issues for consideration;
- Recovery – comparison and evaluation of past v future LTP models, govern best practice and provide robust benefits realisation;
- Develop recovery models within Simul8 (Scenario Generator) to demonstrate system impact at an individual model basis and at a System model;
- To be aligned to Capacity & Demand Modelling that is necessary to ensure the system can manage local outbreaks and bring back on line services stood down in the immediate response.
- Assist in providing intelligence to the system wide collective response to Winter Planning

20.0 **Key risks**

No	Risk	Mitigation
1	Pre- Covid silo behaviour returns	Collaborative leadership and shared system governance now in place
2	Workforce resilience and stability including staff availability and covid related absence, stress.	OD Plan signed off by system partners Risk assessment process for BAME and other at- risk groups
3	Backlog / system performance challenge (constitutional standards)	Undertake comprehensive modelling of baseline and develop system recovery plan
4	Constraints around drugs and PPE	Work closely with National supply line
5	Testing capacity – equipment, consumables, staffing	- Work with national supply chain, networking, procurement of equipment , development of staffing models
6	Services restoration may negatively impact on wider pathways.	Governance in place for QIA and three tier Overarching system response Bronze to Gold approval
7	Political and reputational risk around Hospital Transformation Programme (Future Fit programme)	- Daily Gold calls - Weekly MP calls - Work Ongoing to strengthen Hospital Transformation Programme Governance
8	Risk of further local outbreaks and impact on restored services	- Ongoing Comms to alleviate concerns and development of real time measures. - Inclusion of flexibility of restored services to stand down considered as part of system restore group.
9	Risks that care homes could lack resilience leading to increased lengths of stay in hospital and negative impact on long term recovery for patients.	Working together as a system across health and social care there has been a programme of enhanced care for care home sector (PPE, swabbing, IPC, psychological support)
10	Risks that increased demands on community bed capacity for covid patients exceeds available bed capacity (especially if capacity is	Establishment of a system wide demand and modelling capacity cell which will provide information re need potentially commissioning additional community capacity

	reduced due to distancing for safety	
10	Risks that demand could exceed capacity for domiciliary community services as community pathways evolve including needs of shielded people and covid patients in their own home	Further modelling to understand capacity.
12	Risk that mental health services are unable to deal with anticipated increase in demand	Strengthen third sector Develop clear single access point Develop ability to meet need Capacity modelling
13	Meeting whole system requirements of maintaining social distancing compliance in services and wider in communities	Regular communications Working with community sources as part of engagement programmes
14	Risk that estate utilisation across the system is not optimised to meet current and backlog needs in speciality specific guidance	Estates optimisation plan Scenario modelling Link to HTP and Future Fit

21.0 A Communications and Engagement Task and Finish Group was formed as part of the LHRP arrangements with representatives from each STP member organisation, including the Local Authorities. Leads have been aligned to other task and finish groups and communications and engagement plans prepared for the more complex temporary service changes. The focus of the messaging has been to reassure people the NHS remains open for business. The Communications and Engagement Task group are currently exploring options for engagement within the constraints of social distancing.

22.0 During restore both CCGs have worked closely with respective Healthwatch groups and Joint HOSC Chairs with the Director of Transformation providing weekly briefings to Joint HOSC Chairs. A series of full meetings to provide greater detailed briefing is planned for July. Both Shropshire and Telford Healthwatches have conducted public surveys on experiences during the covid pandemic and these will be published in the near future.

23.0 The system will be ensuring that the demand and capacity modelling work and the restore /recovery processes are fully interlinked to address the planning that has commenced ahead of the expected surge in demand as part of the Winter Plan process. This will include the restoration/recovery of community models to deliver increased levels of care within people's own homes.

24.0 Learning from the system to date has illustrated that the system has united and worked at pace to ensure the delivery of health and social care services in response to the pandemic and continues to work together as one system as we transition into the future including the formation of a Single strategic Commissioner.

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Clinical Commissioning Group

Agenda item: GB-2020-07.078
Shropshire CCG Governing Body meeting: 8.07.2020

Title of the report:	Governing Body SCCG Performance & Quality Report 2019/20
Responsible Director:	Julie Davies, Director of Performance Zena Young, Executive Director of Quality
Author of the report:	Charles Millar, Head of Planning, Performance and Business Intelligence Helen Bayley, Head of Quality
Presenter:	Julie Davies, Director of Performance Shropshire, Telford and Wrekin CCG's

Purpose of the report:

To update the governing body on the CCGs key quality and performance matters for 2020/21 against the key performance & quality indicators that the CCG is held accountable for with NHS England. This overview provides assurance on performance achievement against targets/standards at CCG, the quality of our commissioned services at provider level as appropriate, and the delivery and contractual actions in place to address areas of poor performance & quality.

Key issues or points to note:

The attached report is our integrated quality and performance reporting for the CCG and sets out Shropshire CCG's performance against all its key performance & quality indicators for Month 1 and 2 where available for 2020/21.

They key standards that were not met YTD for SCCG are :-

62 and 14 day RTT
A&E 4hr target
Ambulance handovers >30mins and >1hr
RTT
Diagnostic waits

Cancer performance has been impacted by the impact of Covid 19 and the operational changes enforced by the need to introduce social distancing and cohorting of patients. Activity numbers and referrals have been significantly reduced as a result of this along with the shielding of certain sections of the population. Clinical prioritisation has been introduced to ensure the available capacity is allocated on a highest need basis.
More use has continued to be made of the Nuffield to deliver cancer services.

Restrictions on capacity as a result of COVID are likely to be in place for some time particularly in respect of diagnostics. Capital and revenue bids for modular units and services have been submitted to NHSE/I to help mitigate diagnostic, bed, theatre and other service capacity restrictions

Quality monitoring arrangements continue to operate with providers and the CCG continues to work closely with SaTH to address issues raised by CQC inspections.

The CCG is working with SaTH to improve processes in ED with respect to waiting times and any safety issues arising from these.
Progress has been made with RJAH in the context of improving discharge arrangements.

A&E performance has improved in May albeit with lower levels of activity. Recent data shows a recovery in A&E activity in particular at the RSH site. Transformation work in this and a number of other areas has suffered a temporary pause while services adjust to changing working arrangements arising from Covid 19. The Quality team continues to work closely with Trust staff at both sites while they are at heightened escalation levels to ensure care of patients on trolleys is being maintained at the highest levels.

Concerns continue around staffing levels in the Trust and the difficulties in filling vacancies in the current situation.

The CCG has continued to fail the RTT target being impacted by reductions in activity resulting from COVID related capacity restrictions. These activity reductions outweigh reductions in referrals leading to an increase in numbers waiting and in length of wait.

There is evidence of changes in the way services are delivered with rapid increases in telephone, video and online consultations both in primary care and outpatients. It will be key to build on this during the restoration and recovery work.

Actions required by Governing Body Members:

The Governing Body is asked to NOTE the contents of the report and sought assurance from the CCG actions contained within it to ensure patients' safety and compliance with quality care.

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of additional resources required* *Bids have submitted to NHSE/I for additional bed, theatre and diagnostic capacity to assist in the recovery of activity post the pandemic.*	Yes
2	Health inequalities *If yes, please provide details of the effect upon health inequalities* *Recovery of elective activity across providers could result in some variation in access. The system is working on clinical prioritization across specialties and providers to try and minimize this as much as possible within the constraints of capacity, staffing and availability of PPE.*	Potential
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the clinical engagement* *Clinical leads have been assigned to all the restore and recovery working groups*	Yes
5	Patient and public engagement *If yes, please provide details of the patient and public engagement* *This is planned as part of the formal restore and recovery process*	Yes
6	Risk to financial and clinical sustainability *If yes how will this be mitigated-* *It is unclear at present how the costs of full recovery will be met and over what time period.*	Potential

GOVERNING BODY

PERFORMANCE AND QUALITY REPORT

July 2020

1 INTRODUCTION

1.1 This performance and quality report provides an overview of the key performance indicators (KPIs) that the CCG is held accountable for with NHS England during 2020/21. Many of these are part of the CCG's NHS Oversight Framework (NHS OF) for 2020/21.

1.2 The monthly data reported is for April and May 2020 where data is available. A number of reporting areas have been suspended during the duration of the pandemic.

1.3 Due to the Covid19 pandemic, there have not been any updates to the NHS Oversight Framework indicators.

1.4 The oversight provides assurance on performance achievement against targets/standards at CCG level and the delivery of actions in place to mitigate.

1.5 The narrative includes details of the reasons for non-achievement of the standards and the actions in place to mitigate the risks.

1.6 Where key standards were not achieved in 2019/20, trajectories have been set as part of the Sustainability & Transformation Fund (STF), in the 2020/21 planning round. For Robert Jones & Agnes Hunt Hospital and Shrewsbury & Telford Hospital Trust, these included;

- A&E 4 Hour Wait
- 18 Weeks RTT Incompletes
- Cancer 62 days wait

2 EXECUTIVE SUMMARY

Shropshire CCG	No of Indicators	GREEN		RED	
		Current Month	Previous Month	Current Month	Previous Month
Cancer	8	4	5	4	3
Elective Access					
Urgent & Emergency Care	12	2	1	10	11
Mental Health	6 (1 avail)	2	2	0	0
Learning Disability	2	n/a	n/a	n/a	n/a
Maternity	4	n/a	n/a	n/a	n/a
Dementia	1	0	1	1	0
Primary Medical Care and Elective Access	4	0	0	4	4
NHS Continuing Healthcare	2	1	1	1	1

3 CANCER

3.1 As at June 2020, performance for the cancer indicators is as follows:

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Cancer	Cancer Diagnosed at Early Stage - % of cancers diagnosed at Stage 1 & 2	2016	50.6% (CCG) 52.6% (England)		2017 49.2% (England 522%)												
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	2017/18	83.5%	85%	67.9%												67.9%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	2017/18	88.6%	90%	80.0%												80.0%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	2018/19	87.5%	No National Standard	86.1%												86.1%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for suspected cancer	2017/18	93.0%	93%	88.5%												88.5%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for breast symptoms	2017/18	91.5%	93%	80.0%												80.0%
	Cancer 31 Day Wait - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis	2017/18	99.0%	96%	96.3%												96.3%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	2017/18	97.3%	94%	100.0%												97.3%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is anti cancer drug regimen	2017/18	99.9%	98%	100.0%												100.0%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is radiotherapy treatment course	2017/18	99.3%	94%	97.7%												97.7%
	One-year survival for all cancer				2017 72.7% National 73.3%												
	Cancer patient experience of responses, which were positive to the question "Overall, how would you rate your care?"	2017	8.9 (CCG)		2018 8.8 (CCG)												

Cancer:	
Key Performance Headlines Risks and Issues	**Actions to Address**
Performance on 14 day standards declined in April, number of referrals were down against historic levels, this is due to the covid-19 pandemic. For the 2WW urgent, referrals were down to 509, which equates to a 62.6% reduction against April 2019 (1363 refs). 62 day wait performance decreased against March's performance to 67.9%. Performance improved for the 62 day screening standard, achieving 80% in April from the March position of 55.6% Staffing capacity remains a concern for Urology, Haematology and ENT 31 day standards performance all targets were achieved in April. The cancer dashboard also details 3 further indicators, which are all reported on an annual basis. The indicators are; diagnosis at early stage 1&2 which has fallen to 49.2% , one year survival which has increased to 72.7% and cancer patient experience which remains at 8.8. Baselines and the latest position are shown. The patient experience RAG rating is based on a survey where patients are rating their care (excellent or very good).	In addition to the previously reported actions and issues, Covid 19 has clearly had a significant impact on cancer performance. Every effort has been made to preserve cancer services but restrictions are in place, and likely to remain in place, in relation to capacity as a result of social distancing and the need to maintain clear 'blue' and 'green' channels for patients. This has meant very significant reductions in diagnostic capacity across all modalities of approaching 60% in aggregate across the system. In addition several sections of the population have been shielding and consequently been unable to attend appointments. Evidence from referral data showed a very steep fall off in 2ww wait referrals in April which has begun to recover in May and June. As a result, activity is down in April in volume terms between 50% to 70% compared to average pre-Covid levels SaTH is utilising capacity at the Nuffield to undertake cancer related work particularly in relation to Urology, Gynaecology and Gastroenterology Weekly Cancer Assurance and Performance meeting are in place to address issues where possible and service restoration plans are being enacted, initially for category A patients. Work is progressing with the Cancer Alliance to understand the cancer related demand on diagnostics to ensure this is given priority.

Key Quality Risks and Issues	
The end of year Cancer breach report for 2019/20 shows there were 117 '104+ day breaches' across STW within the year. The highest number of delays was related to Urology with 41 Shropshire patients and 18 T&W patients. Following review of the 117 that waited longer than 104 days: 4 were identified as category 1B - 'potential for harm' due to the delay and one patient category 1C – 'Harm caused due to wait and believed to be irretrievable'. Ten '104+ day breaches' were reported in April 2020 across Urology, Lung and Skin. Causes of the delay in the main include patient choice, workforce and delayed diagnostics / pathways.	SaTH are currently reviewing their processes for completing and sharing learning of harm reviews. The CCG new cancer commissioner and quality lead will ensure they are included within the new process.

3.2 The performance at SaTH by tumour site for April 2020 is detailed below compared with the national average where possible. At tumour level, local numbers are small in comparison to national values and consequently more prone to the variability inherent with rates based on small numbers. Significant work is being progressed with the Cancer Alliance on tumour pathways for Lung, Breast, Upper GI and Colorectal as part of the move towards adoption of national optimal pathways.

Apr-20	2 week performance			62 day performance		
Tumour Site	SaTH	National	Comparison	SaTH	National	Comparison
Breast	85.8%	90.4%	Worse	78.6%	89.8%	Worse
Childrens cancer	83.3%	92.1%	Worse			
Gynaecological	81.5%	90.7%	Worse			
Haematological	85.7%	92.5%	Worse			
Head & Neck	75.0%	90.4%	Worse			
LGI	92.8%	80.5%	Better	42.9%	55.9%	Worse
Lung	84.2%	92.0%	Worse	47.6%	64.5%	Worse
Skin	89.0%	90.3%	Similar	96.2%	91.6%	Better
Testicular	66.7%	95.5%	Worse			
UGI	91.9%	80.0%	Better			
Urological	57.3%	88.9%	Worse	44.4%	71.0%	Worse

4 MENTAL HEALTH

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Mental Health	IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG/SSSFT)	2018/19	16.4%	22%													
	IAPT Recovery Rate (CCG/MPFT)	2018/19	53.8%	50%													
	75% of people with relevant conditions to access talking therapies in 6 weeks (CCG/MPFT)	2018/19	95.4%	75%													
	95% of people with relevant conditions to access talking therapies in 18 weeks (CCG/MPFT)	2018/19	98.8%	95%													
	60% of people experiencing first episode of psychosis to access treatment within 2 weeks	2018/19		60%	60.0%	100.0%											75.0%
	Out of Area placements for acute mental health inpatient care - transformation																
	Mental Health - Care Programme Approach (CPA) - % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric patient care	2018/19		95%													

Mental Health:	
Key Performance Headlines Risks and Issues	**Actions to Address**
Due to the Covid-19 outbreak – there is no new data available for the mental health metrics. The CCG was expected to fail narrowly to meet the 22% target at the end of 2019/20 for IAPT access. The recovery rate target of 50% was achieved consistently through the year.	IAPT services have largely been paused during the Covid situation but restoration is being planned. Modelling work has been commenced to estimate the level of the amount of deferred demand in the area. Funding bids have been submitted by the system to allow this recovery. As services are recovered, data flows will be resurrected.
Key Quality Risks and Issues	
The review and monitoring of MPFT serious incidents; the learning identified; the identification of corrective actions; the responsiveness and effectiveness of the actions across MPFT. The sustainability of mental health services during COVID19.	The annual SI report (2018/19) has been shared at CQRM on 31st January 2020 and the learning identified will be monitored through the CQRM. This is in the process of being further reviewed with additional information from the last MPFT suicide report (2017/19). Public Health England is leading collaborative work to enable better understanding of deaths where suicide is recorded and other deaths which are not recorded as 'natural causes'. This will include those people known to mental health services and those who have not accessed services. All previous enforcement and improvement notices issued to MPFT by the Health and Safety Executive and CQC have now been closed. CQC have continued ongoing liaison with MPFT since start of COVID19 effects and subsequent requirements. No issues have been raised by CQC.

5 LEARNING DISABILITIES (LD) Dementia and Maternity

5.1 There are two indicators relating to LD, which are reported annually. For maternity, three out of the four maternity indicator positions are reported annually. There are three indicators in the dashboard, with data now populated. These show the CCG in the middle range of the national distribution.

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Learning Disability	Proportion of people with a learning disability on the GP register receiving an annual health check	2017/18	51.4% (England)		52.68% (2018/19: CCG)												
	Completeness of the GP learning disability register	2017/18	0.49% (England)		0.52% (2018/19: CCG)												
Maternity	Maternal smoking at delivery	Q3 2019/20	10.4% (England)		11.0%			10.1%			11.0%			11.4%			
	Neonatal mortality and still births per 1,000 population	2015	4.64		4.3 (2017: CCG)												
	Women's experience of maternity services	2017	88		81 (2018: CCG)												
	Choices in Maternity Services	2017	66.2%		67.6% (2018 CCG)												
Dementia	Maintain a minimum of two thirds diagnosis rates for people with dementia	2018/19		67%	67.4%	66.0%											66.0%
	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	2018/19	78.0% (England)		79.31% (2018/19: CCG)												

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Dementia	Maintain a minimum of two thirds diagnosis rates for people with dementia	2018/19		67%	67.4%	66.0%											66.0%
	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	2018/19	78.0% (England)		79.31% (2018/19: CCG)												

Learning Disabilities:	
Key Performance Headlines Risks and Issues	**Actions to Address**
Completeness of the GP Learning Disability Register – the CCG performs better than the England average	The CCG is within the top quartile nationally on this measure, but new primary care focus is expected to drive improvement in this measure during 20/21.
Maternity Maternal smoking at time of delivery is reported on a quarterly basis. Q4 2019/20(11.4%) showed an increase against Q3 performance (11%). Preliminary recent data for Perinatal Mortality shows a slight improvement in the level, reversing the slight trend seen in the most recent published metric	The level is slightly better than the average rate for England as a whole. The Improving Births programme is targeting initiatives to improve the CCG's position relative to other parts of England.
Dementia diagnosis failed to achieve the national standard, May 2020 achievement was 66.0%, performance has been impacted by the Covid-19 outbreak and the need to cohort sets of patients. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months, was 79.31% for Shropshire CCG, with the England average being 78.0% (2018/19).	The CCG is the best performing in its peer group of most similar CCGs The CCG is in the top quartile nationally.
Key Quality Risk and Issues	
Learning Disabilities: The ASD and ADHD waiting lists remain a concern. The Mental Health Wellbeing provider commissioned to address the back log of 12months + waiting list had worked work closely with MPFT and managed to significantly	Plans for a neurodevelopmental pathway have been developed but is still awaiting financial approval via NHSEI. Work is taking place across the wider health care and education system to achieve a multidisciplinary

reduce the waiting list, however due to Covid the waiting list has now increased with a new cohort having waited over 12 months.	approach to neurological development support. It is acknowledge that this work requires some pace in order to implement a pathway that address the current waits and improves outcomes for CYP and a panel approach is to be piloted.
Maternity: Between 12th and 20th November 2019, CQC re-inspected the core services on both hospital sites. In addition Children and Young People and Maternity services were inspected at the Princess Royal Hospital. A Well Led Review was held on 8th to 10th January 2020 at PRH and RSH. The CQC report was published in April 2020.	Maternity services showed signs of improvement, with the areas 'effective' and 'responsive' moving from Requires Improvement to Good. The category of 'safe' moved up from Inadequate to Requires Improvement. CQR meetings for Maternity Services have continued virtually each month throughout Covid with consistent good representation from the Trust and the CCG.

6 URGENT AND EMERGENCY CARE -

6.1 A&E Performance and Ambulance Handover Delays

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Urgent and Emergency Care	Achievement of milestones in the delivery of an integrated urgent care service				6	6											6
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q1 2018/19	2074 (England)		Q1 2019/20 845			Q2 2019/20 965									
	A&E Waiting Time - % of people who spend 4 hours or less in A&E (SaTH)	2019/20	67.9%	95%	80.9%	86.7%											84.2%
	Trolley Waits in A&E - Number of patients who have waited over 12 hours in A&E from decision to admit to admission (SaTH)	2019/20	1163	Zero Tolerance	0	0											0
	Ambulance Handover time - Number of handover delays of >30 minutes (RSH + PRH)	2019/20	9190	Zero Tolerance	294	148											442
	Ambulance Handover time - Number of handover delays of > 1 hour (RSH + PRH)	2019/20	2714	Zero Tolerance	3	1											4

URGENT AND EMERGENCY CARE:	
Key Performance Headlines Risks and Issues	**Actions to Address**
The SaTH A&E 4 Hour Wait target has not been achieved and is reported as 80.9% in April and 86.7% in May. This is below the target trajectory.	The action plan agreed through the A&E Delivery Board has identified 6 key action areas: • Ambulance Demand • Frailty • ED Systems & Processes • Same Day Emergency Care • Home First – Pathway Zero • Integrated Discharge Management These areas have been reviewed at a workshop in February to identify which should be continued and which need replaced by an alternate approach. Further development of this work has been impacted by the pandemic but is expected to be resumed in later part of June.
Workforce limitations continue to be the key problem for SaTH, with both middle grade and nursing recruitment impacted by Covid.	The ability to recruit overseas candidates to the middle grade rotas continues to be impacted by travel restrictions and it is not yet possible to predict when this might change. Concern remains around availability of consultant cover which remains fragile, with a high proportion of capacity continuing to being provided through bank and agency routes. Recruitment efforts continue with progress being made on 3 appointments. Collaboration with a neighbouring trust for paediatric consultant cover is being progressed Nursing recruitment of remaining overseas candidates is similarly stymied by Covid travel restrictions, however recruitment drives for UK based staff are continuing. The trust are focussing on retention of existing staff and anticipate ED nursing workforce to be fully established

	ahead of winter 20/21 Attendance numbers at A&E had dropped significantly in April but have seen recovery in May and June. This is different at the two hospital sites with recovery being more rapid at the RSH site. Emergency admissions from A&E show a similar pattern with levels at RSH being almost back to pre Covid levels whilst those at PRH are still someway short of this. Cohorting and social distance requirements are presenting some operational difficulties as activity ramps up which will be a concern going into next winter. Some activity, particularly from PRH, has been diverted to MIUs with the relocation of the UCCs, notably Bridgnorth.
Numbers of Super Stranded patients (>21days LOS) have reduced at SaTH.	Long stay patient numbers have reduced at SaTH since Covid, but there is evidence of these numbers starting to increase again as demand recovers and occupancy levels increase. This is more evident at the RSH site. Joint processes to achieve targeted numbers of Complex discharges continue to operate reasonably effectively. Home First and Pathway 0 is operational on both sites with promising early indications and, crucially, no indication of re-admissions for patients going through these pathways. There is no evidence of build-up of bed pressures in the community hospitals or in the IS beds.
Reported Ambulance handover delays (over 60mins) have improved in May from the April numbers. Walk In demand is still below previous levels but is recovering	Ambulance handover improvement plans are in place between SaTH and WMAS and the AEDG has re-established the Ambulance subgroup with a remit to explore options for reducing conveyances and handover delays.

steadily at both sites.	Ambulance activity has steadily increased at the RSH site following the immediate reduction upon the onset of Covid Capital and revenue bids have been submitted to NHSE/I for additional modular wards and other facilities to aid recovery of services and mitigate against future activity increases. The Trauma service, currently temporarily located at RJAH, is being planned to revert to SaTH in September but is dependent on additional modular capacity being made available to offset the reduction in beds as a result of the 2m social distancing rule.
Key Quality Risk and Issues	
CQC report was published in April 2020. 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). CQC carried out a focused inspection of the Royal Shrewsbury Hospital and the Princess Royal Hospital between 9 and 10 June 2020. Wards inspected were 21, 22 and 32 at the Royal Shrewsbury Hospital and wards 7, 9 and 10 at the Princess Royal Hospital. Staffing levels on some wards were in excess of recommending staffing levels due to the number of patients on the ward. Key areas reviewed were: • End of Life, RESPECT, DNACPR • Falls assessments, TVN and Nutrition • Use of restraint and chemical restraint.	The CCG continues to work closely with the Trust, NHSEI, ECIST and partners to provide support and challenge in driving forward the measures required to improve. Escalations were raised at the end of day one in relation to two patients being cared for and concerns from a safeguarding perspective and whether best interest had been undertaken correctly. The Trust requested that the CCG safeguarding lead attend and review the two cases and provide advice and guidance reduce risk and harm to the patient concerned. Following a full review the CCG were able to confirm that concerns raised by the CQC were accurate and further training is required for all staff not only those on the ward concerned. The CCG nurse will support SaTH in amending their training package to ensure the safety of future patients under our care. CCG quality assurance visits to SaTH have continued throughout the

It was noted that the Trust has a medical model of care and nursing staff did not demonstrate challenge.	Covid pandemic. Informal visits to RSH MLU and a deep dive patient notes review took place on wards 9 and 10 at PRH following the latest CQC visit. The quality team are also attending Exemplar quality assurance visits to work directly with the Trust in operational delivery of quality assurance processes and subsequent monitoring/ implementation of actions. The quality leads have attended 8 joint Exemplar visits to SaTH during May / June. Findings by CQC have been raised previously and the Trust is aware of the issues and actions required. Issues around documentation; appropriate clinical assessment; managing deteriorating patients; falls prevention; delivery of essential nursing care; compassionate care; diagnostic delays are some of the recurring issues shared with the Trust following QA visits and in review of serious incidents. Members of the CCG quality team, who have been redeployed to SaTH during the Covid pandemic, had weekly 'Keeping in Touch' (KIT) meetings to share experiences and provide a 'fresh pair of eyes' on positive areas of practice and progress on areas for improvement. CQC actions are presented to the System Oversight and Assurance Group (SOAG) and to the CQRM each month. CCG continue to chair the weekly assurance calls with SaTH and partners to discuss and manage the risks within ED.
Workforce limitations continue to be the key problem for SaTH, with the level of ED nurses with paediatric competencies remaining a concern.	To address the low numbers of paediatric trained nurses within ED SaTH have developed an action plan to cover each shift with appropriate levels of paediatric trained nurses or trained nurses with advanced skills in paediatric nursing. SaTH report they are ahead of trajectory (12 planned) with achievement of 17 nurses completing paediatric competencies. Their target is 30 completed competency

	training by end August 2020 and this is expected to be met. SaTH director of workforce updates CQRM each month
There have been two 12 hour trolley waits reported in ED in May and two in June. The ongoing process for reviewing harm or potential for harm to these patients has been agreed with the Trust.	The CCG has raised concerns about the 12 hour breeches and is keen for processes to be improved ahead of winter pressures. The issues in the main are related to ED's use of the escalation policy; timeliness of wards to ensure the bed is ready for transfer and mental health patients being transferred to an appropriate placement for care & treatment. The CCG is working in support of SaTH management to ensure the internal escalation processes associated with patients with a DTA (Decision to Admit) are rigorously followed and embedded in practice
There are delays in receiving Serious Incident RCA's due to capacity issues within the patient safety team. There are currently 40 open SI's in the process of being reviewed by the Trust. 7 RCAs have been reviewed and closed during May/ June. Two new Never Events have been reported. One in maternity related to a retained swab and one related to a bed rail incident. The CQC are investigating 6 SIs within their Health and Safety powers.	A new patient safety lead has been appointed within the Trust. The CCG continue to have monthly SI review meetings with the Trust and review RCAs as they are submitted with follow up on actions being monitored via CQRM, QA visits. The CCG have attended a joint meeting with the Trust and NHSEI to carry out a deep dive into the SI's. The CCG are setting up system wide Serious Incident/ Patient Safety meetings to share the learning from SI's with other providers.

6.2 Ambulance Response Times, Crew Clear and Delayed transfers of care

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Urgent and Emergency Care	Category 1 (mm:ss): 90th Percentile	WMAS	12:05	15mins	12:04	12:06											12:05
		SCCG	**22:06**		20:10	20:09											20:10
	Category 2 (mm:ss): 90th Percentile	WMAS	24:37	36mins	20:42	19:04											19:52
		SCCG	39:02		32:09	29:20											30:31
	Category 3 (mm:ss): 90th Percentile	WMAS	103:43	90mins	46:21	31:02											37:38
		SCCG	111:26		50:07	43:38											47:11
	Category 4 (hh:mm:ss) : 90th Percentile	WMAS	149:39	180mins	60:53	50:17											54:52
		SCCG	140:10		67:50	56:46											60:26
	Crew Clear delays of > 30 minutes (RSH + PRH)	2019/20	141	Zero Tolerance	9	11											20
	Crew Clear delays of >1 hour (RSH + PRH)	2019/20	8	Zero Tolerance	0	0											0
	Delayed Transfers of care attributable to the NHS (LA)	2017/18	3381	Reduction 2016/17 Outturn													0
	DTOC Rate (SaTH)			3.5%													0.0%
	DTOC Rate (RJAH)			3.5%													0.0%
	Population use of hospital beds following emergency admission	Q2 2018/19	500.5 (England)		Q1 2019/20 799			Q2 2019/20 815									

Ambulance Response Times, Crew Clear and Delayed transfers of care	
Key Performance Headlines Risks and Issues	**Actions to Address**
The CCG achieved the standards for the Category 2, 3 and 4 calls in May but, failed the standard for category 1 calls. Ambulance demand has started to recover to pre COVID levels. Conveyances to ED are lower than 2019/20 and there has been an increase in 'See & Treat' activity in preference.	Performance issues are raised regularly with the Regional lead commissioner The lead commissioner is planning reduced demand from the 20/21 year based on the joint running of the 999 and NHS 111 services by WMAS
DTOC (SaTH) – No new data has been released for DToC reporting, due to the Covid-19 outbreak.	The CCG works closely with all local providers and local authorities to ensure discharges are made in as timely a manner as possible. Discharge arrangements are working well and there are no current issues in arranging discharges. Due to the ongoing success of the new integrated discharge team, there are no DTOC concerns across the system and even spinal injuries DTOC have been reduced during the pandemic to much lower levels. The challenge will be to maintain this.
Key Quality Risk and Issues	
Delayed discharges, in particular, for spinal patients remain an issue at RJAH as many patients are requiring transfer out of area.	RJAH is currently working closely with NHS England Specialised Commissioning to improve the discharge process for spinal patients and new ways of working to be introduced from January 2020. CQRM discussions in June 2020 demonstrated an improvement in delayed discharges.

7 Primary Medical Care, Community Services and Elective Access

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Primary Medical Care	Patient Experience of GP Services	2019	82.9% England		87.99%												
	Last time you had a general practice appointment, how good was the healthcare professional at giving you enough time	2018 GP Patient Survey	87% England (Good)		91% Good												
	Last time you had a general practice appointment, how good was the healthcare professional at listening to you		89% England (Good)		92% Good												
	Last time you had a general practice appointment, how good was the healthcare professional at treating you with care and concern		87% England (Good)		92% Good												
	How would you describe your experience of your GP Practice		84% England (Good)		89% Good												
	Overall, how would you describe your experience of making an appointment?		69% England (Good)		76% Good												
	Were you satisfied with the type of appointment offered?		94% England (Good)		96% Good												
	Primary care access - proportion of population benefitting from extended access services	Oct-18	98.4% (England)		50%	49%	49%	51%	51%	51%	100%	100%	100%	100%	100%	100%	
	Primary care workforce	Mar 2019	1.06 (England)		'1.21 (March 2019)												
	Count of total investment in primary care transformation made by CCGs compared with £3 head commitment made in the General Practice Forward View	Qtr 2 2018	Green (England)		Green												

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Elective Access	RTT - incompletes (CCG)	2019/20	88.0%	92%	75.2%												75.2%
	RTT - incompletes (SaTH)	2018/19	84.5%	92%	71.5%												71.5%
	RTT - incompletes (RJAH)	2019/20	84.7%	92%	78.8%												78.8%
	No. of 52 Week Waiters (CCG)	2019/20	7	Zero Tolerance	28												28
	Diagnostic Test Waiting Time < 6 weeks (CCG)	2018/19	0.9%	1%	34.2%												34.2%
	Diagnostic Test Waiting Time < 6 weeks (SaTH)	2018/19	0.3%	1%	34.2%												34.2%
	Diagnostic Test Waiting Time < 6 weeks (RJAH)	2018/19	1.0%	1%	22.4%												22.4%
	Cancelled Operations - no. of patients re-admitted within 28 days (SaTH)	2019/20	5	Zero Tolerance													0
	Cancelled Operations - no. of patients re-admitted within 28 days (RJAH)	2019/20	1	Zero Tolerance													0

Primary Medical Care, Community Services and Elective Access	
Key Performance Headlines Risks and Issues	**Actions to Address**
Access to, and satisfaction with, Primary care services continues to be rated highly by Shropshire patients and compares well with the overall England position.	Extended access at weekends and evenings was introduced from the 1st of October 2018 and continues to run smoothly. Additional extended hours are also being delivered via the Primary Care Networks. Delivery of extended access appointments was affected at the onset of the pandemic but are now at near to normal levels.
Comparing the CCG with others in nationally published data, continues to show the Shropshire practices, in general, are rated at the positive end of the national spectrum on almost all available measures.	Following publication of the Healthwatch Engagement Report regarding Experiences of accessing Primary Care Services in Shropshire, the CCG will continue to work with practices in reviewing the recommendations outlined in this report, in order to reduce the variation in patient experience and promote equal access to high quality primary care services across the County. Practices that show as outliers against these measures are supported by the Primary Care Team, via their Locality Managers, to work on improving access, quality and patient satisfaction. Practices in the CCG have made significant advances in the number of online, video and telephone consultations offered since the Covid situation. Practices are mostly working to a total triage system that ensures all patients are spoken to prior to attendance at the practice building to minimise the spread of COVID-19. The implementation of a 'Hotsite' and 'Hot Visiting Service' for patients with COVID-19 symptoms has assisted in ensuring that practice buildings are kept as free from

	potential transmission of COVID-19 as possible. Onward referrals for treatment were reduced by over 60% at the onset of the pandemic, but have since recovered to be around 25% below normal levels. Recovery has been greatest in the 2 week wait referrals and urgent referrals with routine cases still well below previously prevailing numbers.
The CCG failed to achieve the RTT 18 week performance (incompletes) in April (75.2%), performance has been impacted upon by the Covid-19 pandemic. The LHE is working to construct recovery plans. The CCG failed to achieve the Diagnostics Wait target in April.	The impact of Covid on bed, outpatient and diagnostic capacity has been, and will continue to be, significant. Even with reduced referrals in the short term, waiting numbers and times will deteriorate. A bid has been made to NHSE/I for additional bed, theatre and diagnostic capacity to support the required recovery. Current data monitoring sets may not be adequate for the future as they do not differentiate clinical priorities which will become a much more critical factor in allocating capacity compared to waiting times. Work is underway with clinical leads to agree a more accurate way of measuring our recovery.
SaTH failed to achieve their overall RTT target in April at 71.5%. This is largely due to the impact of Covid-19.	Additional bed, theatre and diagnostic capacity bids have been submitted to NHSE/I to facilitate recovery, allow restoration of elective services and mitigate for expected winter pressures
At the end of April there were 28 x 52 week waiters reported for the CCG.	The CCG actively manages the position with long waiters and will ensure such cases are regularly reviewed in the context of clinical importance.
Cancelled Operations –SaTH achieved the target in Q4, SaTH reported 0 cancelled operations.	Any patient safety issues relating to cancelled operations are managed through the contractual quality processes**.**
Key Quality Risk and Issues	

Primary care network (PCN) development	PCN's have been reformed to include 3 PCNs in T&W and 4 in Shropshire. Further work is underway on how the Directed Enhanced Service (DES) will be implemented, in particular for those practices that have opted out of a PCN.
Shropshire and Telford and Wrekin have been accepted to be part of the first Midlands Region Frailty Collaborative programme. The programme will take place over the next 4 months and will be intense in order to be ready to support winter pressures.	The Frailty Collaborative working group has been formed with representation across commissioners and providers. Project implementation and delivery will be supported by the Emergency Care Intensive support team.
There are currently no care homes under level 4 scrutiny.	Ongoing monitoring and information sharing across multiagency organisations continues (both nursing and residential care).

8 NHS Continuing Health Care and HCAIs

NHS Continuing Healthcare	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	Qtr 1 2019	6.54% (England)		1.6%			0.0%									

Additional Indicators Requiring Focus	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
	Healthcare acquired infection (HCAI) measure (MRSA)	2019/20	1	0	0	0											0
	Healthcare acquired infection (HCAI) measure (Clostridium difficile infection)	2019/20	55	43	5	6											11

9 Recommendation

The Governing Body is asked to NOTE the contents of the report and the CCG actions contained within to recover performance in those areas which are currently below target.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.079
Shropshire CCG Governing Body meeting: 8.07.2020

Title of the report:	2020/21 M2 Financial Position
Responsible Director:	Claire Skidmore – Executive Director of Finance
Author of the report:	Laura Clare - Deputy Chief Finance Officer
Presenter:	Claire Skidmore – Executive Director of Finance

Purpose of the report:

This report sets out the 2020/21 Month 2 financial position of the CCG. The report highlights the main areas of overspend but also focuses on run rate and comparison of expenditure between 2020-21 and 2019-20 as this is a better indicator of expenditure trends given that the budgets are not based on the original CCG plan.

- On 15th May 2020, NHSEI issued guidance to suggest that CCGs will be expected to breakeven on an in-year basis. To achieve this, CCG allocations will be non-recurrently adjusted for M1 to M4 to reflect expected monthly expenditure.
- M1-4 budgets have therefore been set by NHSEI and are based on 2019/20 Month 11 expenditure.
- The Month 2 YTD position is an overspend of £5.7m and a month 4 forecast overspend of £10.0m. It is expected that there will be a retrospective allocation adjustment to make the CCG breakeven.
- In Month 2 there is £4.0m of COVID expenditure included in this position and forecast COVID related spend for the 4 month forecast is £6.3m.

Actions required by Finance and Performance Committee Members:

The Committee is asked to:

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

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	No
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the clinical engagement*	No

5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	No
6	Risk to financial and clinical sustainability *If yes how will this be mitigated* The CCG has both a significant cumulative deficit and also a significant planned in year deficit. This is one of the main CCG risks highlighted to Board as part of the Board Assurance Framework. A continued deterioration in the CCG underlying position will impact on the CCG's ability to recover financially over future years. The impact of the COVID-19 pandemic is also now captured as a risk to the financial position within the GBAF.	Yes

Tables included in this report:

Graphs included in this report:

Schedules appended to this report:

Appendix	**Content**
Appendix A	Summary of M2 COVID expenditure return

NHS Shropshire CCG

Governing Body Meeting 8th July 2020

2020/21 Month 2 Financial Position

Introduction

1. The 2020/21 Financial Plan and QIPP plan were presented to CCG Board on 13th May. The Governing Body agreed that the budgets presented could be used as a baseline position in order to support operational budget management in the absence of guidance on in year reporting and plans and acknowledged that they would be subject to change once this was forthcoming. Budgets were therefore initially issued to CCG budget holders on this basis.

2. However, a paper was presented to finance committee in May to outline the significant impact that the COVID-19 pandemic was having on the financial regime within the NHS.

3. On 15th May 2020, NHSEI issued guidance that CCGs will be expected to breakeven on an in-year basis. To achieve this, CCG allocations were non-recurrently adjusted for M1 to M4 to reflect expected monthly expenditure.

4. M1-4 budgets have therefore been set by NHSEI and are based on 2019/20 Month 11 expenditure with the following adjustments:

    - Expenditure with NHS trusts has been adjusted to match nationally calculated block payment arrangements.
    - Independent sector expenditure has been removed as this is being funded nationally.
    - The adjustments in Table 1 have been applied to other providers for growth/price assumptions.

Table 1: Growth/Price assumptions applied

Baseline Service Categories	Annualised Activity (%)	Annualised Price (%)	4 Month Activity (%)
Acute Services	2.0%	1.4%	1.2%
Mental Health Services	2.0%	1.4%	1.2%
Community Health Services	2.0%	1.4%	1.2%
Continuing Care Services	2.0%	1.4%	1.2%
Primary Care Services- Excl Prescribing	2.0%	2.4%	1.2%
Primary Care Services- Prescribing	1.0%	1.0%	n/a
Other Programme Services	2.0%	1.4%	1.2%

- There has also been an adjustment to baselines to fund the retrospective FNC price increase.

5. CCGs will be monitored against the adjusted allocation position. Actual expenditure will be reviewed on a monthly basis and a retrospective non-recurrent adjustment ('retrospective adjustment') will be actioned for reasonable variances between actual expenditure and the expected monthly expenditure. This approach mirrors the approach in place for NHS Trusts.

6. CCGs are yet to receive guidance on the financial regime post month 4. This is expected in early July.

Financial Performance Dashboard

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

8. 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 is shown in the dashboard. The 7 day target is challenging and in April/May 2020 only 47% of Shropshire invoices have been paid within 7 days. We do however meet the usual 31 day target for the CCG for over 95% of invoices. The finance team will continue to monitor this and regularly monitor budget holder workflows to work to improve the 7 day payment position.

9. The 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 unfortunately missed this month in Shropshire due to delayed QOF payments in primary care.

Table 2: Financial Performance Dashboard

Target/Duty	Target	CCG	RAG
Cash	1.25% monthly drawdown	SCCG	R
Better Payment Practice within 31 days (Number of invoices)	>=95%	SCCG	G - 99%
Better Payment Practice within 7 days (Number of invoices)	>=95%	SCCG	R - 47%

Summary Financial Position

10. The table below shows the summary financial position for the CCG. Budgets have only been set by NHSEI for the first four months of this year and therefore at this stage and given the level of uncertainty, we have been asked to provide a forecast to NHSEI up to Month 4 only.

Table 3: Summary Shropshire CCG Financial Position Month 2

Shropshire CCG	Month 1-4 2020/21 Budget £'000	Forecast Outturn Mths 1-4	Forecast Variance		Budget Year to Date	Actual Year to Date	Variance Year to Date	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Total Resource Limit	**174,099**	**174,099**	0	0%	**87,050**	**87,050**	0	0%
Acute Services	83,201	83,434	233	0%	41,600	41,795	194	0%
Community Health Services	16,818	16,950	132	1%	8,409	8,475	66	1%
Individual Commissioning	15,413	17,435	2,022	13%	7,707	8,757	1,050	14%
Mental Health Services	15,559	15,746	187	1%	7,780	7,777	(3)	0%
Primary Care Services	21,779	25,982	4,203	19%	10,889	13,374	2,485	23%
Other	4,685	6,430	1,745	37%	2,344	3,199	856	37%
Running Costs	1,899	2,334	435	23%	950	1,141	191	20%
Primary Care Co-Commissioning	14,744	15,764	1,020	7%	7,372	8,275	903	12%
Total Expenditure	**174,098**	**184,075**	**9,977**	**6%**	**87,050**	**92,793**	**5,743**	**7%**

11. We expect NHSEI to apply a retrospective allocation adjustment which will result in the Month 2 position breaking even overall against the budget.

Year to Date Position

12. The Month 2 YTD position, before NHSEI retrospective adjustment is an overspend of £5.7m.

13. In Month 2 there is £4.0m of COVID expenditure included in the position. The main areas of COVID expenditure are:

- £0.4m Individual Commissioning/Mental Health
- £2.0m Prescribing (based on local intelligence as EPACT data not yet available)
- £0.8m Primary Care expenditure
- £0.8m Local Authority expenditure

14. A summary of the Month 2 COVID expenditure is provided at Appendix A.

15. The other £1.7m YTD overspend can be broken down into the following areas:

- £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 overall overspend on Individual Commissioning/Mental Health. There is an issue in Individual Commissioning/Mental Health due to local growth and price increases being higher than funded by NHSE/I in budgets (our original

plan suggested 7% growth and 2% price increase). We also don't think that the full FNC increase has been uplifted in our budgets and have requested a breakdown from NHSEI of the baseline adjustment that is referenced in the guidance to determine how this has been calculated and factored in.

- £0.2m part to full year effect of 2019/20 contract value increases that were flagged in our plan with regards to patient transport and NHS 111.
- £0.8m year to date cost pressure on Co- Commissioning. As previously notified to NHSE/I the CCG has an underlying overspend against the co commissioning allocation. The new implications of the GP contract have also been factored in to the position and no additional funding from NHSE/I has been assumed.
- £0.2m running cost overspend due to the delay in the management of change process (hence non delivery of running cost QIPP) and some non recurrent items
- (£0.3m) overall underspend on primary care (non covid) year to date mainly due to a prior year benefit from the March prescribing accrual being overestimated for COVID offset with costs pressures built in for Cat M/NCSO.

16. The current position does not assume any further allocations from NHSE/I to address any of the issues above and 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 from NHSEI on this.

Forecast Outturn Position

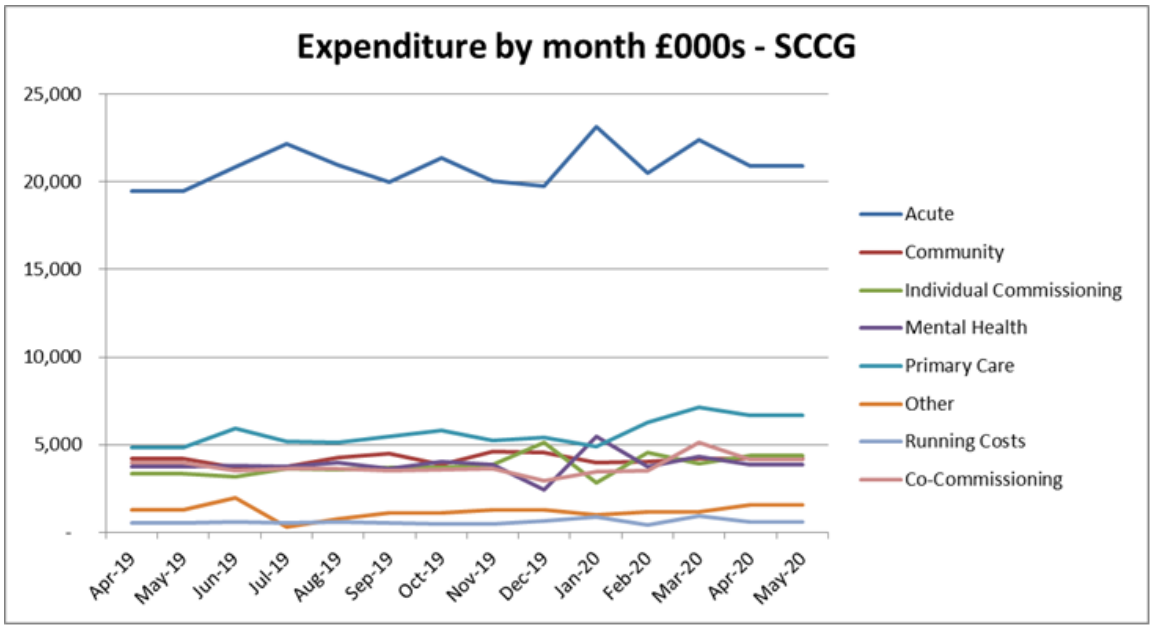
17. The forecast at Month 4 has been constructed on the basis that the rules /guidance remain the same as in Month 2. A month 4 forecast overspend of £10m has been reported.

18. As further guidance and information is received the finance team will produce a 12 month forecast.

Run Rate

19. The graph below shows the trends in expenditure for each category over the last 14 months. A summary of the key movements is outlined below.

Figure 1: Last 14 months expenditure trends by category



20. The table below compares Month 1 to 4 average spend in 2020/21 to the forecast Month 1-4 average spend in 2019/20.

Table 4: Month 1 to 4 run rate comparison

	Shropshire			
	M1-4 19/20 Average Actual £000	M1-4 20/21 Average £000	Variance £000	Variance %
Acute Services	20,482	20,859	377	1.84%
Community Health Services	3,969	4,238	269	6.77%
Individual Commissioning	3,376	4,359	983	29.12%
Mental Health Services	3,770	3,937	167	4.43%
Primary Care Services	5,211	6,496	1,285	24.66%
Other	1,215	1,608	393	32.33%
Running Cost	553	584	30	5.47%
Co Commissioning	3,774	3,941	167	4.43%
Total Expenditure	42,349	46,019	3,670	8.67%

21. **Acute** spend is up by 2% compared to last years M1-4 average. This is due to the fact that block payment arrangements are based on Month 9 expenditure. The overall increase in costs added to reflect growth and price uplift is supressed by the fact that Independent Sector expenditure has been removed in 2020/21 as this is currently funded centrally.

22. **Community** spend is up year on year by 7% overall. The majority of this increase is due to growth applied to the block payments in community contracts.

23. **Individual Commissioning** spend is up year on year by 29% for the four month period. £0.9m of COVID expenditure has been included in M1-4 for 2020/21. In

2019/20 expenditure in this area increased significantly in the latter part of the year. We also had an original planning assumption for 2020/21 that growth would be in the region of 7% and there has also been a national increase to FNC prices.

24. **Mental Health** spend is up by 4% compared to the same period last year. In months 1-4 £0.1m of COVID expenditure has been included which would account for the bulk of this increase. In addition to this there was a significant increase seen in Mental Health NCA expenditure in the latter part of 2019-20.

25. **Primary care** services spend is up by 25% compared to last year. In Months 1-4 an assumption around additional prescribing spend has been included in relation to COVID-19 as patients have attempted to stockpile medication. We have not yet had any prescribing data for 2020-21 but March data showed a 12% increase. Additional costs have also been factored in for the impact of NCSO.

26. Additional Primary care spend has also been included for GP practice spend in relation to COVID-19.

27. **Other spend** has increased by 32%.In 2020/21 the CCG has received cash only allocations to pass to the local authority for COVID-19 expenditure. In Month 4 this equates to £1.4m and the payment sits int his section of our report. There is also increased expenditure due to the full year impact of contract value increases for NHS 111 and patient transport. These were flagged in the CCG financial plan but have not been taken into account in NHSEI issued budgets.

28. **Running costs** have increased by 5% since M1-4 2019-20. This is mostly due to non recurrent costs associated with becoming a Single Strategic Commissioning Organisation.

29. **Primary Care Delegated Co- Commissioning** expenditure has increased by 4% overall since M1-4 2019-20, this is mainly due to the increased projections in spend as a result of the new GP contract.

Contracts

30. In line with NHSE guidance, for the period April - July 2020, completion of contracts with NHS Trusts and Foundations Trusts has been put on hold with Trusts receiving a monthly payment set by NHSE. Whilst confirmed guidance is awaited, it is expected that this will continue for the remainder of 2020/21. Independent Hospitals continue to be contracted directly by NHSEI.

31. Smaller community based independent sector providers are providing their plans for re-opening services via the System Restore Process and we are working with them to reflect the outcome in their contracts.

QIPP

32. In the early part of 2020/21 all CCG QIPP schemes submitted as part of the 20/21 financial plan have been paused due to the response to the COVID-19 pandemic.

33. Moving forward in 2020/21 there is a conflict between our mandate to drive cost out of the system versus the potential increase in costs in relation to the system COVID response (eg due to PPE and social distancing requirements). However, there are also significant opportunities created by the pandemic eg use of virtual appointments etc that are being explored in the longer term transformational plan.

34. The system governance will lend itself to capturing the efficiencies from the system transformational plan as part of the restoration and recovery process.

35. The CCG PMO are also working with budget managers to review internal CCG QIPP schemes in Individual Commissioning and Medicines Management with a view to assessing what might be delivered in-year.

36. Further, all executives have been asked to suggest areas for reducing expenditure during 2020-21. The CCG is continuing to robustly monitor and restrict discretionary spend. Agency spend is now very low and the finance team have reviewed all current agency engagements with budget managers to ensure that they are still required. None have been identified at this time to have their positions terminated early as they are supporting business critical work. Other areas are also being explored, for example, use of estate.

Risks and Mitigations (High Level)

37. There is significant risk inherent in the current financial position due to the levels of uncertainty surrounding the COVID-19 pandemic and the awaited national guidance.

38. The current financial position is predicated on the fact that block payment arrangements are in place with providers. We do not yet know how long this will continue and what the process will be in terms of any reconciliation/settling up. To mitigate against this system DoFs are considering a move to aligned incentive contracts.

39. 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.

40. 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 QIPP section above highlights the fact that 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.

41. 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.

42. 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 with a view to assessing what might be delivered in-year. Further, all executives have been asked to suggest areas for reducing expenditure during 2020-21.

Conclusion

43. At Month 2 the CCG is £5.7m over budget. If direct COVID expenditure is stripped out of the position, this becomes a £1.7m 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.

44. At present we are expecting a retrospective allocation adjustment for Month 2 from NHSEI so that both CCGs will report break even.

45. 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 4 onwards and we will respond appropriately as soon as it becomes available. Current high level risks and mitigations within the position are highlighted above.

Appendix A-

Summary of COVID expenditure Month 2

NHS Shropshire CCG

Summary of Covid Cost for May 2020

	Non ISFE category	SCCG £
A	**Acute Services**	
	Local Maternity Services	
	Winter Resilience	4,820
B	**Mental Health Services**	-
C	**Community Health Services**	-
D	**Continuing Care Services**	
	Other Programme services	723,328
	CCG directly commissioned	484,122
E	**Primary Care Services**	
	Prescribing	1,997,914
	General Practice	462,985
	Hot sites	220,236
	Care Home Support (CHAS)	86,000
	Other	13,960
F	**Running Costs**	20,680
	Total	**4,014,047**

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.080
Shropshire CCG Governing Body: 8.07.2020

Title of the report:	**Governing Body Board Assurance Framework (GBAF)**
Responsible Director:	**Alison Smith - Director of Corporate Affairs**
Author of the report:	**Alison Smith - Director of Corporate Affairs**
Presenter:	**Alison Smith - Director of Corporate Affairs**

Purpose of the report:

To update Governing Body on the latest iteration of the GBAF and ask that the Governing Body reviews the detail of the risks set out in the document.

Key issues or points to note:

The GBAF was previously presented at the Governing Body meeting in May 2020. The GBAF has since been reviewed again and updated by the Directors.

The Governing Body is asked to note the actions taken to mitigate risks as set out in the actions column of the Framework and to give consideration to the risks outlined on the GBAF as it considers its business throughout the Governing Body meeting.

Amendments to the risks are shown in red text.

Actions required by Governing Body Members:

The Governing Body is asked to:

- Review the detail of the GBAF risks and highlight any updates required
- Consider the risks highlighted in the GBAF as it conducts its business

Monitoring form
Agenda Item: GB-2020-07.080

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	No
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the clinical engagement*	No
5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	No
6	Risk to financial and clinical sustainability *This report sets out the range of corporate risk faced by the CCG and their mitigation actions*	Yes

Shropshire CCG Governing Body Assurance Framework Version 20.0

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	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	Likelihood 4 x impact 4 = 16	Claire Skidmore	6.1.20 5.5.20 17.6.20

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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
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 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.	Possible x Moderate = High 9	Julie Davies	6.1.20 19.6.20

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74/16	AS 20/09/16	Key principle 1, 3 and 4	**4. Transformation** There is a risk that the CCG fails to effectively lead transformation of local health services across acute, community and primary care to ensure sustainability for the future.	Sustainability & Transformation Plan (STP) Board and workstreams developed across acute (Future Fit) and 2 neighbourhood working areas SRO leads and support staff in place Future Fit Implementation Oversight Group - includes all providers Transformation Dashboard Clinical Commisioning Committee Clinical Commissioniong Committee Working Group Independent STP chair Alliance Agreement in place with Shropshire Council and ShropComm to drive the changes in the Care Closer to Home programme.	**Lead Committee - Clinical Commissioning Committee** Standing reporting item on Governing body agenda on development of STP Plans. STP standard item on CCC agenda Regular updates to CCG Board and standard update report produced CCG represented in the governance structure of the STP Senior Leaders Group (SLG) NHSE Assurance Meetings	**Gaps in Controls (GC):** GC1: The CCG recovery plan remains to be fully developed although strong progress is being made with NHS England GC2: Shropshire Care Closer to Home programme still under development GC3: Further work required to strenghten STP governance arrangements **Gaps in Assurances GA):**	Almost certain x Major - Extreme 20	GC1: NHSE continues to regularly meet with the CCG to oversee its recovery plans and implementation process. In May 2019 both SCCG and T&W CCG approved plans to become a single strategic commissioner. Plans to achieve this by 1 April 2020 are underway. This will support the recovery programme by reducing costs, duplication and inefficiencies and will create a more robust commissioning voice that is aligned to the STP footprint. Although the creation of the single strategic commissioner has been delayed by 12 months to April 2021 as a result of NHSE/I declining the CCCs application work still continues to bring the CCGs closer together in the intervening period GC2: Case Management pilot is live in 8 GP practives and will run for 9 months. Additional resources have been requested from Providers to deliver the increased activity to community teams. An investment business case is being developed in Janaury 2020. Phase 3 models are signed off and impact assessments are underway, due to be compelted by end October. GC3: The STP governance structure has been agreed and a Shadow ICS Board is being put in place from February 2020	Possible x Major = High 12	David Evans	1.10.19
75/16	AS 20/09/16	Key Principle 1 and 2	**5. Communication and Engagement** There is a risk that the CCG will fail to effectively engage and communicate with its CCG members, the public, partners and stakeholders and the CCG staff.	Communications and Engagement Plan and Strategy Dedicated comms team to support Future Fit and STP Individual Communication and Engagement plans for significant pieces of work Staff newsletter GP newsletter Patient Advisory Group (PAG) Governing Body Press briefing sessions Strong relationship with Shropshire Healthwatch and other patient groups Communication and Engagement arrangements for all QIPP schemes Communication and Engagement Plan for Single Strategic Commissioner Programme	**Lead Committee - Clinical Commissioning Committee** 360 Stakeholder survey feedback Equality Delivery System2 reporting Feedback from Shropshire Healthwatch via formal reporting and feedback into Governing body Monitoring of complaints, PALS and MP letters with regular reporitng to Quality Committee Board reporting on Single Strategic Commissioning programem includes a section on Communicatiosn and Engagement strategy development progress Executiev Group oversight of Single CCG Programme delivery Comms and Engagement Workstream within Single CCG Progarmme Governance	**Gaps in controls (GC):** GC1: Improve communications to staff and member practices GC2: Capacity of CCG Communications and Engagement Team GC3: Lack of dedicated engagement expertise within Communications and Engagement Team GC4: Development and adoption of a Comms and Engagement Strategy for the new singel CCG. **Gaps in Assurances (GA)**:	Likely x Major = Extreme 16	GC1: There is a rolling programme of communicatioin and engagement with both staff and member practices in light of the Governing Body's approval to move to a single strategic commissionin organisation with T&WCCG which is articulated in the Comms and Engagement Plan for the Programme. Ongoing to March 2021 AS GC2: 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 GC3: 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 GC4: Delivery of a final Comms and Engagement Strategy for the new Single CCG planned for December 2020	Possible x Major = High 9	Alison Smith	30.04.20

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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	**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
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

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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 Patrication 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	6.1.20 23.06.20
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	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 th 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 chnage/staffing design. DE/CP Sep 2020 New Directors to design new staffing structure in preparation for staff management of change which will clarify operating model. Sep 2020 (AS) Proposal being developed to set out process for developing further information to be added to the Commissioning Staregy post application July/Sep 2020 ST/AP Timeline for additoonal modelling to inform Finance plan agreed with NHSE/I post application July - 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~~ Awaiting National Committee outcome following receommendation to approve application with conditions made by Regional Panel. Recruitment process has started and planned to be completed by 31st July 2020. AS Risk around ratification of both new Constitutitions required by 31st July 2020 raised nad discussed with NHSE/I who have arrange additonal	Unlikely x major = moderate 8	Alison Smith	30.04.20 28.06.20

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
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	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
5/20	06/05/20 TJ	Key Principle 1	**13. Opportunity to lock in beneficial chnanges resulting form Covid 19 response** Failure to capture and act upon learning from local system responses to Covid 19 poses a risk to longer term system recovery. Opportunity to 'lock in' beneficial changes that we have collectively brought about in recent weeks, This includes backing local initiatives 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 consulttations.	Current LHRP to address immediate response to Covid	LHRP Reporting to CCG Governing Body	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)	Possible x moderate = moderate 9	Steve Trenchard	Added STH 5/05/20

Governing Body Issues Log July 2020						
Issue ID	Date	Description	RAG	Management Response	RAG status after action	Owner
Jan-20	17.06.20	**QIPP Delivery** ~~Capacity for delivery of QIPP transformational schemes is an issue both external and internal to the CCG. Concern that system cluster groups are not progressing to the delivery of target savings plans quickly enough is now further impacted by the impact of COVID-19 on provider capacity to implement transformational change.~~ In the early part of 2020/21 all CCG QIPP schemes submitted as part of the 20/21 financial plan have been paused due to the response to the COVID-19 pandemic. Moving forward in 2020/21 there is a conflict between our mandate to drive cost out of the system versus the potential increase in costs in relation to the system COVID response (eg due to PPE and social distancing requirements). However, there are also significant opportunities created by the pandemic eg use of virtual appointments etc that are being explored in the longer term transformational plan . Recognising the impact that Covid-19 will have on the delivery of QIPP Schemes, it is likely that there will be material changes to QIPP Plans that were set out in April and form part of the Long Term Plan.		~~High Level Plans on a page have been requested from the STP PMO Team by Programme Leads . CCG PMO are working closely with the System PMO Team to ensure updates are fed into CCG Plans. The CCG PMO team continue to build upon local level QIPP plans. The CCG to be kept regularly informed on the impact of Covid-19 and the impact this has on staff members and the general public. Exec Leads to agree on alternative ways to deliver schemes.~~ The Strategic System Evaluation Hub will identify and report on cost reductions that emerge through the restoration of services. System governance will provide a focus on Acute, Community and Mental Health whilst the CCG will also be looking to capture efficiencies from existing plans within the CHC and Medicines Management teams. Additional costs associated with waiting list backlog will be reviewed seperately as part of the wider demand and capacity Models.		CS
Feb-20	5.5.20	***IG Compliance*** *There are 4 key risks currently impacting on CCG IG compliance* ***Records Management*** *- There is a risk that poor records management in the CCG leads to loss of corporate memory, failure to identify information assets and therefore risks around information governance.* ***Data Handling*** *- There is a risk that*		Executive team have oversight of records management improvement progress across the CCG and continue to push this with the IG team. As part of creation of a single commissioning organisation an overall induction pack for new staff will be developed to include IG. CSU IG team working closely with high risk teams to address data handling issues		CS
Mar-20	5.5.20	***Counter Fraud*** The highest risks of fraud within the ccg are associated with bank mandates, individual commissioning payments and cyber fraud. There is now also heightened risk during the COVID-19 pandemic		Counter fraud work plan in place that is a risk based assessment of areas to target for review and support throughout the year. Fraud awareness sessions to be held at staff briefings		CS
Apr-20	01-Apr-18	**Quality & Safety** Triangulation of intelligence from a range of sources has highlighted a range of Quality issues for ongoing management		Working with providers to ensure patient safety. Ongoing monitoring arragenments in place. Quality Strategy and delivery plan developed to focus action where needed. Utilising NHS quality escalation framework in addition to our own reporting mechansms to identify and manage concerns SaTH actions and monitoring • 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 • CCG seeking to commission a review mortality data and learning from deaths • Unannounced site visits undertaken • WMQ Review of Critically Ill and Injured Children at SaTH with action plan in place - daily oversight of service provision in EDs via safe today process. • NHSE&I Chaired SATH Safety and Oversight Assurance meeting and Maternity Oversight meeting in place attended by Chief Nurse and Medical Director. Review of Maternity Care underway as commissioned the Secretary of State for Health is in progress. Media coverage is on national platforms which impacts on staff within SATH and confidence in maternity services for the population		ZY

4.18	6.1.20	**Constitutional Targets** Failure to meet targets on A&E 4 hour wait and Cancer 62 day RTT		Cancer 62 day RTT- SaTH have detailed remedial action plans by tumour site including findings of the recent NHSI deep dive. These are monitored via the monthly contract meetings and assurance calls with NHSE/I. Also work is ongoing with the Cancer alliance to target 4 tumour sites where regionally there are challenges upper and lower GI, Lung and Urology. Additional funding for project management capacity has been provided by the Alliance to support this work. A&E - The national ECIST continue to make an impact in supporting SaTH to improve systems and processes including the implementation of Same Day Emergency Care. Workforce issues remain the largest single issue, but plans for increasing the nursing and middle grade workforce are in place and been executed which is having a positive impact but not in time for this winter. Consultant staffing is now an issue again with fewer WTE this winter than in 2018. The CCG is supporting the Trust by ensuring delayed transfers of care are kept to a minimum (<2%), patients who are medically fit for discharge are discharged within 48-72hrs. The CCG is also working with WMAS and community provider to try to better manage demand and reduce conveyance to hospital and subsequent admissions.		JD
1.2	17.06.20	**System Management** Financial risks of pressure to manage the whole LHE system rather than just the finances of the CCG ~~impcts on the CCG~~. Significant deficits ~~now~~ seen in neighbouring Trusts and CCGs. Development of system financial modelling now being led through the Strategic Evaluation Hub as part of the restoration and recovery proccess. This will need to include and align with the modelling associated with Future Fit ~~is led by partner organisations. This work needs to be refreshed~~		CFO to ensure alignement of assumptions through system financial plan, including Future Fit		CS

Risk Matrix

Risk Matrix		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
Consequence	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

		Low risk
		Moderate risk
		High risk
	15 - 25	Extreme risk

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.081
Shropshire CCG Governing Body meeting: 8.07.2020

Title of the report:	**Review of Governance Arrangements in Response to Covid 19**
Responsible Director:	**David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG**
Author of the report:	**Alison Smith, Director of Corporate Affairs, NHS Shropshire CCG and NHS Telford and Wrekin CCG**
Presenter:	**David Evans, Accountable Officer, Telford & Wrekin CCG**

Purpose of the report:

The purpose of this report is to highlight the need to review the Governance arrangements adopted by the CCG during the Covid 19 management response.

Key issues or points to note:

Amending Governance processes as outlined in this report has aligned to and supported the CCG's response to the pandemic and has ensured that the CCG maintains timely and effective decision making.

Actions required by Governing Body Members:

The Governing Body is asked to:

- review the current temporary governance arrangements adopted during the Covid 19 management response; and
- approve 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.

Monitoring form
Agenda item: GB-2020-07.081

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications	Yes
	The CCG has introduced separate accounting for direct costs incurred as a result of responding to Covid 19.	
2	Health inequalities	No
3	Human Rights, equality and diversity requirements	No
4	Clinical engagement	No
5	Patient and public engagement	Yes
	Due to social distancing requirements Governing Body and Primary care Commissioning Committee meetings will not be held in public. Proposed mitigation is outlined in the report.	
6	Risk to financial and clinical sustainability	No

NHS Shropshire CCG Governing Body Meeting 8th July 2020

Review of Governance Arrangements in Response to Covid 19

David Evans, Accountable Officer,
NHS Shropshire and NHS Telford and Wrekin CCGs

1. Introduction

At the beginning of the emergency response to Covid 19, the CCG reviewed its internal Governance arrangements to ensure they were aligned with the nature of the crisis we were then facing. In a letter from Amanda Pritchard, Chief operating Officer, NHS England/Improvement, dated 28 March, entitled "Reducing the burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic" the high level guidance was outlined for Trust and CCG governance and meetings. Those directly relating to the CCG are shown below:

Governance and meetings

No.	***Areas of activity***	***Detail***	***Actions***
1.	*Board and sub-board meetings*	*Trusts and CCGs should continue to hold board meetings but streamline papers, focus agendas and hold virtually not face-to-face. No sanctions for technical quorum breaches (e.g. because of self-isolation)* *For board committee meetings, trusts should continue quality committees, but consider streamlining other committees (eg Audit and Risk and Remuneration committees) and where possible delay meetings till later in the year.* *While under normal circumstances the public can attend at least part of provider board meetings, Government social isolation requirements constitute 'special reasons' to avoid face to face gatherings as permitted by legislation* *All system meetings to be virtual by default*	*Organisation to inform audit firms where necessary*
4.	*Annual accounts and audit*	*Deadlines for preparation and audit of accounts in 2019/20 are being extended. Detail was issued on 23 March 2020.*	*Organisation to inform external auditors where necessary*

As a result, the CCG took a number of steps outlined in appendix 1, to realign the governance of the CCG to reflect the decision making requirements of the emergency.

Following a number of months of these new arrangements being in place and the transition into restoration of normal working by the NHS, the Governing Body is asked to review the need to continue with these arrangements and to consider at what point the CCG reverts back to its normal governance processes.

2. Report

The revised governance processes adopted have enabled the CCG to continue to have robust decision making, whilst also releasing capacity of its staff into focusing on the Covid 19 crisis.

However, with the start of a transition to restoration by the NHS, the Governing Body is asked to consider reverting back to normal governance processes in September 2020. This would coincide with the beginning of the planned move to a new shared governance framework between the two CCGs with the Boards and other Committees meeting in common and new joint committees being established.

As the Covid 19 crisis still has the potential to derail future plans, this is proposed with the caveat that the Chair and Accountable Officer review the situation in August.

3. Recommendations

The Governing Body is asked to:

- review the current temporary governance arrangements adopted during Covid 19 management response; and

- approve 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.

Appendix 1

Alternative temporary governance processes adopted by the CCG

Board and Committee meetings

In response to the letter, the following proposal is made regarding both NHS Shropshire CCG and NHS Telford and Wrekin CCG Board and other committee meetings to ensure we still have the ability to make decisions and to receive assurance on CCG functions during the response to Covid 19.

All meetings identified as needing to take place will be done remotely via Microsoft teams or by other virtual means. Where meetings need to be convened for both CCGs to discuss the same issue, we will try to arrange at the same time and run as Committees in Common wherever possible to reduce the burden, although this may not be possible due to availability and ensuring individual meetings remain quorate.

Shropshire CCG	**Telford and Wrekin CCG**
Locality Committees To be stood down.	**Practice Forum** To be stood down and convened only if decision reserved to the membership is required.
Governing Body Remains at Bi monthly meetings – May/ July/September via Microsoft teams Reduced agenda focussing on Assurance from committees (F&P, Quality, Audit), Covid 19 response updates, GBAF, strategic or investment decisions that need to be made in the period. Informal joint briefings by AO of both Boards to take place in April, June and August instead of Board informal/development days - early evening	**Governance Board** Remains at Bi monthly meetings – May/ July/September via Microsoft teams Reduced agenda focussing on Assurance from committees (PPQ, Audit), Covid 19 response updates, BAF, strategic or investment decisions that need to be made in the period. Informal joint briefings by AO of both Boards to take place in April, June and August instead of Board informal/development days - early evening
Finance and Performance Committee (F&P) Remains but regularity reduced to bi-	**Planning, Performance and Quality Committee (PPQ)** Remains but regularity reduced to bi-

monthly meetings – May/July/September via Microsoft Teams Exec Director of Finance and Director of Performance and Chair to meet to discuss issues arising in between formal meetings. Reduced agenda to be proposed by CFO and Director of Performance and then approved by Chair	monthly meetings – May/July/September via Microsoft Teams Exec Directors Finance and Quality and the Director of Performance and Chair to meet to discuss issues arising in between formal meetings. Reduced agenda standing items to be proposed by CFO, Exec Directors of Quality and Transformation and Director of Performance and then approved by Chair
Quality Committee Remains but regularity reduced to bi-monthly meetings – May/July/September via Microsoft Teams Exec Director and Chair to meet to discuss issues arising in between formal meetings. Reduced agenda standing items to be proposed by ED of Quality and then approved by Chair	
Clinical Commissioning Committee (CCC) Remains but regularity reduced to bi-monthly meetings – May/July/September via Microsoft Teams Exec Director for Transformation and Chair to meet to discuss issues arising in between formal meetings. Reduced agenda standing items to be proposed by ED of Transformation and then approved by Chair	
Primary Care Commissioning Committee (PCC) To be stood down and convened only as required.	**Primary Care Commissioning Committee (PCC)** To be stood down and convened only as required.

Audit Committee Immediate meetings In April and June required for sign off of accounts and annual report taking into account extension of deadlines recently announced. Remains at Bi monthly meetings therein – July/September via Microsoft teams Reduced standing agenda items to be proposed by CFO for approval by the Chair	**Audit Committee** Immediate meetings in April and June required for sign off of accounts and annual report taking into account extension of deadlines recently announced. Remains at Bi monthly meetings therein – August via Microsoft teams Reduced standing agenda items to be proposed by CFO for approval by the Chair
Remuneration Committee To be convened only as required.	**Remuneration Committee** To be convened only as required.
No equivalent	**Pathways Committee** To be stood down and convened only as required.
No equivalent	**Individual Funding Committee** Currently only convened as required which will continue during Covid 19, although referrals from GPs and Consultants are expected to rapidly decrease due to Covid 19 focus.
Shropshire Patients Group Stood down.	**Assuring Involvement Committee** Stood down.

Decision making

It is not anticipated at this current time that either CCG will need to change the way decisions are taken if we continue to have Board meetings and some committee meetings taking place.

Both CCGs have the ability to make emergency decisions where a meeting will not be quorate or meetings cannot be called in a timely way:

NHS Shropshire CCG:	NHS Telford and Wrekin CCG:
Constitution, Standing Orders Section 3.8 – Emergency Powers and Urgent Decisions: *'Emergency powers and urgent decisions are covered in the scheme of delegation – Approve any urgent decisions taken by the Chairperson of the CCG and Accountable Officer for ratification by the CCG in public session.'*	*Constitution, Standing Orders Section 3.9 – Emergency Powers and Urgent Decisions:* *'The powers which the group have delegated to the CCG Governance Board within these standing orders may in emergency or for an urgent decision be exercised by the Chair of the CCG Governance Board and Accountable Officer, after having consulted at least one other member of the CCG Governance Board where there is not sufficient time to hold a meeting of the CCG Governance Board which will be quorate.* *The exercise of such powers by the Chair and Accountable Officer shall be reported to the next formal meeting of the CCG Governance Board in public session for formal ratification.'*

In order to maintain a level of transparency to decision making, given that meetings of the Board or Primary Care Commissioning Committee cannot be held in public due to social distancing we will:

- Allow members of the public to submit questions on Board or Primary Care Commissioning Committee papers up to the Monday prior to the meeting being held by email or post. Answers to the questions will be released 2 weeks after the meeting on the website and sent to the individuals concerned.
- Release draft minutes of the meetings of Boards and Primary Care Commissioning Committee where these take place, into the public domain two weeks following the meeting by placing on the website.
- Shropshire Healthwatch will continue to be invited to take part in any meetings normally held in public for Shropshire CCG (Governing Body and Primary Care Commissioning Committee). The Chair of the Shropshire Health and Wellbeing Board will continue to be invited to meetings held in public of the Primary Care Commissioning Committee where these are held.
- Telford and Wrekin Healthwatch and Chair of the Telford and Wrekin Health and Wellbeing Board will continue to be invited to meetings held in public of the Primary Care Commissioning Committee where these are held. The Chair of the Telford and Wrekin CCG Assuring Involvement Committee who is an appointed member of

the public, will continue to be invited to the Governance Board meetings held in public.

In order to facilitate rapid decision making, The Local Health Resilience Partnership is managing the Covid 19 response for the health system for Shropshire, Telford and Wrekin by instigating Bronze, Silver and Gold Command, with decisions being made at Gold Command level. A record of these decisions is being routinely kept and will be shared on a regular basis with a virtual joint group of CCG Chairs and Committee Chairs from both CCGs, to provide a level of assurance on what and how these decisions are being made.

Where operational decisions are being made to support Covid 19 response the associated cost is being recorded separately from routine commissioning spend and reported monthly to NHSE/I in order to recoup costs centrally.

Any procurement decisions made that need an urgent response due to Covid 19, but which cannot go through a full procurement/tendering process will be dealt with via waiver and reported into both Audit Committees as necessary, in order to ensure there is transparent reporting.

Risk management

The Board Assurance Framework for both CCGs will continue to be maintained on a proportionate basis given the current capacity of CCG staff during the Covid 19 response period. With the focus maintained on those risks that are linked to, or impacted by Covid 19.

In addition Gold Command will maintain a detailed risk register for the management of the Covid 19 response, which will underpin the high level Covid 19 risk recorded in the current CCG BAFs.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.082
Shropshire CCG Governing Body: 8.07.2020

Title of the report:	Shropshire CCG Strategic Priorities Update
Responsible Director:	David Evans – Accountable Officer
Author of the report:	Sam Tilley – Director of Planning
Presenter:	David Evans – Accountable Officer

Purpose of the report:
To update the Governing Body on progress in relation to the current Strategic priorities for Shropshire CCG.

Key issues or points to note:
In June 2019 Shropshire CCG's Governing Body undertook a development session focused on agreeing a set of strategic priorities for delivery during 2019/20. The priority areas set out below were selected from a longlist of options generated at the development session by Governing Body members and then put to a vote to create a shortlist.

- Development of a single strategic commissioning organisation across Shropshire, Telford & Wrekin
- Urgent & emergency care
- Primary Care
- Mental health & learning disabilities
- Planned Care
- Cancer

The short list was formally adopted by the Governing Body at its confidential meeting in August 2019 and it was agreed that regular updates would be brought back to each Governing body meeting to demonstrate progress in delivery. Further to this a high level Performance Indicator has been added to the update and the creation of more detailed performance indicators will form part of the work to create a single strategic commissioning organisation.

It is suggested that as these have now run a 12 month cycle and as we make preparations for restoration from the height of COVID19 activity and prepare to become a single strategic commissioner that the Strategic Priorities are reviewed with a view to establishing a new set of priorities appropriate for the future landscape.

Actions required by Governing Body Members:
The Governing Body is asked to:

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

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of the effect upon these requirements*	No
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the effect upon these requirements*	No
5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	No
6	Risk to financial and clinical sustainability *If yes how will this be mitigated*	No

Shropshire CCG Strategic Priorities Update Tracker – July 2020 (updates shown in red)

Priority	Action	Update (as at 1 July 2020)
Development of a single strategic commissioning organisation across Shropshire, Telford & Wrekin We have recognised the importance of moving to a single strategic commissioning organisation across the STP area as a key means of delivering our overall ambitions, with an aim of achieving that by April 2020.	Develop a transformation plan to deliver a new CCG and ensure that we support staff through the change	Lead: David Evans Update provided as a separate item on the Governing Body Agenda
Urgent & emergency care We continue to face increasing pressures on the urgent & emergency care system. It is essential that we address these pressures through our care closer to home programme to improve the quality of care and to deliver commitments we have made as part of the Future Fit programme.	Support the system wide development of the co-ordination of a comprehensive community offer with an innovative integrated front door	Lead: Steve Trenchard With regard to the comprehensive community offer, work on the Care Closer to Home programme had to be paused as part of the Covid emergency response as staff were redeployed to other essential roles. We are now starting to look at how we can restore and recover the community care programme, incorporating learning and development from the Covid response, as this will be an essential part of our winter pressures planning, as well as supporting the Hospital Transformation Plan. An Out of Hospital Programme Board to be established (replacing CCtH Board) to continue to drive forward the community model taking into account learning from Covid-19. With regard to the integrated front door, Urgent Treatment Centres procurement has now moved to mobilisation. Urgent care "flow" ,including SDEC, has been identified as one of the system priorities for 20/21 and work is therefore underway to develop the specific implementation plans that support this. The UEC Board has been re-established chaired by Dave Evans (AO) and the UEC Delivery Board continues with focus on flow and D2A processes in addition to supporting quality improvements identified by CQC.

Primary Care GPs and practice teams provide vital services for patients. They are at the heart of our communities and we recognise the importance of having good access to the full range of primary care services, not only to a GP practice but to the full range of Primary Care Providers.	Use innovation and work in collaboration with NHS England as the commissioner of community pharmacy, dentistry and optometry to ensure improved patient access to all areas of primary care, which in turn will reduce the pressure on the wider health	Lead: Claire Parker commissioners for community pharmacy, dentistry and optometry discussing potential collaboration in delivery of wider Primary Care Services A meeting with the Local Pharmaceutical Committee Chair has taken place specifically around the new Pharmacy contract to commence April 2020 and the links to the wider delivery of the Long Term Plan. Primary Care Commissioning Committee received a paper at the October 2019 meeting outlining the Governing Body priority to work closer with community Pharmacy, Optometry and Dentistry and similarities between the four contracts. A meeting has now been held with NHSE and representatives of all 4 Primary Care Contractors where 3 potential priority areas have been highlighted for further consideration. The areas are **diabetes**, **frailty** and **ophthalmology**. Post meeting, Shropshire CCG highlighted **minor ailments** as also being a priority and a request will be made at the next meeting to add this as the 4th priority. The group is also looking at how the digital agenda could be progressed, specifically around enabling optometry and dentistry to have access to the Summary Care Record. A recent development with respect to SCR is the roll-out of the SCRai (additional information) which has been implemented across all practices in response to the pandemic. The next stage is for a workshop to be held to explore these 4 areas in greater detail, which will include the relevant lead commissioners for the areas highlighted. This workshop has been postponed due to Coronavirus and this piece of work will be picked up again once all of the restore/recovery work is complete.

		Minor ailments and self-care is part of an ongoing comms plan with patients and practices. Covid has seen prescribing in self-care increase, particularly paracetamol and vitamin D both have potential links to Covid due to shortages in shops of paracetamol early on and speculation of protective effects of vitamin D. The comms campaign is being relaunched with a self-care and be prepared with a well-stocked medicines cabinet during Covid focus. Now that new PCNs are agreed, the CCG will be working in partnership with them to develop some of the work across the wider Primary Care providers.
Mental health & learning disabilities In line with delivering the mental health long term plan, we are committed to meeting the mental health investment standard.	Prioritise the management of mental health crisis and improve follow up for those who present in crisis	Lead: Steve Trenchard Planned Transformation work against the four strategic priorities has not progressed due to Covid-19. The STW MH Cluster stood down but has been meeting in different format to respond to system priorities to keep people safe. Further work required to refresh the MH and LD priorities for the next 4 years including crisis for both adults and CYP, developed trauma informed pathways, rehabilitation pathway. New strategies for people with a Learning Disability and for people with Autism are in progress. Papers to confirm financial investment in line with LTP paused which is creating additional pressure in already under-funded system. KPI: To be confirmed following confirmation of allocation
Planned Care We have a wide programme of transformation of planned care services set out in the operating plan. Within that programme, one specific priority given the scale of the opportunity to	Develop a single integrated model of care of MSK services across Shropshire, Telford & Wrekin that requires more integrated provision	Lead: Lead: Steve Trenchard This priority is being taken forward via the MSK Alliance Board which has replaced the MSK Transformation Board. The Alliance agreement is on track for agreement by the end of March. The new single model of care is now planned to be delivered across the county from the 1st September 2020.

deliver significant quality and value for money improvements is the transformation of MSK services (including the existing SOOs/TEMS services, pain management, rheumatology and metabolic bone disease).		KPI: to be agreed by the MSK Alliance Board in March as part of the formal Alliance Agreement. Whilst the MSK Transformation Board has continued the sub-groups responsible for work-streams stopped due to Covid-19 and staff redeployment/reprioritisation etc.
Cancer We recognise that there are particular challenges in delivering some cancer pathways in Shropshire, Telford & Wrekin given workforce issues for our local providers and access issues for our patients.	Work with providers to address access and workforce issues by developing wider alliances with bigger hospitals	Lead: Gail Fortes Mayer A significant amount of work has been ongoing across the STW system, through an integrated approach to delivering cancer services. Led by the commissioning SRO for Cancer, reporting into the Acute cluster of the STP, the work programmes supporting the strategy focus on delivery of the national cancer plan and LTP objectives. Challenged cancer pathways have been identified which are the focus for commissioners and providers, to develop best practice pathways. Significant progress has been made across the 4 challenged cancer sites, most notably Lung, where the system had moved "Straight to test" in Q4. (this has continued, however the pandemic has resulted in significantly less 2ww referrals for suspected lung cancer).. The pathway work entails focusses on reviewing the pathway end to end to identify the key blocks to delivery. As part of a system response commissioners and providers are working to reduce and remove pathway blocks, to ensure delivery of timely cancer management. There are a number of key trends emerging including – volume and detail of 2ww from primary care, where there is potential to re-scope pathways, access to diagnostics (straight to test following

		triage), physical capacity with the current acute estate and sustainability of work force. Digital, workforce and support services are key enablers to delivery of the cancer agenda in STW. The Cancer Commissioning SRO is engaged across these enabling groups and the networking of care pathways at a supra STP (ICS) level with Staffordshire. The Cancer Strategy Board has oversight of the cancer strategy, which is being refreshed to take account of the developing networks and the move to a population health approach to cancer commissioning pooling NHSEI and CCG resource. NHS England & NHSI continues to support the network development of a strategic commissioning intention to develop specialised kidney, bladder and prostate cancer service specification published in 2019.. The specification requires significant reconfiguration of a urology specialist centres, (potentially from seven centres to four) in the West Midlands. An engagement event held in 1st November to review all urology (including cancer) across the West Midlands outlined the potential network providers. STW and Staffordshire has already commenced this work. NHSEI administers a Urology Partnership Board; setting the strategic direction for the planning and delivery of General Urology and Urological Cancer services in the West Midlands is now in place. The first meeting was held on 11th December 2019 and the board has representation from STW. Its purpose is to define a commissioning framework which will set the parameters for local

		systems to implement and will oversee delivery of each network's plans. STW and Staffordshire are trail blazing this network development through the work undertaken to address the urological capacity in Shropshire. The STW STP is working as part of the West Midlands Cancer Alliance to progress work on networked diagnostics, Rapid Diagnostic Centre and technology driven solutions to STW patients have equitable access to all services, if not at SaTH.. **RDC**: Shropshire will receive resource over the forthcoming 4 years to develop its RDC approach. This approach is aligned to the best cancer pathways previously cited. The role of an RDC is t expedite diagnostic pathways, as described in Long-term Plan (LTP). **Digital Pathology:** The West Midlands Cancer Alliance (WMCA) was successful in securing further transformation funding bid for 2019/20. The successful bid included the development of a West Midlands integrated pathology network where four tertiary centres would form a regional networked digitalised diagnostic service. Pathology services at the four tertiary centres will be defined as lead digital laboratories (LDLs). University Hospitals Birmingham Foundation Trust (UHBFT) are leading the procurement process on behalf of WMCA and its constituent members. The procurement process will enable a managed service agreement via a framework agreement (Queen Elizabeth Clinical Information Technology Framework). The invitation to tender was made available on 19 November 2019 and deadline for receipt of tenders is 6 January 2020.

		STW STP will have representation in the procurement evaluation process Evaluation of tender bids took place on 26th February 2020. **KPIs**: The Acute Cluster deliverables for 2021 are – 62 days diagnosis and development of the RDC. STW STP early diagnosis and survival trajectories have been developed. The trajectories provide a basis on which to focus work programmes for cancer services across STW. The trajectories have been formally included in the STW Long Term Plan. As part of the WMCA, STP level early diagnosis and survival trajectories have been developed. These provide a basis on which to focus work programmes for cancer services across STW.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.083
Shropshire CCG Governing Body: 8.07.2020

Title of the report:	Learning Disabilities and Autism Board - Update July 2020
Responsible Director:	Steve Trenchard, Executive Director of Transformation Mrs Zena Young, Executive Director of Quality, NHS Shropshire and NHS Telford and Wrekin CCGs
Author of the report:	Frances Sutherland, Head of Commissioning Mental health and Learning Disabilities Helen Bayley, Associate Director of Quality & Nursing
Presenter:	Frances Sutherland, Head of Commissioning Mental health and Learning Disabilities Helen Bayley, Associate Director of Quality & Nursing

Purpose of the report:
To provide an update of the Learning Disabilities and Autism programme with its aim to reduce health inequalities. The report includes the annual report for LeDeR.

Key issues or points to note:
The LD&A Board is system wide multi agency board which oversees delivery of the services for people with a learning disability and or autism.
Local services are not meeting all the required NHSE/I targets set out in the long term plan and an action plan has been developed to move the issues forward
The LeDer annual report is included in this paper which articulates the performance and learning from the reviews of those with a learning disability who have died in the past year

Actions required by Board and Committee Members:

- Note the update report from the LD&A board
- Approve the LeDer annual report prior to its publication on the CCGs' websites

Learning Disabilities and Autism Board- update July 2020

1. Introduction

This paper provides an update on the Learning Disabilities and Autism (LD&A) programme across the Shropshire, Telford and Wrekin (STW) system. It highlights the key areas of work, performance against targets and describes high level actions where required.

2. Background

The Learning Disabilities and Autism Board is a multi-agency board bought to together to oversee this programme. It originated from the Transforming Care Partnership (TCP) which had a focus on reducing the number of individuals, with learning disabilities and or autism with behaviours that challenge, in long stay hospitals. The programme was developed after the horrific abuse uncovered at Winterbourne view. The programme focused on reducing the numbers of individuals in mental health or learning disabilities beds to 30 per million adult populations and for children to 12-15 beds per million children's population by 2023/24. The two CCGs have worked on this programme together with the two local authorities for the past 5 years. In the last 18 months the focus has changed from this cohort to all individuals with a learning disability and/or autism to include a focus on physical health because of the health inequities that show that this cohort of people have a 15-20 year reduction in life expectancy comparted to the rest of the population.

3 Governance

The LD & A board is a sub group of the Mental Health, Learning Disabilities and Children's STP work stream. There is a tactical group that reports into the board which was set up as part of the covid work which supports the development of action plans. Since the covid pandemic commenced there are also multi-agency operational groups that meet on a regular basis to discuss and share knowledge regarding the support to individuals. A key element of the refreshed system action plan is to review the governance system and the effectiveness of the LD&A board to ensure it is fit for purpose

4 Performance

4.1 Inpatient beds:-

Over the past 2 years the system has failed to meet its agreed trajectories for the number of patients in hospital beds. At present the performance of the system rates 44th out of 48 TCP areas for the number of patients per million in mental health or LD specific beds. NHSE specialist commissioning have worked closely with the system but ensuring safe effective discharges for the most complex of individuals has proved challenging. There have been concerns regarding:-

Issues	Impact	solution
Lack of capacity in commissioned community services, both children and adults services	Inability to work on enough specific cases at one time as well as admission avoidance. Inadequate capacity to support individuals in the community	Investment in the numbers of case managers, case coordinators and community services
Lack of suitable housing in	Once it is agreed what an	The system is working in

the community and the length of time to develop this on a bespoke basis.	individual requires regarding housing it can take 12-18 months to secure and make adaptation's prior to the person moving in	the development of the housing market- this is led by the local authorities
Lack of skills and capacity in the care market	The individuals in this cohort can have very high risks to both themselves and the community and require specialist care providers	The system is working on the development of the care market to develop a dynamic purchasing system- this is led by the local authorities
Lack of consistent senior leadership across the system	Difficulty raising issues at senior level across the system	Review of the LD&A board function including membership

The system is on track to meet the required target of 37 beds per million by Q3 of 2020/21(14 beds). Further work will be undertaken to meet the 2023/24 target of 30 per million (11 beds). It should be noted that this is a small system so numbers are small, with very little room for manoeuvre. In addition performance at national level is described as % from target which again is impacted by the small numbers the system is working with. There are still some individuals with significant length of stay in hospitals and they need to be the focus to ensure they have effective treatments so they can live in a least restrictive environment.

The system has worked well together to ensure there have been no adult community admissions into long stay beds during the past 2years.There have been admissions via the court system and for tier 4 mental health beds for children. The target figures include any person with a learning disability or autism in a mental health or learning disabilities bed and some of these are appropriate but the focus is to ensure they have effective treatment and are discharged as soon as it is safe to do so.

4.2 Annual health checks

There is a requirement for 75% of individuals with a learning disability over the age of 14 who are on a GP practice register to have an annual health check. This is part of the Quality and Outcomes Framework (QOF). The CCGs are measured as separate entities for this target.

	2015/16	2016/17	2017/18	2018/19
TWCCG	18%	28%	37.2%	44.1%
SCCG	46.5%	65%	64%	52.7%

Work has been undertaken with GP practices and MPFT (providers of the community learning disabilities team) and an action plan is in place to ensure the correct individuals are on the registers and we are aiming to undertake 100% of these checks.

4.3 STOMP

This programmes focus is to reduce inappropriate over prescribing of medication to this cohort of patients. Providers are required to have action plans in place as part of the contract and the system wide action plan is due to be reviewed

4.4 LeDer

This programme ensures that all deaths of individuals with a learning disability are reviewed and that any learning is put into place. The system is performing well in undertaking the reviews. The annual report to be published on the CCGs websites is in appendix A for approval

5 Next steps

There is significant work to be undertaken across the health and social care system to improve the lives and health inequalities of this group of patients. A system wide action plan is in place which will be overseen by the LD&A Board

6 Recommendations

The board is asked to:

- Note the update report from the LD&A board
- Approve the LeDer annual report prior to its publication on the CCGs' websites

Appendix A

NHS
Shropshire
Clinical Commissioning Group

Title of the report:	LeDeR annual update report (2019/20)
Responsible Director:	Mrs Zena Young, Executive Director of Quality, NHS Shropshire and NHS Telford and Wrekin CCGs
Author of the report:	Helen Bayley, Associate Director of Quality & Nursing
Presenter:	Helen Bayley, Associate Director of Quality & Nursing

Purpose of the report:
To provide an update of the LeDeR programme and its aim to reduce health inequalities and support services by embedding the learning from the LeDeR reviews across Telford & Wrekin and Shropshire. The report includes activity from April 2019 – End of March 2020.

Key issues or points to note:
The reduction of the premature mortality of people with a learning disability (PWLD) has been identified as one of the four main priorities for the NHS for the next 10 years. The Learning Disabilities Mortality Review (LeDeR) programme is a national project to review the deaths of all patients with Learning Disabilities. 58 deaths have been notified across Shropshire, T&W since the programme started in June 2017.

Between April 2019 and March 2020, 20 deaths were notified locally, this is a reduction from the 29 deaths reported across Shropshire, Telford & Wrekin in 2018-2019. 17 of the deaths were Shropshire patients and 3 Telford & Wrekin. The mean age of death in 2019/20 was 50 years compared to 58 years in 2018/19.

16 reviews were completed and submitted to the Bristol team in 2019-20.

The causes of death were varied during this reporting period. Pneumonia accounted for the highest cause of death with 4 people having this documented as the primary cause.

Much learning has been identified during 2019/20, with the key points listed within the report.

Shropshire/ Telford and Wrekin remain one of the best performing CCG's nationally, having a low number of unallocated cases, and a high number of completed cases. 39/58 reviews have been completed since commencement of the programme. There are currently 15 reviews allocated to reviewers which are in progress of being reviewed, 7 of these have taken over 6 months to complete.

Actions required by Board and Committee Members:
To receive and note the content of the provider quality exception report.

1.0 Executive Summary

The Learning Disabilities Mortality Review (LeDeR) programme is a national project to review the deaths of all patients with Learning Disabilities. The programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. The programme is led by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. This is a joint health and social care project, involving healthcare providers across the health economy, Local Authority and CCG's.

The NHS long-term plan, published on January 7, confirmed that the NHS will continue to fund the Learning Disability Mortality Review Programme (LeDeR). It stated: "Across the NHS, we will do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives." The plan went further in saying: "Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people" and "the whole NHS will improve its understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing".

Locally Quality and Outcomes Framework (QoF) data for 2015-16 states that the prevalence of learning disability on GP practice registers is 0.53% which accounts for 1,610 of the population in Shropshire. Nationally the QoF data prevalence of learning disability is lower at 0.46% of the population (263,588 people). However, QoF data only includes people registered as having learning disabilities and is most likely to include people with moderate to profound learning disabilities.

There is predicted to be a 4.9% reduction in the number of people aged 18-64 for Shropshire in the next 18 years, compared to a 5% increase in the national figure. In the over 65s Shropshire is predicted to see an increase to 37.6% during this time period, which is lower than the national predicted increase of 38.1%. The number of people in this age group is far smaller compared to the under 65 year age group, but is predicted to increase which reflects the general increase in the ageing population experienced both locally and nationally.

The LeDeR programme is led locally by the quality team, with two Local Area Contact's (LAC's) working across both CCG's. Shropshire, Telford and Wrekin have consistently been one of the best performing CCGs nationally, having in the top 5% of the lowest number of unallocated cases and the one of the highest number of completed cases.

Since the LeDeR programme started in Shropshire, Telford and Wrekin (STW) in June 2017, there have been 58 deaths notified and 39 deaths reviewed. Between April 2019 and March 2020, 20 deaths were notified locally, this is a reduction from the 29 deaths reported across Shropshire, Telford & Wrekin in 2018-2019.

17 of the deaths were Shropshire patients and 3 Telford & Wrekin. The average age of death in 2019-20 has been 49 years. This is lower than the national average which is 60 years.

The causes of death were varied during this reporting period. Pneumonia accounted for the highest cause of death with 4 people having this documented as the primary cause.

The CCG continue to support and train reviewers to ensure reviews are completed within timeframe and fully capture the learning. The quality team and reviewers from providers, aim to maintain the high quality of reviews completed and ensure the learning from these reviews are embedded into practice to transform services for people with learning disabilities with the aim of reducing health inequalities.

2.0 Review process

LeDeR reviews are not investigations of care but aim to develop learning and improve care. The focus of the reviews is to:

- Identify potentially avoidable factors that may have contributed to a person's death.
- Identify differences in health and social care delivery across England and ways of improving services to prevent early deaths of people with learning disabilities.
- Develop plans of action that will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities

For each death, there is an initial review. Someone who knew the person well, such as a family member, is invited to contribute their views. This is a fundamental part of the review. The reviewer will also look at relevant case notes relating to the person who has died, and will make contact with relevant organisations/ agencies to discuss cases and access notes if required. This involves the range of agencies that have been supporting the person who has died, (e.g. health and social care staff).

The review looks at three levels of care:

a) Initial diagnosis and management of the condition
b) Ongoing management of the condition from initial diagnosis to critical illness
c) Management and care received during final illness

There 21 reviewers trained locally. All LeDeR reviewers training is now being delivered through eLearning. Every organisation across the health and social care system has trained reviewers.

A local steering group has been in place since the onset of the programme in 2017. The aim of the LeDeR Steering Group is to monitor the actions, learning and recommendations that arose from completed reviews from providers to ensure service improvement for people with learning disabilities.

3.0 National Progress

In the 2018/19 national report, which was published in May 2019, the leading causes of death were: 19% due to respiratory related issues; 14% attributable to cancer and 7% deaths from sepsis.

A Learning into Action collaborative was set up by the NHSEI to better co-ordinate national responses to premature mortality review learning. The collaborative brings together experts by qualification, professional experience and lived experience. The Learning into Action group have provided information slide decks in relation to cancer, constipation, respiratory disease, sepsis, pharmacy, annual health checks, improvement standards and do not attempt cardiopulmonary resuscitation orders (DNACPRs). These have all been shared with the steering group for wider distribution onto partners.

An additional £5 million was invested by NHS England and NHS Improvement in 2019/2020 to address the backlog of un-reviewed cases and increase the pace with which reviews are allocated and completed. The money was invested in developing a dedicated workforce through CSU to undertake reviews and develop systems and processes to embed mortality reviews and quality improvement activity across the health and social care system. At the time of allocation STW did not have a back log of reviews to be completed and were therefore not eligible to join the scheme.

However a small amount of funding was provided directly to the CCG, some of this has been used in 2019/20 to develop a small pool of reviewers, and in order to prevent any potential back log of reviews as has happened in many areas nationally. The steering group agreed that the local process of reviewers based in provider organisations provided a greater opportunity of sharing learning into practice.

LeDeR has Section 251 approval in place to provide a legal framework for sharing of information.
The Confidentiality Advisory Group has now conditionally approved moving ownership of S251 approval from the University of Bristol to NHS England this provides the statutory power to ensure that NHS patient identifiable information needed to support essential NHS activity can be used without the consent of patients.

4.0 Local Progress

Between April 2019 and March 2020, 20 deaths were notified locally, this is a reduction from the 29 deaths reported across Shropshire, Telford & Wrekin in 2018-2019. 17 of the deaths were Shropshire patients and 3 Telford & Wrekin.

16 reviews were completed and submitted to the Bristol team in the 2019-20.
One of the reviews were graded as *excellent care*; twelve reviews have been graded as *good care*; two graded as *satisfactory care* and one as 'care fell short of best practice'. The one identified as having some gaps in care, was considered that lapses did not contribute to the death.
15 reviews are still in progress of being reviewed.

The causes of death were varied during this reporting period. Pneumonia accounted for the highest cause of death with 4 people having this documented as the primary cause. Other causes of death included: cardiac related issues (MI, AF, mitral value disease); Cancer and Sepsis

Of these, 13 patients died in Hospital, 5 died in their usual place of residence i.e. either a care home or their own private home; one in the hospice and one in a new care home.

Of the 20 deaths, 11 of the deaths were males and 9 females. The mean age of death in 2019/20 was 50 years compared to 58 years in 2018/19.

Age range	Number of deaths
5 -19	0
20 - 29	2
30 - 39	3
40 - 49	6
50 - 59	2
60 - 69	6
70 - 79	0
80 +	1

In 2019/20 three key areas for development were:

- Completion of Annual Health Checks
- Improved medication reviews including STOMP/ STAMP
- Improved Advance Care planning.

Of the reviews completed in 2019/20: 75% had received an annual health check (↑ from 47% 2018/19); 75% had a medication review with the last 12 months (↑ from 68% 2018/19); and 58% had an advanced care plan (↑ - 48% 2018/19). Work continues with the community learning disability team (CLDT) who are working closely with GP's to cleanse registers and support the completion of Annual Health Checks using the Shropshire AHC tool which is combined with the HEF (Health Equalities Framework).

Shropshire/ Telford and Wrekin remain one of the best performing CCG's nationally, having a low number of unallocated cases, and a high number of completed cases. 39/58 reviews have been completed since commencement of the programme. There are currently 15 allocated cases in progress of being reviewed, 7 of these have taken over 6 months to complete. There are a number of reasons contributing to the delays in completion of reviews, including; police investigation; request of timing of family involvement; capacity of reviewers to complete; access to notes.

4.1 **What we have learnt in 2019/20**.

Much learning was gained from the 16 reviews completed in 2019/20. The recommendations made by reviewers, as identified below, will continue to be followed up in 2020/21.

Increase knowledge and awareness of caring for people with Learning Disabilities within the Acute Trust:

- Promotion of the hospital carer's policy. Review content and include detail around the importance of patient advocates. Review accessibility of services when carers stay with their relative in hospital.
- When carers are unable to continue to support an individual when they are admitted to hospital, hospital staff to recognise that the people who know the person best may not be there when the individual needs them most.
- Review the use of the health passport to ensure consistency of use; areas noted to be poorly completed include medical history and holistic assessment of patient baseline abilities.
- Consideration of how assessment tools can be modified for use in patients with learning disabilities.
- Hospital staff to increase knowledge of MCA process for people with LD.
- To utilise NHS England's Learning into Action Group resources developed to support quality improvement and enhance compliance with MCA within secondary care - It has a specific focus on the issues around assessing capacity and best-interest decisions for deteriorating patients who have learning disabilities.

Primary Care:

- Continue to promote the importance of the annual health check, with the aim to get 100% of patients offered a check and to meet the national target of 75% of people with LD receiving a health check.
- Increase the uptake of AHC's for 14-19 age group.
- GP's to support transition into Adult services, identify gaps and ensure good relationships with both patient and family
- GP's to ensure appropriate screening at all age levels.

Learning Disability Services:

- Community team to raise awareness of services provided with partner organisations.
- Newly established Intensive Health Outreach Team (IHOT) to continue to establish links with local GP Practices. Acute trust LD liaison team to make clear recommendations needed on discharge to the community team, family and carers.

Local Authority and Care Homes:

- Ensure resources are in place to support vulnerable adults across the county.
- Increase knowledge and understanding of ensuring timely communication about changes in a client's condition. Acknowledgment of 'soft signs' and the need to raise concerns about subtle changes in a person's condition early. Individuals with LD can often deteriorate slowly. But, if care staff/ carers can flag simple changes sooner, appropriate action can be taken and avoid unnecessary, and often distressing, transfers to hospital. This is particularly important for people with learning disabilities. Early changes were noted in sleeping patterns; feeding; toilet habits; an increased lack of interest, or more fatigue than usual or increase in behaviours issues. People with learning disabilities can struggle with having their blood pressure, or temperature, taken using medical equipment. Therefore increased use of a 'soft-signs' system could lead to fewer hospital stays.

Healthcare and social care appointments across the system:

- Consistent flagging systems to ensure staff are aware when appointments are being made that the person has a learning disability.
- Timing of appointments to be made at a time of day to meet the needs of the individual.
- Referral letters into specialist services to advise of the reasonable adjustments that would be helpful for the individual, not just state the patient has a learning disability. This will enable providers to make reasonable adjustments in advance of the appointment.
- Improved follow up processes, for DNA's to understand why an individual did not attend.
- RESPECT forms need to be written so they can be shared or reviewed when a person moves between hospital and community. This can avoid inconsistency and repeat conversations.

4.2 What we did well

Many areas of good practice were identified in the 16 reviews completed in 2019/20. These will be shared in order to maintain these areas of good practice and promote consistency across the system for all people with a learning disability.

- Reasonable adjustments made for family to attend appointments
- Completion of MCA and best interest decision assessments, with good documentation of conversations with parents.
- Consistent contact, ensuring the same clinician saw the individual at all their hospital appointments.
- Pro-active Intensive Health Outreach team (IHOT) - providing good support for care home's over a long period.
- A number of care homes were noted as 'exceptional' by family members for the care shown to individuals.
- Very good care from Hospice, GP and District Nurses was sited in a number of reviews.

Good quality reviews have been continuously submitted with only a very few needing returning for additional information.

LeDeR reviewers continue to be committed to completing the reviews, and sharing the learning within their own practice areas

STW have managed to avoid a backlog of reviews with timely allocation, in the main within a week of notification (the national target is allocation within 3 months)

The steering group met quarterly in 2019/20, and continues to include members from across the health and social care system. The group review completed cases to gain a wider discussion on learning into action.

Regular newsletters on LeDeR learnings from reviews are sent to the CCG which are forwarded to all steering group members for wider distribution. Leaflets from the National Team in Bristol for e.g. the management of constipation, dysphasia and aspiration pneumonia are shared with our main providers, General Practices and care homes.

Between March – May 2019, the local Healthwatch carried out an engagement plan based on the NHS Long Term Plan. A series of focus groups took place from across the county with people with dementia and their carers, and adults with learning disability (& autism) and their carers. The focus groups were delivered in partnership with Taking Part, an Independent Service for people with learning disabilities with Health and Social Care needs. The findings showed that what matters most to people in Shropshire, Telford & Wrekin who have learning disabilities and autism. The report was shared with the steering group and will also continue to be used to inform the action plan and learning from LeDeR reviews during 2020/21.


healthwatch
20190716 Shropshire

[Appendix A]

NHS England has produced a guidance document explaining how best to make information accessible for people with a learning disability. It sets out guidance on what needs to be considered so that information is easy to understand. This guidance has been shared with all providers to include as part of the organisations Accessible Information Standard.

5.0 Next Steps in 2020-2021

This report once signed off by the LD & A Board will be presented at both CCG Boards and will be published on the CCG websites. It will also be shared with the CCGs Quality Committee; PPQ and the four main providers at CQRM.

The steering group has not yet met in 2020/21 due to changes as a result of the Covid pandemic, but it is due to meet in July.
The steering group will:

- agree a set of key local priorities for 2020/21 based on the findings above;
- continue to compare the local findings to national findings and share learning from other areas;
- use the information collected and talk to key partners;
- will include people with learning disabilities and their carers to inform decision making and co-produce any new developments;
- review the deaths of those during the Covid period to capture any learning related to service changes.
- ensure the actions required are implemented;
- closely monitor the impact of reviewers being redeployed to frontline services, to prevent a back log of reviews.

6.0 NHSEI Assurances

There are 3 key priorities for LeDeR as a programme across the Midland and East

1. Improving the rate at which reviews are assigned. NHSEI have now specified that reviews should be allocated within 3 months and CCGs have to report on this monthly. 90% of local reviews have been allocated within 3 months.
2. Improving the length of time which it takes for the reviews to be completed. NHSE have now specified that reviews should be completed within 6 months and CCGs have to report on this monthly.
3. Ensuring action is taken to address the recommendations emerging from completed reviews.

There are also four key statements NHSE requires each CCG to report against when assessing how well we are doing with local delivery of the LeDeR programme.
These statements are:

- CCG's are a member of Learning from Deaths Report (LeDeR) Steering Group and have a named person with lead responsibility.
    - ✓ STW Rating is Green
- There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.
    - ✓ STW Rating is Green
- Each CCG has systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.
    - ✓ STW Rating is Green
- An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.
    - ✓ STW Rating is Green

Anyone can notify LeDeR of a death, including people with learning disabilities themselves, family members, friends and paid staff. Notifications can be made online via this link https://www.bris.ac.uk/sps/leder/notification-system/ or by calling 0300 777 4774.

7.0 Recommendations to committees

CCG Boards/ LD & A Board/ Safeguarding Board/ QC and PPQ are asked to:

1. Receive and acknowledge the key points identified in this report.

2. To note that the capacity of reviewers may become a concern in 2020/21 due to redeployment of reviewers to frontline services.

3. To note that further assurances are requested from providers regarding the implementation of learning and improvement to ensure robust processes are in place to address the gaps identified and improve care for people with learning difficulties.

healthwatch Shropshire

healthwatch Telford and Wrekin

NHS Long Term Plan

Shropshire, Telford & Wrekin

Engagement report

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what would you do?

It's your NHS. Have your say.

March – May 2019

Contents

Sir Neil McKay

Independent Chair

Shropshire, Telford & Wrekin Sustainability and Transformation Partnership (STP).

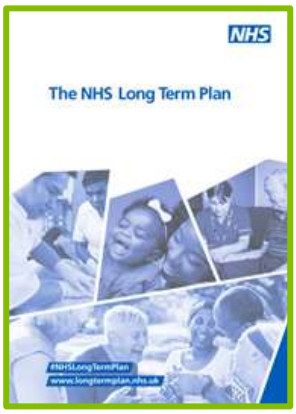
"I would like to thank Healthwatch Shropshire and Healthwatch Telford & Wrekin colleagues on producing this important report, which has reached many different people across Shropshire, Telford & Wrekin.

As an STP we understand the importance of developing our health and care services based on the views of our local population, alongside the evidence on population health. It is interesting to note that people said they wanted: 'A person-centred approach to our care,' and this is central to all the work we are doing. People are at the heart of everything we do and by delivering joined up services in both the acute and community settings we can give everyone the best start in life, creating healthier communities and helping people to age well.

Together with the views of our partners, clinicians, staff and service users we can identify what is working well, what can be improved and what is important to them. This will enable us to plan, design and deliver health and social care services that are right for our local population of Shropshire, Telford & Wrekin."

Sir Neil McKay

Executive summary



NHS England published 'The NHS Long Term Plan' in January 2019. The aim of the plan is to take 'three big truths' as its starting point:

- 'There's been pride in our Health Service's enduring success, and in the shared social commitment it represents.
- There's been concern – about funding, staffing, increasing inequalities and pressures from a growing and ageing population.
- But there's also been optimism – about the possibilities for continuing medical advance and better outcomes of care.'[1]

It sets out some priorities for the future, including:

- Improving how the NHS works so that people can get help more easily and closer to home
- Helping more people to stay well
- Making care better (e.g. for people with cancer, mental health, dementia, lung and heart diseases and learning disabilities such as autism)
- Investing more money in technology

Early 2019, NHS England asked all local Healthwatch to give people in their community the opportunity to have their say on how the national plan is delivered locally, so that their views can feed into the development of local NHS plans.

Local Healthwatch were asked to work within their Sustainability & Transformation Partnership (STP) area. In Shropshire the STP is made up of health and care commissioners and providers from across the Shropshire and Telford & Wrekin local authority areas, so it includes both Councils, both Clinical Commissioning Groups, all the hospital Trusts and West Midlands Ambulance Service.

In the Shropshire, Telford & Wrekin STP area, Healthwatch Shropshire and Healthwatch Telford & Wrekin have worked together to complete this work. Healthwatch Shropshire has acted as co-ordinating Healthwatch and led on this report. Both Healthwatch have worked with the STP to agree our local priorities and approach to gathering people's views. The STP have told us that what people have told us will 'inform the development of the NHS local long term plan for Shropshire, Telford & Wrekin' and help them to make 'real improvements to services and outcomes for patients across Shropshire'.

Our approach to public engagement in Shropshire, Telford & Wrekin

Healthwatch Shropshire, Healthwatch Telford & Wrekin and the Shropshire, Telford & Wrekin STP agreed that we would use a variety of methods to gather people's views. We wanted to give people as many ways as possible to answer the question - 'What would you do?', while also giving them the chance to share their current experiences of health and care services and voice their thoughts on how these services could be improved. We had to consider the fact that we

[1] www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

had a short period of time to complete this public engagement (March to May 2019) because the STP has to produce the local plan by the Autumn.

We chose to:

- Use two questionnaire's designed by Healthwatch England; one focusing on the main priorities of the NHS Long Term Plan and the other focusing on specific health conditions
- Hold two public events; one is Shropshire and one in Telford & Wrekin, asking the broader question 'What would you do?'
- Run focus groups across the county with people with dementia and their carers and adults with learning disability (and autism) and their carers

Summary of findings

1. Questionnaires

Questionnaire 1 - General experiences of health and social care

167 people in Shropshire and 116 people in Telford & Wrekin completed this questionnaire (Total 283)

People were given groups of statements that described the measures that would support four areas of their lives and they were asked to choose the most important.

The results were:

1. Living a healthy life - "Access to the help and treatment I need when I want it"

   The detailed responses highlighted what people felt could help them to live a healthy life, including:
   - Quicker / more timely access to treatment and services
   - Help to make the right lifestyle choices, including access to physical activity
   - Appropriate advice and support
   - Improved communication, including trustworthy and reliable information
   - Access to resources, training and research for staff

2. Being able to manage and choose the support I need - "Choosing the right treatment is a joint decision between me and the relevant health and care professional"

   In the detailed responses people called for:
   - Professionals to take a person-centred approach that involved them in decision making
   - Better communication and standards of information that is reliable and timely
   - Local services that meet local needs
   - Increased resources, including more staff and specialist staff
   - Easier access, e.g. to GPs, other health professionals and services (appointments)

3. The help I need to keep my independence and stay healthy as I get older – "I want to be able to stay in my own home for as long as it is safe to do so"
   Detailed responses highlighted the need for:
   - More financial support and practical aids, such as independent living aids
   - More support including support for family members
   - Support to stay at home and being helped to make real choices
   - Support to choose what happens at end of life
   - Better transport, including public transport

4. How you interact with your local NHS – "I can talk to my doctor or other health care professional wherever I am"

   In particular people identified:
   - The need for better access to GPs including more time to speak to GPs and seeing the same GP
   - The role of technology while also recognising that not everyone has access to a computer/mobile phone or can/wants to use it in this way
   - The need for staff and people using services to have access to relevant and reliable information, education and research
   - The need for more staff and specialist services
   - The need for improved communication between services, including access to shared records

When the importance given to all 25 statements were considered, it was possible to rank them in order of importance.

The **top 10 statements** from all respondents for the Shropshire, Telford & Wrekin STP were:

1. "Professionals that listen to me when I speak to them about my concerns"
2. "Access to the help and treatment I need when I want it"
3. "I want to be able to stay in my own home for as long as is it is safe to do so"
4. "I want my family and me to feel supported at the end of life"
5. "Choosing the right treatment is a joint decision between me and the relevant health and care professional"
6. "I want there to be convenient ways for me to travel to health and care services when I need to"
7. "Easy access to the information I need to help me make decisions about my health and care"
8. "Having the knowledge to help me to do what I can to prevent ill health"
9. "Communications are timely"
10. "I have to consider my options and make choices that are right for me"

The top four statements were the same for people who reported having a long-term condition. The others appeared in a different order, apart from the final statement (statement 10). In the ranking for people with a long-term condition, the final statement was not in the top 10 and was replaced with "For every interaction with health and care services to count; my time is valued".

Questionnaire 2 – Long term conditions

77 people from Shropshire and 88 people from Telford & Wrekin completed this questionnaire (Total 165)

In this questionnaire people were asked about:

- Their **overall experience of getting help**
- The impact of having **more than one condition at a time** on seeking support
- **Waiting times**, including how long people had to wait to get a diagnosis, between assessment/diagnosis and treatment and between initial assessment and seeing a specialist
- **Access to ongoing care and support**
- **Communication** and whether it was timely and consistent from all services they had come into contact with
- **Transport and travel**, including methods of transport and how long people are prepared to travel for to receive quick and accurate diagnosis and specialist treatment or support

As expected, we heard from people who had a range of experiences of getting help across the STP.

Main findings:

Getting help and communication

- The groups that reported the poorest experiences of getting help were those people who had long-term conditions such as arthritis and diabetes, people with mental health difficulties and people with heart and lung disease.
- The majority of respondents from these three groups also reported feeling that they had not received timely and consistent information about their condition from all services.
- People with cancer seemed to be the happiest with the communication that they had received.

Impact of having more than one condition

- 82 people across these groups had more than one condition and 51 (62%) said they thought that it made seeking support 'harder'.
- The groups that felt it made it hardest were adults with learning disabilities (86%), people with mental health difficulties (71%) and people with autism (67%).
- Only six people (7%) thought it made it 'easier'. Three had a long-term condition, two had mental health difficulties and one had cancer.

Waiting times

- None of the nine respondent with dementia described the amount of time they had to wait to receive their initial diagnosis/assessment, then receive treatment and then see the specialist as 'fast' or 'very fast'. Five did not answer the question about how long it had taken between receiving a diagnosis and seeing a specialist.
- None of the respondents with a learning disability or autism described the amount of time they had had to wait to see a specialist as 'fast' or 'very fast'. However depending on their diagnosis and when this had happened they might not have remembered seeing a specialist (e.g. if they were diagnosed as a child).

- The majority of people with a mental health difficulty described the waiting times as 'very slow' or 'slow' at each of the three stages. For example, 22 people (65%) said that the time they had to wait to receive an initial assessment or diagnosis was 'very slow' (10) or 'slow' (12).
- The only condition where the majority of people described these waiting times as 'fast' or 'very fast' was cancer.

Access to ongoing care and support

- A recurring theme from people with a variety of long-term conditions including Autism, Mental Health challenges and cancer was improved access to the most appropriate specialist service at each stage of diagnosis and treatment.
- Direct access to specialist staff includes telephone access for those on mental health waiting lists, specialist nurse support for neurological conditions and follow up from clinical cancer nurses.

Transport and travel

- The majority of respondents from all groups told us they would be prepared to travel up to an hour to receive a quick and accurate diagnosis or to receive specialist treatment and support. This is likely to have been linked to access to transport, for example, the majority of respondents reported having their own car or access to somebody else's.
- The groups where a significant number of respondents said they would be prepared to travel for between 1 – 2 hours or over 2 hours to get a quick diagnosis and receive specialist treatment and support were those people who had a long-term condition such as arthritis and people with a mental health problem. Both of these groups also reported slow waiting times for diagnosis and treatment.

2. Public events – 'What would you do?'

A total of 38 people attended the two public events, 19 joined us at Meeting Point House in Telford and 19 came to The Trinity Centre in Shrewsbury.

The three questions we asked were:

- How can you be supported to live a healthier life?
- What can services do to provide you with better care and support?
- What would make it easier for you to take control of your health and wellbeing?

People told us that a number of things are important and should be priorities:

1. **Access and timely intervention** e.g.
   - local services that people know about, that are available when people need them (including 24 hour) and that they can get to easily, including services that can help people to live healthy lives such as affordable gyms and social groups
   - services that have time to spend with people, where people can see the same professional/s
   - Consideration for the challenges people face regarding travel to services, including anxiety, timing of appointments, etc.

2. **Tackling isolation and loneliness** e.g.
    - Making sure socially isolated people know what support is available to them and how to access it, including homeless people and people who do not have a named GP or relationship with services
3. **Consistent and reliable information and education for all ages**[2] e.g.
    - Reducing confusion by giving clear and consistent information that can be trusted, including information about services such as available appointments
    - Giving people a single point of contact to improve consistency, including appropriate signposting and offering information and advice (e.g. advice about medication)
    - Working with education to ensure the right messages are given from an early age about healthy lifestyles, care and compassion, emotional intelligence, resilience and how to use services
4. **Services working together, including information sharing and a flexible approach to working** e.g.
    - Ensuring staff know what other services are out there and talking to each other, improved referral processes, social services and the NHS working together
    - Building trusted networks to help organisation work together and share knowledge and experience (including with organisations like Parish Councils)
    - Having shared digital records, including care plans
5. **Building strong communities and investment in local people**
    - Supporting and promoting local groups to enable and encourage people to get together, e.g. walking groups, dementia groups
    - Raising awareness (conditions and services available) across all ages, e.g. awareness of mental health to reduce stigma and enable people to ask for help sooner
    - Addressing needs, including housing, food banks and public transport, e.g. housing that works for people as they age or their needs change, easy access to living aids to help people stay at home for as long as possible
    - Recognising the role of needs of carers
6. **Individualised care, including using a range of communication methods**, e.g.
    - Using the most appropriate form of communication for each individual in order to share information quickly, e.g. text or email instead of letters
    - Making sure people understand the information they are given
    - Involving people and helping them to make informed decisions

3. Focus groups

People with dementia and their carers

Across Shropshire, Telford & Wrekin we ran a total of 16 focus groups and spoke to 48 people with dementia and 49 carers.

People told us about:

- Their experiences around getting a diagnosis, including the information they were given

[2] The issues around Accessible Information were explored in the HWS 'NHS Accessible Information Standard in GP Practices' report

- The support they have received post-diagnosis, including from GPs and the Memory Service
- Their experiences of being in hospital
- The role of carers and the importance of support groups and social connections

Our findings show that what matters most to people in Shropshire, Telford & Wrekin who are living with Dementia and their carers is:

1. **Receiving timely, on-going, reliable information**, including:
    - Information about the diagnosis and on-going support available, e.g. for incontinence
    - Information about local support / social groups (either Dementia friendly or specifically for those with dementia and their carers), help and advice about using public transport
    - Practical information, e.g. wills and probate, mental capacity and Power of Attorney, driving and the DVLA
2. **Support for carers**, including:
    - Weekly, planned breaks from caring responsibilities while their loved one is cared for in a safe environment, e.g. Day centre, 1:1 care at home
    - Having their concerns heard and responded to, e.g. around diagnosis, the need for help
    - Support for their own emotional health and wellbeing, e.g. emotional support and reassurance that what they are doing is the best for their loved one
3. **Access to and on-going support for the person with Dementia and their carer**, including:
    - Seeing the same GP
    - Priority GP appointments, longer appointments, in particular for emergencies
    - Crisis support out of hours and at weekends
    - Help to link in with other services and information about the support available, possibly from a named link worker
    - A consistent approach to identifying, recording, flagging and sharing the needs of people with dementia and their carers to prevent repetition, in line with the NHS Accessible Information Standard
    - Consistent Memory Service provision across the County
    - Effective and consistent use of Care Plans, 'This is me' and the Butterfly symbol

These findings supported many of the issues highlighted in a survey completed by Dementia Action Alliance (DAA) Autumn 2018.[3]

People with a learning disability (including autism) and their carers

Taking Part helped us to engage with 58 people, 48 in focus groups and ten in one to one sessions. Of the 48 people in the groups, 42 had a learning disability, four had autism and two had both a learning disability and autism. Eighteen people also had other long-term conditions.

[3] Dementia in Shropshire and Telford and Wrekin https://drive.google.com/file/d/1FZrzKCmWYD-92JLMY1ZFxveI-I2wVDea/view

Our findings show that what matters most to people in Shropshire, Telford & Wrekin who have learning disabilities and autism is:

1. **Clear communication with health workers**, including easy read information
2. **Consistency of health care professional** e.g. the same doctor
   - This was highlighted by all members of the focus groups (those with learning disabilities and those with autism). However, those with autism who filled out the second questionnaire indicated that it was less of an important factor in the various stages of their support
3. **Compassion**, understand that I am a person not a 'condition' and do not let my disability overshadow other potential conditions.
4. **Easy access to appointments**
   - A theme raised by respondents with autism indicated the importance of seeing a specialist at the initial stages of assessment.
5. **Carers who I know and I can trust**
6. **Timely, on-going, reliable information and advice for carers**
7. **The importance of the Annual Health Check**

Key messages for the Shropshire, Telford & Wrekin Sustainability and Transformation Partnership

To achieve the following priorities people told us they want the NHS to:

1. **Improving how the NHS works so that people can get help more easily and closer to home**
   - Give us access to help and treatment when and where we want it
   - Give us easier and quicker access to GPs
   - Have enough staff, including specialist staff, to help us get a diagnosis and receive treatment more quickly
   - Provide us with appropriate, clear and timely information and advice, e.g. from a single point of contact
   - Let us know what support is available so we understand our options, including support from the community (e.g. advocacy support and support/social groups)
   - Help us to stay in our own home for as long as it is safe to do so, including access to financial support, practical support and independent living aids
   - Help us when we have to travel, including giving us information about transport and convenient ways to travel. (Remember some of us might be willing and able to travel further if it means getting a quicker appointment, diagnosis and treatment)
   - Consider the timing of appointments so you take into account how we are going to get there and remember that some of us need to be supported to attend appointments, e.g. due to a health condition, including anxiety. Remember some of us might be willing and able to travel further/longer if it means getting a quicker appointment
   - Give staff access to resources, training and research so they understand our needs, the full range of services and support available to us and can make appropriate referrals (e.g. to other parts of the NHS, social care, community support)
   - Make sure services work more closely together, including sharing information and communicating better to avoid confusion and misunderstanding

2. Helping more people to stay well

- Make sure the information you give us is reliable and consistent and we can easily understand it (including following the NHS Accessible Information Standard), e.g. about how we can stay well and what to do when we first feel unwell
- Help us to make the right decisions that will keep us fit and healthy longer, including helping us to get good food, use gyms and have health checks (e.g. Annual Health Checks for people with learning disabilities)
- Contact those of us who are socially isolated and vulnerable to make sure we have equal access to information, advice and services

3. Making care better

- Make sure all staff take a person-centred approach to our care, that takes into account our individual needs and those of our family/carers, including information and support to make real choices (e.g. about end of life)
- Treat us all with compassion and see past a pre-existing condition to make sure other health problems are not missed, e.g. when treating those of us with a mental health condition or learning disability/autism
- Provide us with consistency to build our trust, including consistency of staff, information and advice, e.g. known carers, use of 'This is me' and the Butterfly symbol for people with a dementia diagnosis/confusion across services and departments
- Make sure our care plans are created with us and our family/carers and that they are useful and meaningful

4. Investing more money in technology

- Use shared digital records, including care plans, that can be accessed by all professionals involved in our care
- Support us to use technology but also recognise that we don't all have access to a computer or smart phone and we can't all use technology in this way (some of us don't want to)

Background

Purpose

The Shropshire, Telford and Wrekin Sustainability and Transformation Partnership (STP) is one of 44 STPs across England. It is made up of heath and care commissioners and providers including:

- Shropshire Council
- Telford & Wrekin Council
- NHS Shropshire Clinical Commissioning Group
- NHS Telford & Wrekin Clinical Commissioning Group
- Shrewsbury & Telford Hospital NHS Trust
- Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership NHS Foundation Trust
- Shropshire Community Health NHS Trust
- West Midlands Ambulance Service NHS Foundation Trust

The role of the STP is to:

- Encourage health and care organisations to work more closely together to improve outcomes and care for local people
- Reduce pressures on services
- Make best uses of financial resources

The NHS faces a growing demand for its services, with growing pressure nationally from an ageing population, more people living with long-term conditions and lifestyle choices affecting people's health. Change is needed to make sure everyone gets the support they need so in January 2019 NHS England published its Long Term Plan and every STP has been asked to produce a local plan for their area.

The Long Term Plan is all about:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well
- Ensuring NHS staff get the support they need
- Digitally enabled care
- Effective use of resources

Priorities include:

- Improving how the NHS works so that people can get help more easily and closer to home (e.g. being able to speak to your GP on your computer or smart phone)
- Helping more people to stay well (e.g. helping people to stay a healthy weight or stop smoking)
- Making care better – the NHS wants to get even better at looking after people with cancer, mental health, dementia, lung and heart disease and learning disabilities such as autism
- Investing more money in technology so that everyone is able to access services using their phone or computer, and so that health professionals can make better, faster decisions

People told Healthwatch that they wanted to be involved and take more control of their health and care. In January 2019, Healthwatch England asked all local Healthwatch[4] to work within their STP areas to find out what local people think about the NHS Long Term Plan and reach out to specific communities. The STP (NHS) is expected to undertake its own public engagement work. The activity of Healthwatch aims to complement and support this work.

In our STP area Healthwatch Shropshire and Healthwatch Telford and Wrekin met with the STP to agree our local priorities and how Healthwatch would engage with people across the county to get their views.

The Shropshire, Telford and Wrekin STP priorities for 2019/20 are:

- Urgent and emergency care
- Mental health
- Out of hospital care

We agreed to do general engagement around the priorities of the NHS Long Term Plan and focus on mental health because work is already underway in Shropshire, Telford & Wrekin looking at urgent / emergency care and out of hospital care. The STP includes dementia and learning disability under 'mental health' and it was agreed that we would do more focused engagement with these groups to make sure they could contribute to the discussions in a way that met their needs, e.g. face-to-face, informal conversations. We planned to get responses to three key questions:

- How can you be supported to live a healthier life?
- What can services do to provide you with better care and support?
- What would make it easier for you to take control of your health and wellbeing?

Objectives - The challenge

The challenge for the STP and Healthwatch Shropshire and Healthwatch Telford & Wrekin was to reach a diverse population living in both urban and very rural areas. We wanted to gather the views from as many people as possible that recognised the wide variation in personal experiences of accessing and using health and social care services across the county so decided to use a range of engagement methods.

[4] All 152 Local Authority areas in England have a Healthwatch

Context: Our population

In 2017, Shropshire had a population of 317,459[5] and Telford and Wrekin had a population of 175,271[6].

Shropshire:

- In Shropshire a higher proportion of residents live in rural areas as defined by the 2011 rural urban classification scheme with 0.98 people per hectare compared to 4.24 in England.
- The age profile of Shropshire shows that over 45.1% of residents are aged 50 and over. This is higher than the rate for both England (36.7%) and West Midlands (31.9%) which stands at 36.5%. Life expectancy in Shropshire is above the average for England.
- According to the Index of Multiple Deprivation which separates the county into areas of 1,000 to 3,000 people there are nine areas in Shropshire that fall within the 20% most deprived in England. They are all located within urban areas of the county. Harlescott in Shrewsbury falls within the 10% most deprived areas in England. Other areas of multiple deprivation are in Ludlow and Oswestry.

Telford & Wrekin:

- The population of Telford &Wrekin is 'younger' than the national position, although with the fastest growth being in the 65+ age group the age profile of the borough is now much closer to the national position. Reflective of the population, Telford &Wrekin has a higher proportion of households with dependent children and a lower number of households aged 65+.
- Male life expectancy has increased over the last decade, but has been significantly worse than England average since 2006-08. Female life expectancy has increased, but has been worse than England average since 2008-10.
- The population is becoming more diverse. As well as new migrants a key driver of change has been the younger age structure of BME groups leading to a greater likelihood of them having children.
- A higher proportion of people in Telford & Wrekin report having bad or very bad health than the England rate.
- In 2015, more than a quarter (27%) of the Telford & Wrekin population lived in the 20% most deprived areas nationally, an increase on 24% in 2010.

Engagement methods:

In the Shropshire, Telford and Wrekin STP area we agreed to use the following methods to engage with people:

- Healthwatch England Questionnaires (primarily on-line and paper)
- Focus groups / workshops / 1:1s
- Public events
- General public engagement (e.g. talks, stands)

[5] All data from 'Shropshire Council Key Facts & Figures Shropshire Data 2017/18'

[6] All data from 'Facts and Figures – Key Messages for Telford & Wrekin December 2017'

- Press releases
- Newsletter and email publicity
- Social media (including Twitter, Facebook, Instagram)
- Looking at existing evidence (including previous Healthwatch Reports and other reports by local organisations that offer views relevant to the long term plan)

External factors:

At the time of doing this piece of work, local Council elections were taking place in Telford & Wrekin. According to the Local Government Association:

> 'The term 'purdah' [is used] across central and local government to describe the period of time immediately before elections or referendums when specific restrictions on communications activity are in place.' www.local.gov.uk

This had a direct impact on Healthwatch Telford & Wrekin's plans for engagement, for example Telford & Wrekin Council declined to share any press releases, social media posts or posters to people on their correspondence lists. Healthwatch Telford and Wrekin were also told by several venues and organisations that they could not promote the questionnaires or their public event, or hold a focus group, e.g. public libraries. Even local supermarkets refused to promote any materials.

Next Steps

The STP have told Healthwatch Shropshire and Healthwatch Telford & Wrekin that the views gathered and shared in this report will:

- Inform the development of the local long term plan for Shropshire, Telford & Wrekin
- Turn the national ambitions contained in the NHS Long Term Plan into real improvements to services and outcomes for patients across Shropshire

Following this engagement and the publication of this report, both Healthwatch will continue to share any results from our wider engagement, including relevant comments and reports with the STP so that the views of people in Shropshire and Telford & Wrekin continue to be taken into account as the long term plan is implemented.

What we did

Across the Shropshire, Telford & Wrekin STP area we heard the views of 641 people. Healthwatch Shropshire heard from 376 people (0.12% of the population of Shropshire) and Healthwatch Telford & Wrekin heard from 265 people (0.15% of the population of Telford & Wrekin)

Details of our engagement activities:

1. Questionnaires

We promoted two questionnaires developed by Healthwatch England to get people's feedback. The first questionnaire was more general and an opportunity for people to say what they thought

the local NHS should do to make care better for their communities. The second questionnaire was specifically to gather the views of people with long-term conditions, including:

- Cancer
- Heart and lung diseases
- Mental Health
- Dementia
- Learning disability
- Autism
- Long-term condition e.g. diabetes, arthritis

Responses:

1. The **general questionnaire** was filled out by 167 people from Shropshire and 116 from Telford & Wrekin. Full results are in Appendix 1

2. The **long-term condition (LTC) questionnaire** was filled out by 77 people from Shropshire and 88 from Telford & Wrekin. Full results are in Appendix 2

Respondents (order in which these conditions appear in the report)

Condition	Shropshire	Telford & Wrekin	Total*
Dementia	4	5	9
Learning disabilities	10	9	19
Autism	3	8	11
Long term condition (e.g. diabetes arthritis)	29	33	62
Mental health	19	17	36
Cancer	8	9	17
Heart and lung disease	4	7	11

**Please note: Not all respondents answered all questions*

2. Focus groups

We ran focus groups / small groups discussions or 1:1s with people with dementia and their carers and people with Learning Disabilities and their carers. This gave us the opportunity to speak to people in a way that could support their understanding and ensure they could communicate their views in a way that worked for them.

Dementia focus groups

Shropshire Groups	People living with Dementia	Carers	Area
Alzheimer's Peer Support Group	0	9	Shrewsbury
Dementia Football	4	3	Highley
Alzheimer's Dementia Café	5	6	Ludlow
Market Drayton Festival of Wellbeing	3	1	Market Drayton
Alzheimer's Peer Support Group	0	3	Church Stretton
Rural Community Council (RCC) Care & Share Group	6	6	Church Stretton
DEEP[7] Group	5	0	Shrewsbury
Alzheimer's Dementia Café	3	4	Oswestry
Alzheimer's Dementia Focus Group	4	0	Bridgnorth
Memory Service & Age UK group	5	8	Bridgnorth
Total	**35**	**40**	
Telford & Wrekin Groups			
Age UK	4	2	Ketley Bank
Age UK	2	2	Dawley
Carers Centres (combined)	1	2	Hadley, Leegomery, Newport
Age UK	1	0	Wellington
Alzheimer's Society	4	0	Telford
Rose Manor family meetings (x2)	1	3	Ketley
Total	**13**	**9**	

[7] DEEP stands for the Dementia Engagement and Empowerment Project – it is the UK network of dementia voices

The feedback is summarised on page 39. Full details of the feedback are in Appendix 3.

Focus groups with adults with learning disabilities and autism

We worked in partnership with *Taking Part*, an Independent Service for people with Health and Social Care needs in Shropshire including Telford & Wrekin, to engage with adults with learning disabilities and autism. Taking Part's existing relationship with this group is based on trust and they were able to explain the value of their involvement and encourage them to share their views.

The feedback from the groups is summarised on page 40. Full details of the feedback are in Appendix 4

Taking Part spoke to 58 people: 28 people in groups in Shropshire and 20 in Telford, they also spoke to 10 people in Shropshire on a one to one basis.

Note about other conditions

Healthwatch Shropshire and Telford & Wrekin did not have the time or capacity to complete any face-to-face engagement with people about the other conditions listed on p.6 as part of this piece of work, e.g. cancer, heart and lung disease, diabetes, long-term conditions such as arthritis and diabetes, or wider mental health conditions.

A breakdown of the responses people with these conditions gave when completing the long-term condition questionnaire is included in this report from p. 66

3. Public events – 'What would you do?'

We ran two **public events**, one in Shropshire and one in Telford and Wrekin.

The aim of these events was to give people another way to respond to the three key questions and share their views, particularly if they did not choose to complete the questionnaires. It also allowed us to give people information about the work already being done in the county that illustrate the ambitions of the NHS long term plan, e.g. Social Prescribing and Care Closer to Home (Shropshire), Neighbourhoods (Telford & Wrekin).

- Nineteen people attended a public event, led by Healthwatch Telford & Wrekin (HWT&W) and supported by Healthwatch Shropshire (HWS), at Meeting Point House, Telford Town Centre.
- Nineteen people also attended a mirror event, led by HWS and supported by HWT&W, at The Trinity Centre in Meole Brace, Shrewsbury.

Full details of the feedback are in Appendix 5.

Please note: It is not clear how many people completed the questionnaires and then also shared their views with us at a focus group or public event.

What matters most to people in Shropshire, Telford & Wrekin

General experiences of health and care services

In Questionnaire 1, people were asked to rate the importance of 25 suggested measures that helped to support the following four areas:

1. Living a healthy life
2. Being able to manage and choose the support I need
3. The help I need to keep my independence and stay healthy as I get older
4. How you interact with your local NHS

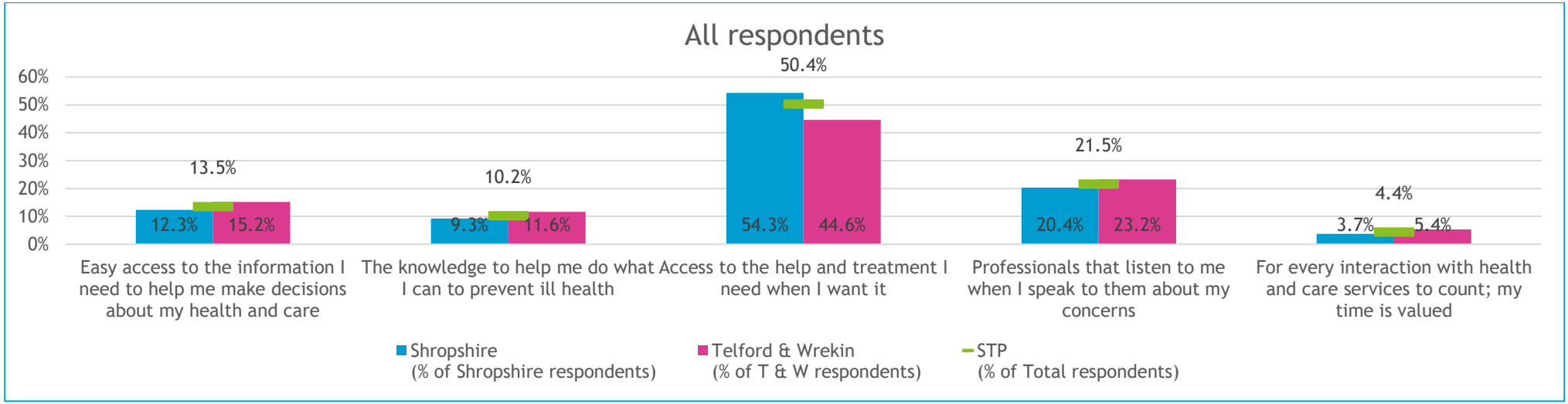
This questionnaire was completed by 167 people from Shropshire and 116 from Telford & Wrekin (Total 283).

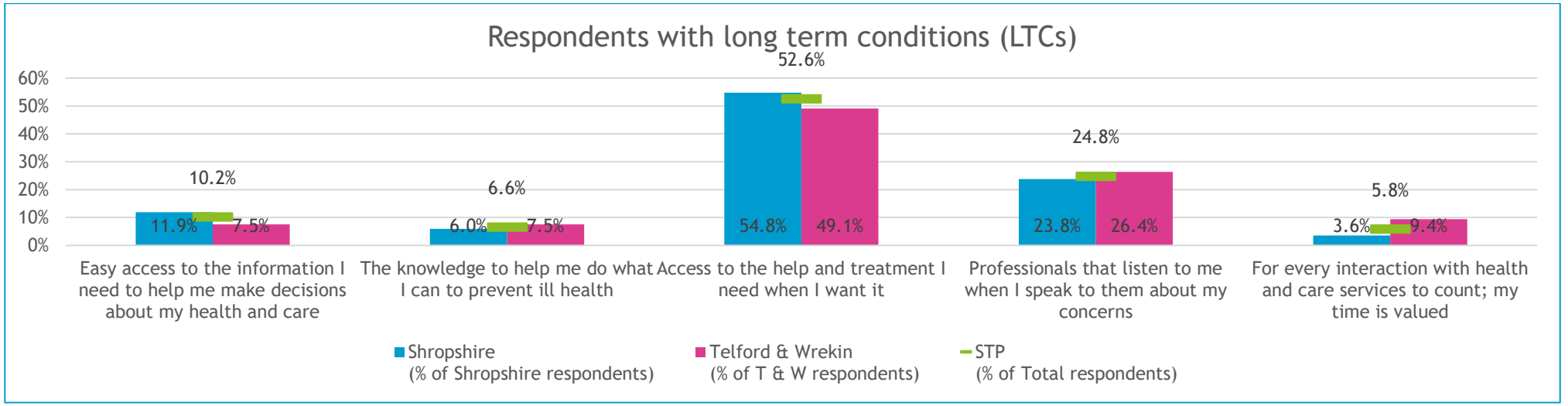
All twenty-five measures were deemed overwhelmingly important or very important. Overall importance rating of all statements:

- **Very important** **58.77%**
- **Important** **27.96%**
- *Neutral (or left blank)* *12.72%*
- Not important 0.49%
- Not very Important 0.07%

Respondents were then asked to choose the most important measure from each of the four areas.

1. Having what I need to live a healthy life





Most important to live a healthy life:

"Access to the help and treatment I need when I want it"

When the responses from people with long-term conditions (LTCs) and people without LTCs were analysed separately the two top most important measures were the same as the overall results.

If there were one more thing that would help you live a healthy life, what would it be?

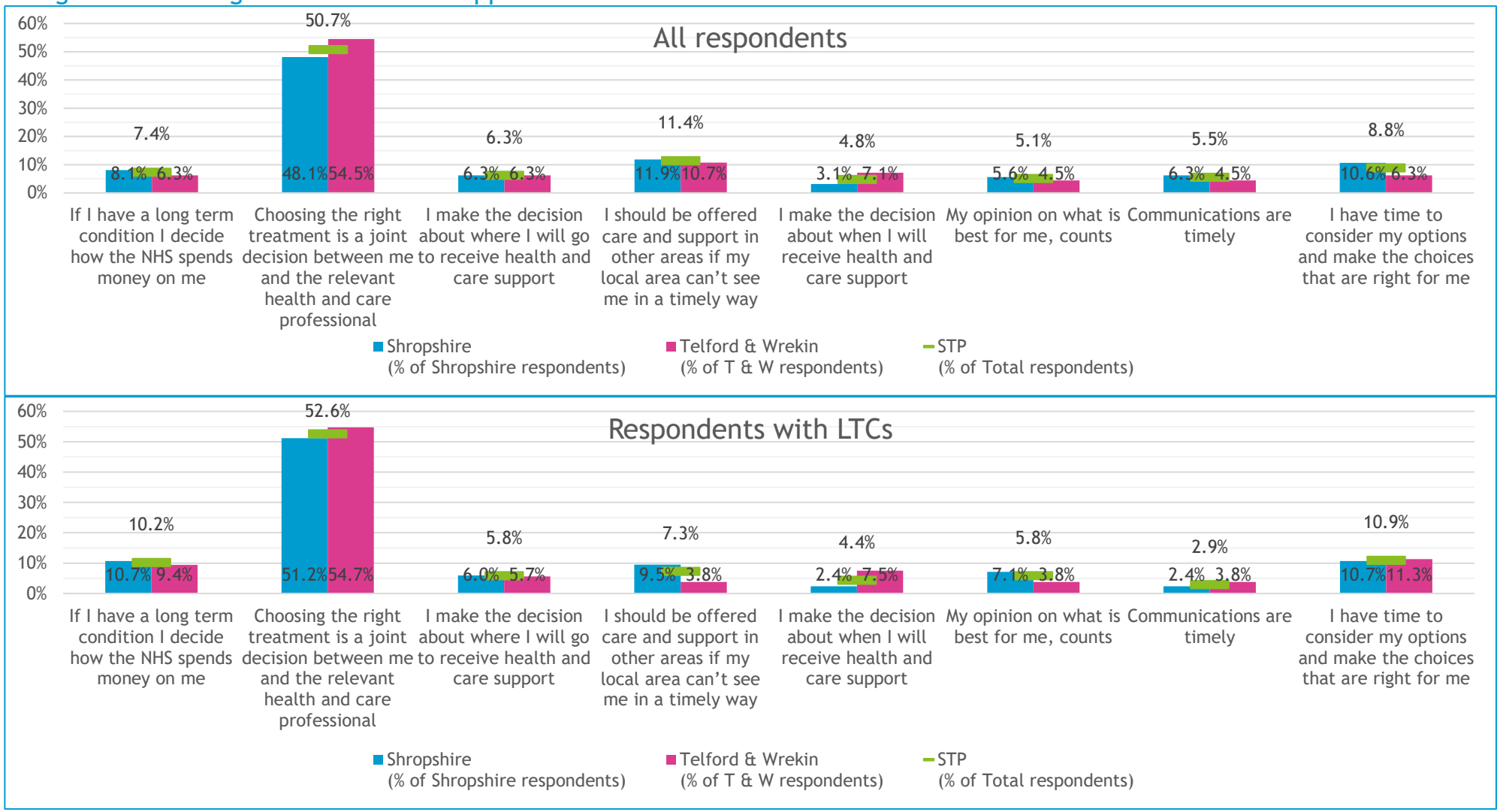
In the free text box, people told us that the following things would help them to live a healthy life:

Summary of top five things people thought would help in order of importance (number of respondents):

1. **Access to treatment and services** (Shropshire 34, Telford & Wrekin 12), e.g. "short waiting times" and "access to help and treatment when I need it"
2. **Help to make the right lifestyle choices** (Shropshire 16, Telford & Wrekin 10), over half referred to physical activity, e.g. "cheaper access to sport facilities"
3. **Advice and support** (Shropshire 12, Telford & Wrekin 12), e.g. information about "what support is available after diagnosis", "supporting me when I am on the right track"
4. **Improved communication** (Shropshire 13, Telford & Wrekin 5) e.g. "knowing how to differentiate between the misinformation fed to me by the media…", "better communication about preventative tasks and health checks"
5. **Staff access to resources, training and research** (Shropshire 10, Telford & Wrekin 4) e.g. " understanding from all health professionals of mental health"

For additional information see Appendix 1

2. Being able to manage and choose the support I need



Most important in being able to manage and choose the support I need:

"Choosing the right treatment is a joint decision between me and the relevant health and care professional"

When the responses from people with LTCs and people without LTCs were analysed separately the most important measure, choosing the right treatment being a joint decision, is the same for both groups. However those with a LTC felt that the next most important measure was 'deciding how the NHS spends money on me' whereas those without a LTC felt that the next most important was being offered care in other areas to achieve timely treatment.

If there was one more thing that would help you manage and choose how the NHS support you, what would it be?

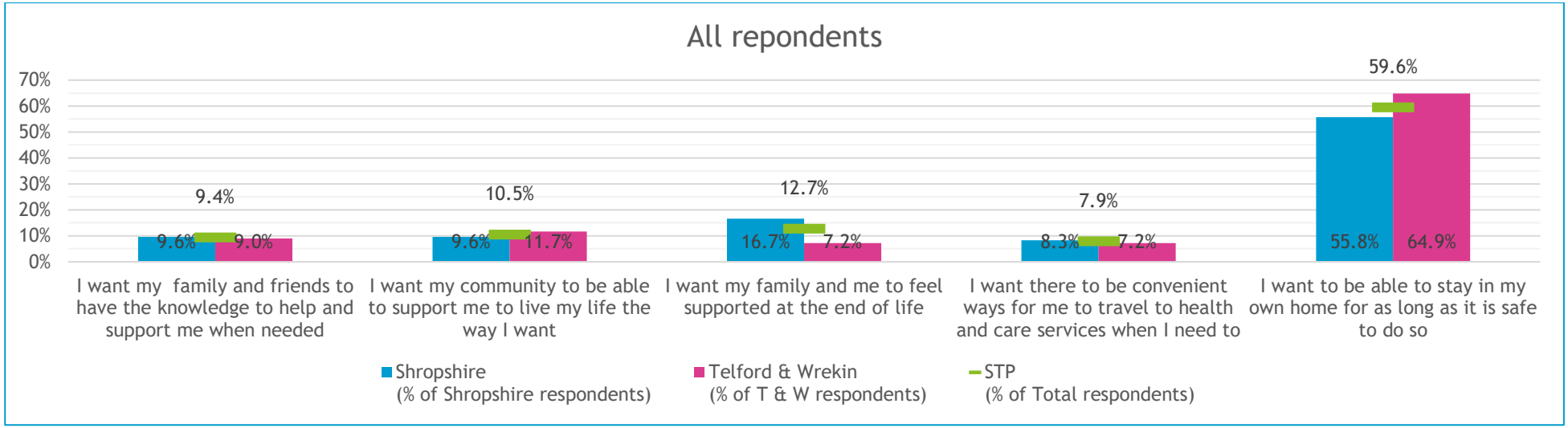
In the free text box, people told us that the following things would help them to manage and choose how the NHS support them:

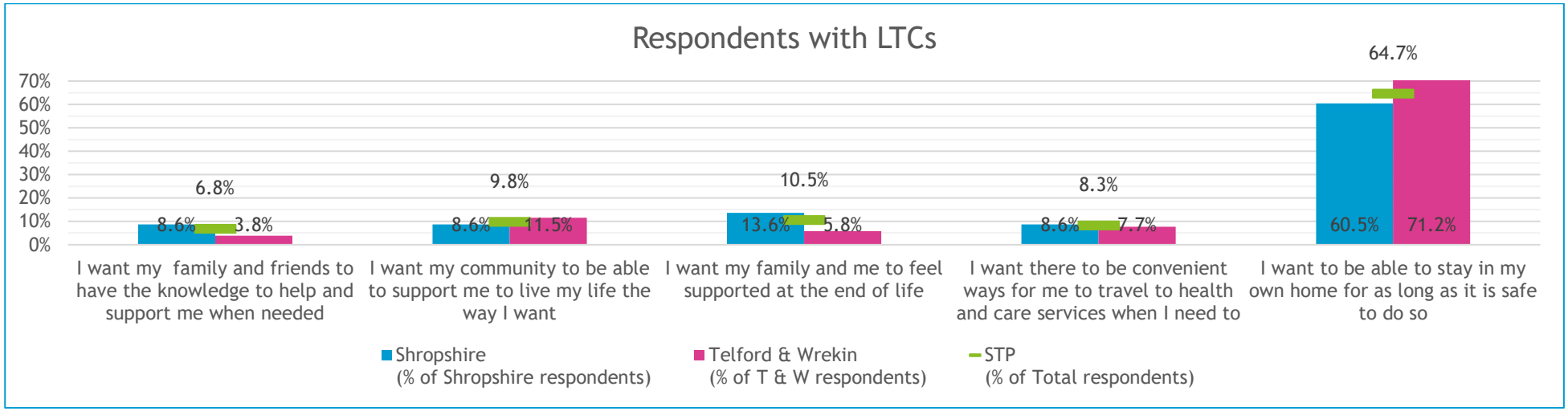
Summary of top five things people thought would help in order of importance (number of respondents):

1. **Professional taking a person-centred approach** (Shropshire 17, Telford & Wrekin 14), e.g. being "involved in decision making", "listen to me…", "professionals to have the time", being given information to make an informed choice, access to the right professionals
2. **Better communication and information** (Shropshire 18, Telford & Wrekin 11) e.g. reliable, efficient and timely information including information about service performance
3. **Local services to meet local needs** (Shropshire 8, Telford & Wrekin 7) a number of people mentioned Future Fit and planned changes to urgent and emergency care, "Don't close accident and emergency in Telford", "it would be beneficial if local commissioners acted on local needs…"
4. **Increased resources such as staffing** (Shropshire 13, Telford & Wrekin 1) more than half of these people mentioned staffing, e.g. "network of appropriate support workers", "more GPs..", "make sure there are enough specialists"
5. **Easier access to GPs/health professionals/services** (Shropshire 7, Telford & Wrekin 5), e.g. appointments,

For additional information see Appendix 1

3. The help I need to keep my independence and stay healthy as I get older





Most important in being able to manage and choose the support I need:

"I want to be able to stay in my own home for as long as it is safe to do so"

When the responses from people with LTCs and people without LTCs were analysed separately the two top most important measures were the same as the overall results.

If there was one more thing that would help you retain your independence and live healthily for as long as possible, what would it be?

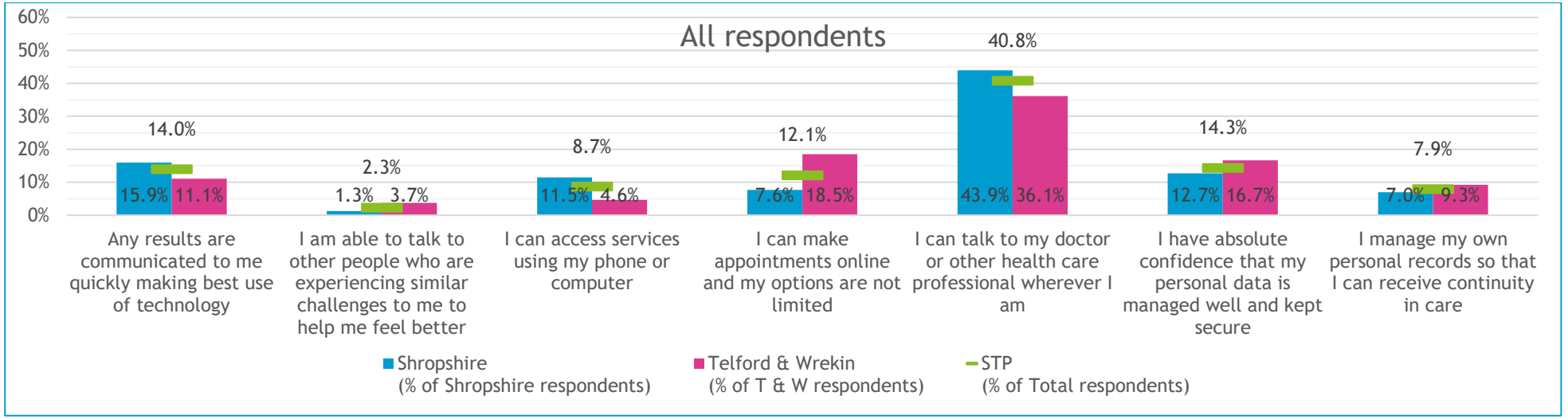
In the free text box, people told us that the following things would help them to retain their independent and live healthily for longer:

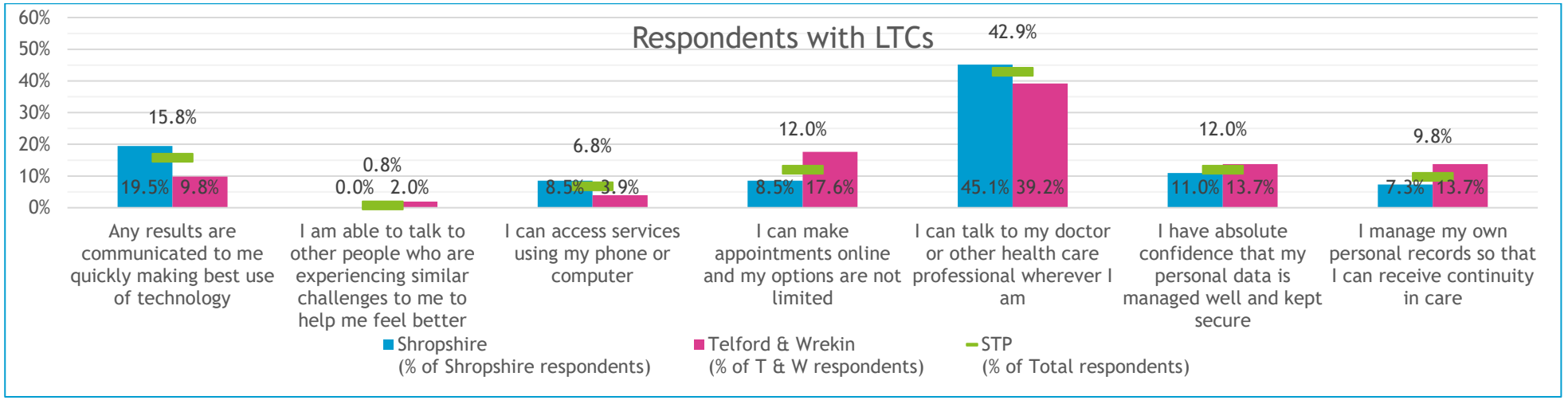
Summary of top five things people thought would help in order of importance (number of respondents):

1. **Increased resources including financial support and practical aids** (Shropshire 15, Telford & Wrekin 8), e.g. "easy access to aids and adaptations", "financial support to adapt my home if necessary", "investment in community support"
2. **Support** (Shropshire 10, Telford & Wrekin 8) including support for family members
3. **Care at home** (Shropshire 7, Telford & Wrekin 8), e.g. "better community response to home" to be at home as long as possible" and a **person-centred approach** (Shropshire 11, Telford & Wrekin 4) to ensure personal needs are met and people can make "real choices"
4. **End of life care** and having a say so that people have a choice about what happens and "feel supported at end of life (Shropshire 9, Telford & Wrekin 3)
5. **Better transport** (Shropshire 4, Telford & Wrekin 4) including more transport and "better public transport"

For additional information see Appendix 1

4. How you interact with your local NHS





Most important in being able to manage and choose the support I need:

"I can talk to my doctor or other health care professional wherever I am"

When the responses from people with LTCs and people without LTCs were analysed separately the top most important measure was the same as the overall results.

The second most important measure differed. Those with a LTC prioritised, 'Any results are communicated to me quickly making the best of technology' while those without prioritised 'I have absolute confidence that my personal data is managed well and kept secure'.

If there was one more thing that you think needs to change to help you to successfully manage your health and care, what would it be?

In the free text box, people told us the thing they thought would need to change to help them to manage their health and care.

Technology was mentioned in a number of ways which proved challenging when analysing the comments. People identified a need for an improved use of IT by services, including shared records, but its limitations for communication with patients was highlighted, in particular those people with limited access to IT or no experience of using it.

Summary of top five things people thought would help in order of importance (number of respondents):

1. **GPs** (Shropshire 10, Telford & Wrekin 16) 69% of the people who highlighted GPs felt better access would be most helpful, including GPs having time to speak to them, reduced waiting times and "having access to the same Doctor…"
2. **Developing technology*** (Shropshire 19, Telford & Wrekin 6) 11 people made negative comments about the current use of technology but also its limitations, e.g. "Elderly people are not always computer literate…"
3. **Access to information, education and research for professionals but also people using services** (Shropshire 9, Telford & Wrekin 8) including an improved understanding of the other services/support available, e.g. "Professionals should acknowledge patients' support groups…"
4. **Increased staffing and service provision** (Shropshire 9, Telford & Wrekin 5) e.g. "more doctors and nurses", "the way people access services particularly mental health help…."
5. **Communication and patient records** (Shropshire 13 , Telford & Wrekin 5) e.g. "better communication between services and hospital departments", "All medical records kept on a single data base and available to both patient and medical practitioners…." ***This links to developing technology.***

For additional information see Appendix 1

Overall ranking

To gauge relative importance between all 25 measures, the importance given to each individual statement was weighted and amalgamated.
Weighting: Very Important = 2, Important = 1, Neutral = 0, Not important = -1, Not important at all = -2

Top 10 statement - All respondents	Shropshire Score	Shropshire Rank	Telford & Wrekin Score	Telford & Wrekin Rank	STP Score	STP Rank
Professionals that listen to me when I speak to them about my concerns	296	1	215	2	511	1
Access to the help and treatment I need when I want it	287	3	216	1	503	2
I want to be able to stay in my own home for as long as it is safe to do so	292	2	206	3	498	3
I want my family and me to feel supported at the end of life	277	4	204	4	481	4
Choosing the right treatment is a joint decision between me and the relevant health and care professional	264	8	200	5	464	5
I want there to be convenient ways for me to travel to health and care services when I need to	270	5	192	6	462	6
Easy access to the information I need to help me make decisions about my health and care	269	6	188	9	457	7
Having the knowledge to help me do what I can to prevent ill health	268	7	182	11	450	8
Communications are timely	257	10	190	7	447	9
I have time to consider my options and make the choices that are right for me	248	12	189	8	437	10

Top 10 statements - Respondents with LTCs	Shropshire Score	Shropshire Rank	Telford & Wrekin Score	Telford & Wrekin Rank	STP Score	STP Rank
Professionals that listen to me when I speak to them about my concerns	159	1	104	1	263	1
Access to the help and treatment I need when I want it	152	3	101	2	253	2
I want to be able to stay in my own home for as long as it is safe to do so	155	2	95	3	250	3
I want my family and me to feel supported at the end of life	147	4	94	4	241	4
Easy access to the information I need to help me make decisions about my health and care	143	5	92	7	235	5
Choosing the right treatment is a joint decision between me and the relevant health and care professional	140	6	94	4	234	6
I want there to be convenient ways for me to travel to health and care services when I need to	139	8	93	6	232	7
Having the knowledge to help me do what I can to prevent ill health	140	6	89	8	229	8
For every interaction with health and care services to count; my time is valued	134	9	86	10	220	9
Communications are timely	132	10	88	9	220	9

Public events - 'What would you do?'

The Healthwatch Telford & Wrekin Event was held at Meeting Point House at Telford Town Centre on 29th April 2019. It was attended by 19 people; nine of these completed the Equality & Diversity Monitoring Form.

The Healthwatch Shropshire Event was held at the Trinity Centre in Shrewsbury on 1st May 2019. It was also attended by 19 people, 11 of these completed the Equality & Diversity Monitoring Form.

	Telford & Wrekin Event (9 responses)	Shropshire Event (11 responses)
Age range	18-24 to 75+	35-44 to75+
Nationality	9 White British	10 white British, 1 other
Disability	3	4
Conditions	2 long term conditions	2 long term condition, 3 multiple conditions
Carer	4	2
Gender	5 male, 4 female	7 male, 3 female

Full Equality & Diversity Data is listed in Appendix 5

People attending both events were asked the following key research questions:

- *How can you be supported to live a healthier life?*
  - What is stopping you from living a healthier life
  - What could help you to live a healthier life
  - What could health and social care services do to help you to live a healthier life?
- *What can services do to provide you with better care and support?*
  - What is your experience of care and support now?
  - What small changes would make a difference?
  - In an ideal world, what would services do? (differently, more of)
- *What would make it easier for you to take control of your health and wellbeing?*
  - What do you do now to take control of your health and wellbeing?
  - What would help you to take control?
  - If you need help to take control of your health and wellbeing, who would you like to help you? How would you like to be helped? When?

Summary of findings

1. How can you be supported to live a healthier life?

What is stopping you from living a healthier life?

The main themes we heard from both events were around:

Access

- Cost – particularly due to transport, e.g. to appointments. Also, funding cuts to third sector / voluntary organisations who have previously provided help and support.
- Location – in Telford we heard that the need to use public transport can be a problem due to money but also the lack of support to help people go to appointments. In Shropshire we heard about the impact of rural isolation and the need to use more than one type of transport to travel to different appointments, e.g. bus, taxi
- Time - we heard that people believe that long waiting times/waiting lists are often due to a lack of staff. In Telford people commented on the length of time GPs spend with patients and appointments feeling rushed. More generally we heard that people feel they do not have the time to do everything they need to do, including taking care of their own health.
- Early intervention – people recognised a need for 'consistent and regular' intervention but felt that not enough people knew how or where to access this.

Isolation

- Social isolation and loneliness – these were identified as key factors as they can lead to not knowing what help and support is available and where it is. We heard that this can be more challenging if you do not have a named GP and a relationship with services.
- Homelessness - in Telford we heard about the additional difficulties experienced by homeless people and were told they are often 'turned away as they have no fixed abode'.

Information

- Communication – People talked about the impact of 'mixed messages' and not knowing what help and support is available, e.g. lack of advertising about 'available appointments'. In Shropshire we were told that 'organisations should be leading on what messages the public listen to, to be the trusted voice', and this information 'should be simple' and 'the channels of communication need to be appropriate for the person'. In Telford we heard that this information includes information about financial support.
- Education – Some people thought education could help from an 'early age', including giving people information about healthy 'lifestyles' and 'health promotion'. In Telford someone told us that they thought there should be more emphasis on 'teaching kindness, etc.' in schools as well as academic achievements.

What could help you to live a healthier life?

The main suggestions we heard were:

Services working together

- Model of care – In Shropshire people spoke about 'moving away from the medical model to social model' and that 'specific information about issues/conditions [should be] given, not just treatment but community support'.
- Shared services / facilities – In Shropshire it was suggested that Community nurses could be on mobile libraries and it was hoped that 'community hubs' could be where services come together.
- Sharing information – including 'service awareness (awareness of other options within the services themselves'. In Telford people explained the need for 'GPs and other organisations [to] talk to each other and have a register for people who live on their own' so that there can be a 'telephone call to check up on people who live alone, say once a week. British Red Cross do'. The role of information technology was highlighted; 'IT from different organisations need to talk to each other'.
- Best practice and research – For services to work well together a Shropshire resident suggested that 'trusted networks' (e.g. Parish Councils) share their experience and best practice of how to work well together. Another person said that Primary Care Networks should improve 'sharing knowledge and experience amongst organisations'.

Building strong communities

- Improving access and 'information about how to access help' and services available. In Telford this was a role of 'Care Navigators – [with] knowledge of what is important to you'. 'Promoting what's going on locally – getting together, walking groups, etc.'
- Raising awareness, e.g. of mental health and reassuring people generally 'that it's OK to seek help and not a failing'.
- Issues around food were raised in Telford, including the need for 'better donations to food banks', 'reliable suppliers for home deliveries of food who check quality' and 'free home food deliveries for people who live alone' (as you have to pay for delivery if it is under a certain amount).

What could health and social care services do to help you to live a healthier life? (Priorities)

Several priorities were identified. Providing:

Individualised care

- People felt it was important for people to feel that professionals are 'treating 'you' as a person' and for 'professionals to take time for people – find out what they need and how to achieve this'

Timely intervention

- The need to 'target communities as well as the individuals (for prevention)' and for 'timely availability of services, rehab, support, etc.' This was linked to a need for 'investment' in professionals and services so there is more of them and a 'better spread of services around the county'. In Telford it was highlighted that services should be replaced if they are 'lost' (e.g. British Red Cross) and there should be 'more recognition of third sector services by organisations'.

Investment in local people

- 'Taking time to educate and understand people will help to relieve service strain further down the line'. For example, 'encourage people to use other Health professionals – educate and raise awareness of alternative access points (e.g. pharmacy, nurses, etc.)'.
- It was suggested that there should be 'early access – in life (e.g. teaching skills and raising awareness at young ages). Such as 'emotional intelligence [which is] not taught in schools and should be', supporting people 'through adolescence and beyond'. Raising 'awareness in school around physical/emotional health – involving families in education'.

2. What can services do to provide you with better care and support?

What is your experience of care and support now?

People at the events described a range of experiences (see Appendix 5)

GP services were highlighted in both Shropshire and Telford & Wrekin, notably:

- Limited access to GP appointments
- Services available in GP practices – in Shropshire people commented on 'traditional GP services being moved to hospitals, e.g. ear wax removal, phlebotomy' and 'Chiropody services cut from GP surgeries leads to impact on those with diabetes or sight loss'
- Mental health – in Telford we heard about the 'battle between GPs and mental health services (depending on level and intensity)'

What small changes would make a difference?

People made a range of suggestions to tackle the issues, including:

Information sharing

- In Shropshire one person asked 'Why is everyone so worried about data and confidentiality when information *needs* to be shared?', 'correctly work through what is confidential material and correctly share it'.
- It was suggested that for 'complex care, there is one person to contact who takes responsibility rather than multiple contacts and this person needs to have good local knowledge, to be able to disseminate information to other professional/carers involved

on key information like medication'. 'Having a local point of advocacy (access) for signposting for extra support, continuing support and prevention'.

- Other solutions included:
  - 'A shared care plan that works'
  - 'Continuity of forms – for patients and professionals'
  - 'Digital records so professionals can access patient information quickly'
  - 'GP surgeries – better telephone system'

A range of communication methods

- We heard that people can get anxious waiting for an urgent appointment, 'why not text, email or use the quickest form of communication rather than waiting for letters', 'don't outsource appointment letter sending'

In an ideal world, what would services do? (differently, more of)

Suggestions include:

Joined up working within the NHS

- 'Multi-disciplinary working – knowledge and skills sharing', 'physiotherapy attached to wards to enable patients to walk',
- 'Increasing rehab staff and Occupational Therapy provision'.
- 'Specialists visits to GP services to work alongside GPs with complex cases to skill share'.
- 'Joined up IT systems'

Joined up working with social care

- 'Social services and NHS to work together – need to be one organisation', 'shared budgets'.
- 'Regional/across an area planning'.

The role of housing

- 'Better housing which works for people as they age'
- 'Retirement villages where care levels can increase when needed'

3. What would make it easier for you to take control of your health and wellbeing?

What do you do now to take control of your health and wellbeing?

People told us about a range of things they are currently doing to support their own health and wellbeing, including:

- Mental and social activities – such as reading, socialising and being involved in groups (e.g. walking groups in the community), volunteering and 'community involvement', working towards a 'Positive Mental Attitude (PMA) – Behaviour, attitude and meditating' and 'C.L.A.N.G (C – Connect, L – (keep) Learning, A – (Be) Active, N – (take) Notice, G – Give)'
- Physical activities – such as 'walking', 'anything simple/intense'

- Finding information for themselves – asking for signposting (including from GPs), finding 'information in the community', accessing 'online guides, information and support', 'internet searches: symptom checkers'

Some of the barriers people identified to taking control of their health and wellbeing included:

- Lack of 'motivation/resilience'
- Needing 'quick and easy access to someone to get support and advice' and finding 'the right person to speak to'
- Access, for example the need for '24-hour access' and 'transport – bus routes, too far away, medical transport – need more' (particularly if you have a disability or limited mobility)
- Fear and anxiety, including around travelling

What would help you to take control?

People made a number of suggestions, including:

Consistent, reliable information/guidance for all ages - People told us there is 'too much information – that can be contradictory, always changing', and they would like 'helpful guidelines (food/diet)', 'information given in an appropriate way (including signposting/social) by professionals'. One person felt it was important to keep 'reminding, especially children, to connect with people physically rather than by mobile'

Support - Including assistance for those people with 'impairments', people valued 'peer support groups' (e.g. Care and share groups for people with dementia)

Flexibility - Such as a 'flexible approach to working, e.g. shifts'

If you need help to take control of your health and wellbeing, who would you like to help you? How would you like to be helped? When?

People told us that they wanted the help they are given to:

- ✓ Be 'person-centred' and 'inclusive', that 'reduces stigma/labelling (shouldn't be the only way you can get care)'
- ✓ 'Recognise carer's involvement. Value people'
- ✓ Be available through 'one point of access with knowledge, support, who do I see?', a 'single point of access for information, advice and guidance' that is provided by a 'skilled/trained person 24:7'
- ✓ Take into account the fact people want to receive information in different ways ('not everyone can use technology') and from different people ('prefer to have help from elsewhere, rather than a GP')
- ✓ Be available early in order to prevent further needs, including 'more social care input'
- ✓ Be 'fast/rapid and the right treatment'

Meeting the health needs of people with dementia

Overview

In the seventy years since the founding of the NHS, life expectancy has increased by around 13 years; however, people are more likely to live with multiple long-term conditions, or live into old age with frailty or dementia.

One in six people over the age of 80 has dementia and 70% of people in care homes have dementia or severe memory problems. There will be **over one million people with dementia in the UK by 2025**, and there are over 40,000 people in the UK under 65 living with dementia today.

Dementia is of particular concern in Shropshire due to its large and growing ageing population:

> *'Figures collected by GPs show that in Shropshire and Telford & Wrekin there are 4,751 people over 65 who have been diagnosed with some form of dementia.*
>
> *But, estimates from the NHS, based on the on the age profile and gender of patients, suggest the real figure for the county could be as high as 6,831.*
>
> *That means an estimated 2,080 pensioners are living with the debilitating illness that has not been formally recorded by their doctor.' (Shropshire Star 22/12/18)*
>
> *'As far as Shropshire health conditions go, we believe that dementia is a "sleeping giant"… one that has begun to wake up.' 'Projections show that by 2031, 45% of the South Shropshire population will be over 65 years of age and will be among the three oldest populations across England and Wales.'* (Shropshire Dementia Strategy 2017-2020, Shropshire Clinical Commissioning Group / Shropshire Council)

Over the past decade the NHS has successfully **doubled the dementia diagnosis rate and halved the prescription of antipsychotic drugs**. It has continued to improve public awareness and professional understanding.

Our findings

Long Term Condition Questionnaire Respondents

In the questionnaire about NHS support for specific conditions nine people, four from Shropshire and five from Telford & Wrekin, told us about their experiences of dementia support.

Healthwatch Shropshire and Healthwatch Telford & Wrekin also attended a number of focus groups, speaking to people with dementia and their carers:

Healthwatch	Number of groups	Number of people with dementia	Number of carers
Shropshire	10	35	40
Telford & Wrekin	6	13	9

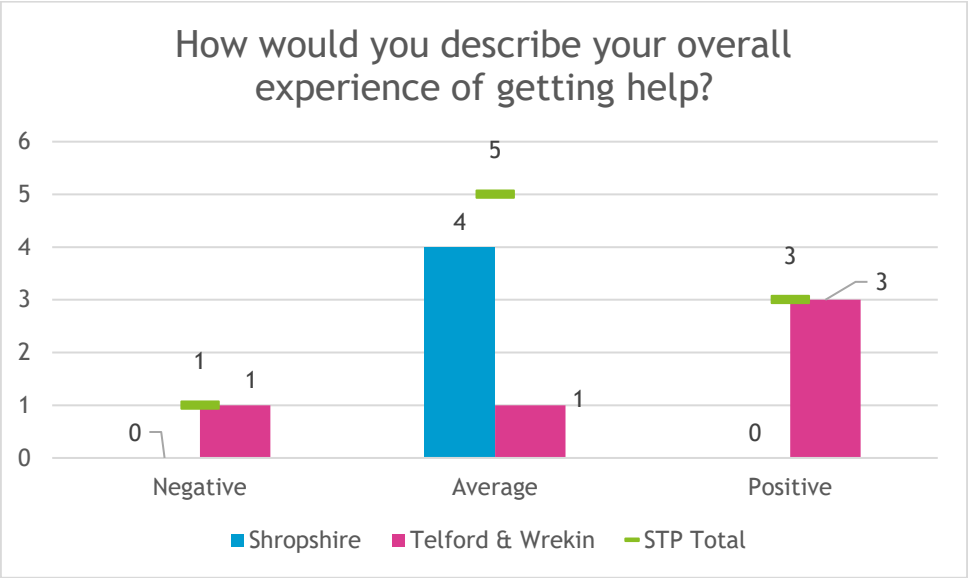
For full details of the focus groups and findings, see Appendix 3

Overall Experiences

Questionnaire Responses

Nine people living with dementia responded to these questions:

Getting Help



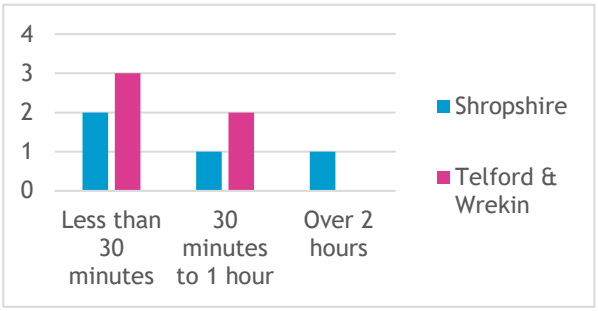
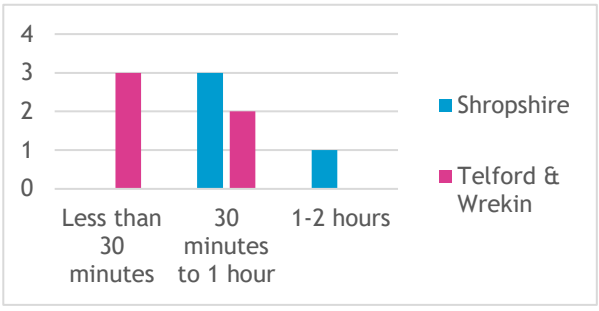
All four respondents from Shropshire felt their experience was 'average' while the majority of Telford & Wrekin respondents described it as 'positive'. The responses do not give us the information needed to identify why their experiences might be different, e.g. if it is due to a variation in expectations or due to the fact that Admiral Nurses work in Telford & Wrekin but not in Shropshire.

Communications

When asked if people received timely and consistent communication three of the nine respondents felt they did, four they did 'somewhat' and two that they did not.

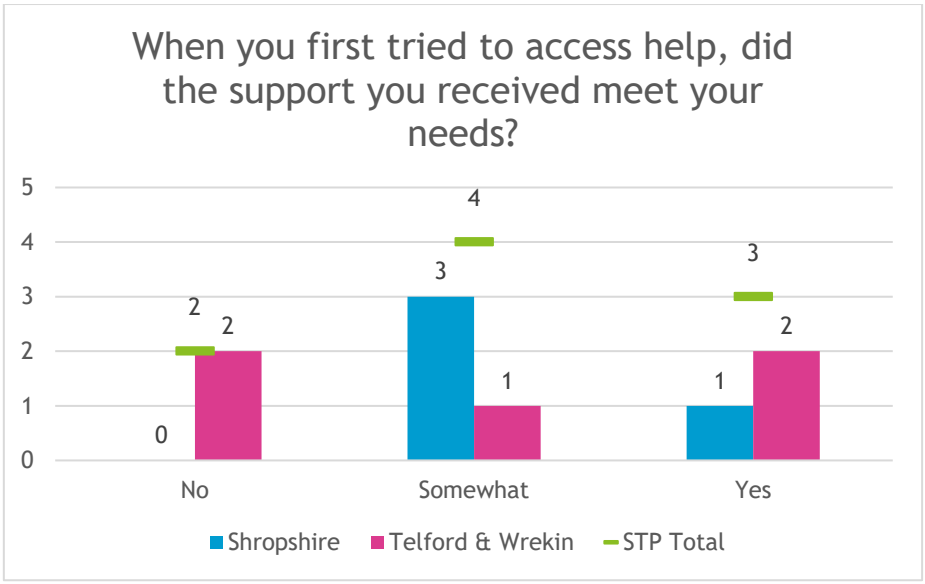
Transport and Travel

All respondents' main means of transport was their own or somebody else's car.

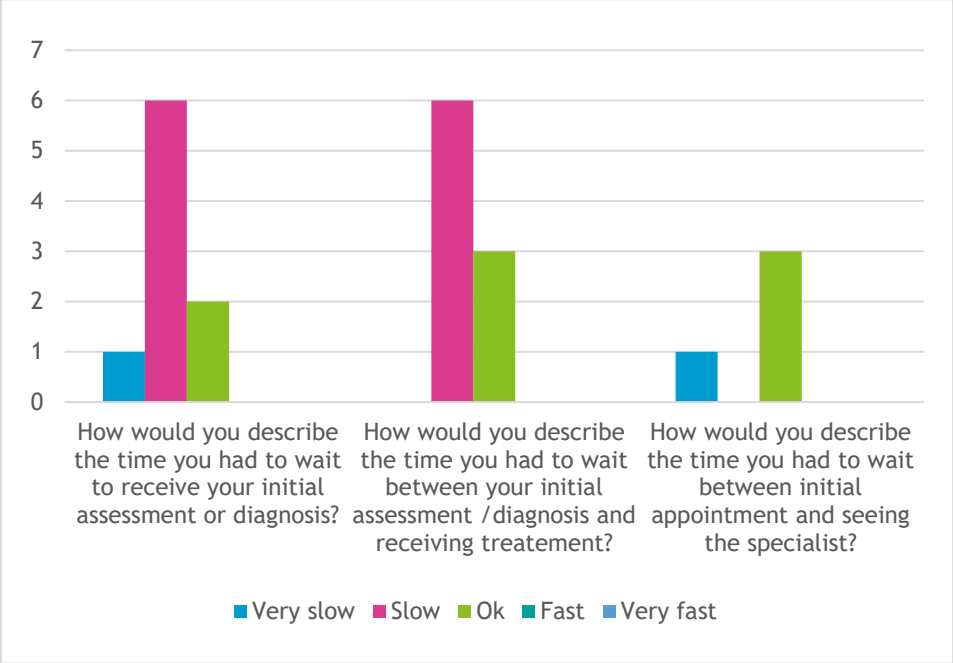
How much time would you be willing to travel for to receive a quick and accurate diagnosis?	How much time would you be willing to travel to receive specialist treatment or support?
	

Assessment, diagnosis and treatment

Questionnaire responses



- How would you describe the time you had to wait?



Focus group findings

The people who attended the focus groups were asked:

- What was it like when you (your family member) received a diagnosis of dementia?
- What support would you have found helpful at this time?
- What could have made that experience better?

Please note: Some comments from the focus groups are followed by a group code as shown in the appendix to indicate if the comments relates to Shropshire (S) or Telford & Wrekin (T). No differentiation is given to comments from carers or people living with dementia.

Receiving a diagnosis

A number of people we spoke to could not remember being given a diagnosis, those that did told us the experience was emotionally hard and overwhelming:

- "felt like crying but I had to keep saying to myself pull yourself together" S7
- "The process was unbelievably horrendous; I was just told I had it and that was that" S9
- "Overall, the diagnosis was traumatic for family members and the patient themselves" T1
- "Like getting hit in the face with a baseball bat…I've had dementia for a while I can't tell you how long" S9

One person living with dementia said that

- "Dementia isn't just a 'memory problem'. Its brain failure. It should be classed on the same level with heart failure and liver failure. That would help make it feel like it's not your fault"

Support around diagnosis

People told us about the time they had had to wait to get a diagnosis. For example, of the five people attending a support group in Shrewsbury, four told us it had taken over two years with a second scan being given.

Carers told us they were not always heard when noticing early changes and sharing concerns and this led to frustration and a delay in getting a diagnosis. Wives were reported as being the first people to really notice the differences in behaviour and although each one was aware of changes within themselves. Several were initially told it was nothing and don't worry about it, with one GP saying he had similar problems. Family members commented that the most difficult part of diagnosis was the feeling they were not listened to.

- "It would be good if GP's were less dismissive when the family highlights that a problem is developing"

The most commonly reported pathway to receiving a formal diagnosis was: GP appointment, GP refers to the Memory Service who diagnose by using simple tests and one or two scans. In one group it was commented that the tests done by the Memory Clinic during diagnosis don't feel like they reflect the seriousness of the diagnosis.

Improving the experience of diagnosis

- Mis-diagnosis

We heard accounts from people who had been initially misdiagnosed or told it was "nothing" and not to worry about it, particularly amongst the young-onset group. One person told us that had gone to their GP for a whole year, each time answering the same set of questions. Another had initially been given antidepressants. Four member of one group told us they had first been told by the Memory Clinic that they had depression and stress and one of these was told he had obsessive-compulsive disorder.

- "Diagnosis part being extremely hard due to [husband] having a very high IQ, doctors mistakenly saw this as an advantage and disbelieved our concerns. Once eventually diagnosed there was not a lot of support given from the Memory Clinic either" T1

- *Timely information and guidance*

People said that getting the right information at the point of diagnosis would have helped "so that you don't feel alone and can get help if you need it" (including around finances). Some people said that information should be staggered rather than given all at once. People said that

some information was not appropriate at that particular time; although it was useful it was put away and not read. Suggestions included:

- After having an "assessment with the memory clinic [] at that point it would have been helpful to have a flow chart to point her to information and groups for support. This could have included information about which benefits to claim for etc." S8
- "You could be given information on what to search and where to find it, so you can go at your own pace".S7
- "I think hospitals and GP practices ought to have pamphlets regarding support groups" S9

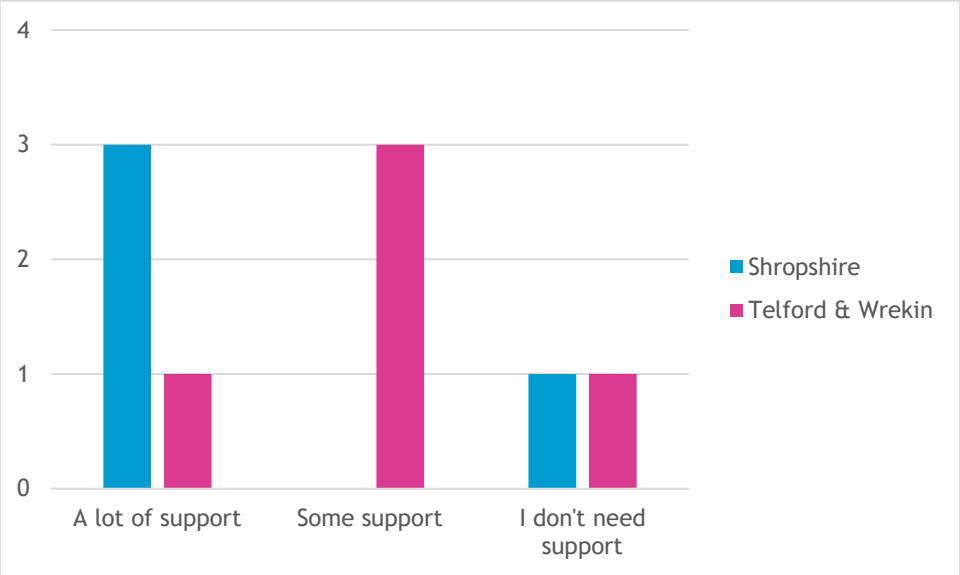
People also wanted some guidance, including on which information / support groups are "best":

- "One point of contact would have been helpful, someone to reach out too instead of multiple amounts of information" T3
- "Hardest part was the uncertainty of what vascular dementia was time line etc. There was not a lot of information given verbally just many leaflets to read through which was overwhelming" T4.

The provision of ongoing care and support

- What level of support do you want the NHS to provide to help you stay healthy?

Questionnaire responses



After diagnosis one person found it 'Easy' or 'Very easy' to access on-going support, four found it 'Difficult' or 'Very Difficult' and four said it was 'OK'.

When asked if the support options offered met expectations, three people replied that it did, two replied somewhat and two replied that it did not.

Focus group findings:

Care Plans

During focus groups we asked people:

- How useful is your care plan?
- Have you been involved in developing/writing it?
- What would you like to see in a care plan?

Most people had no or little knowledge of care plans and many were not aware of the GP or Memory Service having a care plan. Only a small number of the group were aware of a care plan being in place, or had seen a care plan. In one group, only one of the five people living with dementia had seen their care plan. One person told us:

- "If you need us, phone us. That was my care plan" T5

Many people commented that this might have been something that had been set up at first diagnosis but if that was the case it had not been reviewed or mentioned since.

Those that were aware of Care Plans told us that the content and usage were inadequate:

- "Who looks at that?" "As the staff come into D's home they are basically unmonitored and it is up to the individual whether or not they read it. When the supervisor visits, she will not know if things are in order because I have been in and sorted things out or not." S8
- "Very little meaningful within them"
- "A care plan is a care plan – it doesn't tell me what will happen to me and it doesn't tell me what to do"

Support post-diagnosis

We asked the focus groups:

- What support have you had since your diagnosis?
- What support do you/ would you find helpful?
- Where would you like to receive this support, e.g. at home, in a local setting?

We heard that:

- "The post-diagnosis time is the most frightening. You really should have immediate support at this time to help with the shock"

Continuing, timely information remained a key theme and some gaps were identified.

People told us about the information that had been given following their diagnosis, e.g.

- "Post-diagnosis, we received a book of information that talked about the next steps and what dementia meant" S1

The type of information given varied and was not easily available to all and did not always take into account people's needs:

- "My GP practice are hoping to create and give us a leaflet that explains what dementia means to the person"
- "I was told to get info from so-and-so, read a book… I CAN'T read as I forget what I've been reading, it's useless."

One person told us that she had found a coping course about dementia online that was free and it had helped her greatly however this has been cut due to funding. She said, "That could help so many people".

Other people wanted specific information and support about:

- incontinence
- wills and probate
- mental capacity and Power of Attorney
- driving and the DVLA
- using public transport

GPs and Primary Care

In focus groups there was a great deal of discussion centred on GP surgeries including appointments and the level of support from the GP themselves.

Some people felt they had been well supported by their GP:

- "I have full confidence that if needed I could get a GP phone about to talk about my concerns, outside of our 6 monthly check up". (Bridgnorth Medical Practice)

While others did not:

- "The GP never asks me how I am coping."
- "For me support from this group but not much from the GP."
- "They [GPs] don't believe people that young have got it"

There were concerns around the difficulties in getting appointments and being able to see the same GP. We heard that some GPs tell patients to follow up with them directly, but when the patient tries to do so they are told they have to speak to whoever is available.

- "You have to fight to get the GPs out to you."
- "Getting a GP appointment is very hard."

Some people felt GPs should work more closely with other services:

- "Closer communication between the GP and the Memory Service regards medication would be helpful"
- "GPs should consider dementia as a potential diagnosis with younger patients. There is a guide for GPs from Young Dementia UK which is very helpful and is on line."

Memory service

The Memory Service received mixed reviews about how helpful the intervention and support had been. The Psychiatrist had visited one couple who found that extremely helpful. They were able to go through medication in detail and were told they would have another appointment within 3 to 4 months.

Other positive comments include:

- "The memory service is our sanity."
- "The Bridgnorth Memory team are very respectful, took the time to explain to both my husband and me as his carer. My husband was given 12 weeks of 30 min counselling sessions so that he could talk about how he was feeling."
- "I phoned the memory service and within two hours the problem was sorted"

While other people told us of less positive experiences and the difficulties accessing the support needed. One person told us that the memory clinic called every 6 months for a 'chat'. If the carer said that all was 'ok' then it was decided an appointment wasn't necessary. Another person said they had had such a bad experience when being told of their diagnosis that they refused to have anyone from the clinic in the house.

Other comments were:

- "Memory care service very helpful but it would be helpful if it was the same person each time as having to keep explaining yourself and the situation is difficult."
- "Not a great service, lost touch with them"
- "No follow up to see how we are, which groups have helped us etc."
- "The Memory Clinic are good for technical understanding, but you don't feel that they have proper practical understanding and knowledge of how hard dementia can be and what it means. We need more practical help." S1

Support/social groups and courses

People told us that groups are valued especially long standing ones and they are concerned that a lot of groups are stopping when there is a need for more offering a range of activities for people with a dementia diagnosis:

- "You go to other things, as soon as you say 'dementia' they look at you like you're totally thick"
- "I love gardening, but no gardening groups available. Me and my wife would love to still be able to enjoy these things together"

One person with dementia particularly emphasised the need for groups that she and her husband could go to together. She is worried about speaking to people without him there. She wants to socialize but needs his support.

We heard that the Memory Group at Bridgnorth is so valued that when faced with closure or paying £5 each all members present agreed to continue and pay.

At one group in Shrewsbury we were told:

- "The Midlands Partnership Foundation Trust Memory Service is closing two support groups and two carers support groups this summer. The reason given was that there was an imbalance in the provision for the young onset compared to the older group. Now that the two are merging what is the reason? Given that there are over 4800 people in Shropshire with dementia there is only sporadic support available."

Feedback about the importance of support groups included:

- "Mayfair centre – very helpful especially letting everyone know what is happening. E.g. this Care & Share Group, Breathe Easy all have to be self-funded."
- "She attends 'Connect for Life' on Wednesday every week 10.30 – 2.30 where she has a cooked lunch and she is very happy with this. They have different people to talk, sing, games, they are friendly, helpful and comfortable."
- "I like coming to here (dementia football he is driven by group leader) it's very friendly"
- "The 'Singing for the Brain' group is what keeps us going."
- "Having support after my diagnosis has been very important, we enjoy 'Singing for the Brain' and the Age UK groups. They are very important to us all as a family"
- "Having to find your own support stream is frustrating but nothing would stop me I'm still an active gentleman, I need stimulation not leaflets and sent away!"

Many of the groups offer courses and practical information which people find invaluable:

- "The courses ran by Alzheimer's Society for Carers are very helpful. Gives you information on how to look after yourself as a Carer as well as information on dementia. One session a week for 4 weeks"

Hospital

The people we spoke to shared a range of experiences of being in hospital:

- "She had a fall and was very ill in hospital which she doesn't really remember." J reports "the ward sister was extremely helpful. Rails and adaptations were put into the house at this point by the Occupational Therapy Department".
- "Oswestry (RJAH) are very good […] way ahead of the NHS […] they are aware of everything. My wife told them I have dementia and it's all in my notes. She could stay with me until I was put under" T5

We heard about the use of 'This is me'8 and the Butterfly9 symbol to indicate a dementia diagnosis but people felt they were not used well by all staff and departments:

[8] ''This is me' is a simple leaflet for anyone receiving professional care who is living with dementia or experiencing delirium or other communication difficulties' www.alzheimers.org.uk

[9] 'The Butterfly Scheme provides a system of hospital care for people living with dementia or who simply find that their memory isn't as reliable as it used to be' https://butterflyscheme.org.uk/

- One person had been in hospital in Birmingham and their 'This is me' form was put in a drawer and not referred to. There was a butterfly at the back of his bed, however he was repeatedly asked, by his Consultant, 'how do you feel compared to yesterday?' His reply was always 'I don't know I don't remember yesterday'.
- A couple said that, while they were happy with the operation at RJAH, they were distressed by the lack of awareness of dementia despite completing a form about his history at an outpatient appointment. Throughout his stay on the ward his wife had to repeatedly explain his condition which they found "embarrassing".
- Another person told us that the Butterfly symbol worked very well whilst in hospital for a knee replacement operation in Robert Jones and Agnes Hunt Hospital (RJAH). However this did not link through to booking appointments and the outpatient appointment itself.

One person told us:

- "They put a butterfly above the bed [in the hospital] but that was it."

Support for families/ carers

We spoke to 49 carers across the focus groups and asked

- As a family member what support have you received?
- What support would you like to help you stay well?
- What information has been made available to you and has it been useful?

We heard that there is a massive need for ongoing information, practical help and support and respite for carers.

- "Carers and patients need practical support, not policy."
- "Someone you can ring in a crisis for help and advice, not just through the week, but out of hours and weekends"

Carers told us that a lot of what they know they are learning from groups and the experiences of others. One person told us:

- "It would be nice to have someone come and tell you that you are doing the right things"

People welcomed the support provided by Admiral Nurses, not just to the person with dementia but the family unit.

- "Admiral nurse has been wonderful."

However, other people felt that not everyone receives the same level of support:

- "I feel like people who live in other areas are getting different levels of support [sometimes better]"
- "Should be more support, no one prepares you for the reality you will leave with a long term bereavement. More should be offered, what would happen to her if something happened to me?"

People told us that carers needed someone to come and help who could:

- "Help with tasks like cleaning in the home, chat with person with dementia and carer, and stay whilst the carer goes out for short period."

Particularly if there are no friends or family nearby.

People told us that ongoing, regular respite is needed:

- "Respite care is very important – particularly like a local care home where someone could be dropped off in the morning and then collected after lunch."
- "The only respite we've been offered if some a few days to a week, as a one off. But what we need is ongoing support for a few hours a week"

At one focus group we heard that consistent support to give carers free time for themselves would be the biggest help. They also agreed that being offered support, rather than having to ask all the time, would be helpful.

- "Planning who to ask for help can feel like a marathon sometimes"

Common themes from the questionnaire

The responses to questions in the questionnaire around the quality of support that respondents had experienced, what they felt could be improved and what they felt the NHS could provide showed some common themes. These themes have been collated to indicate the areas of support that respondents commented on most. A full count of the themes is in Appendix 2 along with the question answers on which they are based (questions 6b, 13, 14, 18b, 19b, 25, 26).

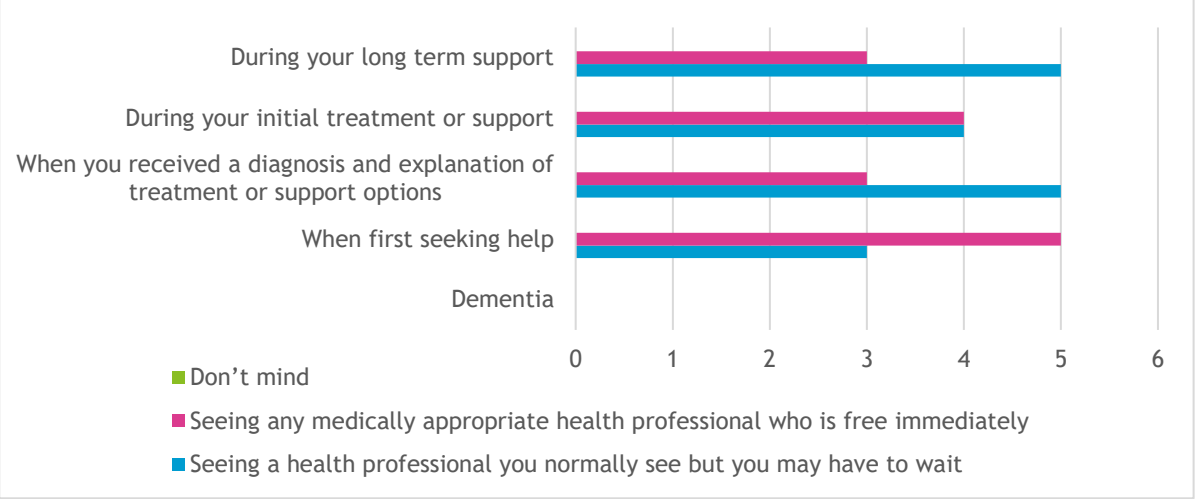
The two main themes from the questionnaires were:

1. **Support for carers** – Two respondents identified the lack of resources to meet the needs of carers as an issue
2. **Information and advice** – Two respondents called for more information and advice; "my son got a diagnosis and that was it, I have no idea what to expect or what help we can get", "more specialist advice

Multiple Conditions

Five people who completed the questionnaire had additional conditions and two of those felt that it made getting support harder, two thought it made no difference and it was not applicable to one.

- What is most important to you at each stage of your care?



Prevention and/or early intervention

Questionnaire responses

When asked about the time people had to wait for their initial assessment or diagnosis two people described it as 'Ok' and seven as 'slow' or 'very slow'.

Focus group findings:

At a focus group we were told that work should be done to raise awareness of dementia so that people feel better prepared. This is life changing for the patient, their families and carers:

- "All it takes is one person, one pathway to have guided me on where to go and which support we would need. One point of contact would have helped us all"

Preventing hospital stays:

At a focus group in Ludlow, one carer had recently experienced the Integrated Community Services (ICS) Team (made up of staff from the Community Health Trust and Shropshire Council). This worked extremely well after her husband had fallen and had a urinary tract infection. A social worker visited and put in a package of care for two weeks, which included getting walking aids and carers. More help was offered that the carer decided to accept. They accepted morning and evening daily visits. It was "wonderful" to have the package provided rather than her trying to piece it together and seek out all the services they needed herself. This helped reduce her stress and she was pleased that a hospital stay was avoided. This was exactly what she needed.

Links with other related work

- **'Dementia in Shropshire and Telford & Wrekin'**

Our findings here reflect those issues highlighted by a survey completed by the Dementia Action Alliance in Autumn 2018. The most frequently mentioned areas were:

- General Practice
- Hospital care
- The needs of unpaid care givers
- Social inclusion and activities

The DAA found that:

> 'Regarding General Practice, issues included difficulties making appointments, lack of continuity of care, lack of regular reviews, and staff not understanding dementia'.
>
> 'Unpaid care givers told us they do not receive the support they need to remain strong and healthy, and to have the chance to live their own lives'.
>
> 'Respondents strongly voiced the need to maintain social engagement through activities and groups that are dementia friendly and inclusive'.

This study also highlights the essential nature of peer support and the benefits that are gained through social activity.

Hospital admissions and outpatient appointments were also raised within this report and the lack of staff understanding of how to care for someone who is living with dementia.

- **Healthwatch Shropshire Enter & View Reports to Care Homes registered by the CQC as providing dementia care**

- **Healthwatch Shropshire Enter & View Summary Report 'The NHS Accessible Information Standard in GP Practices' (2018)**

All published on Healthwatch Shropshire website.

These reports support what the DAA survey says, and what we have heard, about the importance of a safe and 'Dementia Friendly' environments for people living with dementia and their carers. One of the DAA conclusions is that 'Shrewsbury and Telford Hospitals NHS Trust should adopt and implement the Dementia Friendly Hospitals Charter' and that GP surgeries should work with the DAA to become Dementia Friendly. The Healthwatch Shropshire report into the NHS Accessible Information Standard in GP Practices also recommends that those people working to support people with dementia and their carers are trained in the requirements of the standard and information is available in a range of formats to make sure it is easy to read and understand.

Summary

Our findings show that what matters most to people in Shropshire, Telford & Wrekin who are living with dementia and their carers is:

1. **Receiving timely, on-going, reliable information**, including:
    - Information about the diagnosis and on-going support available, e.g. for incontinence
    - Information about local support / social groups (either dementia friendly or specifically for those with dementia and their carers), help and advice about using public transport
    - Practical information, e.g. wills and probate, mental capacity and Power of Attorney, driving and the DVLA
2. **Support for carers**, including:
    - Weekly, planned breaks from caring responsibilities while their loved one is cared for in a safe environment, e.g. Day centre, 1:1 care at home
    - Having their concerns heard and responded to, e.g. around diagnosis, the need for help
    - Support for their own emotional health and wellbeing, e.g. emotional support and reassurance that what they are doing is the best for their loved one
3. **Access to and on-going support for the person with dementia and their carer**, including:
    - Seeing the same GP
    - Priority GP appointments, longer appointments, in particular for emergencies
    - Crisis support out of hours and at weekends
    - Help to link in with other services and information about the support available, possibly from a named link worker
    - A consistent approach to identifying, recording, flagging and sharing the needs of people with dementia and their carers to prevent repetition, in line with the NHS Accessible Information Standard
    - Consistent Memory Service provision across the County
    - Effective and consistent use of Care Plans, 'This is me' and the Butterfly symbol

Improving support for people with learning disabilities or autism

Overview

More than 1.2 million people in England have a learning disability and face significant health inequalities compared with the rest of the population. **Autism is a lifelong condition and a part of daily life for around 600,000 people in England.** It is estimated that 20-30% of people with a learning disability also have autism.

On average, adults with a learning disability die 16 years earlier than the general population - 13 years for men, 20 years for women. People with severe mental health illnesses tend to die 15-20 years earlier than those without.

In 2017, the Learning Disabilities Mortality Review Programme (LeDeR) found that 31% of deaths of people with a learning disability were due to respiratory conditions and 18% were due to diseases of the circulatory system.

Since 2015, **the number of people in inpatient care has reduced by almost a fifth** and around 635 people who had been in hospital for over five years were supported to move to the community. However, this has led to greater identification of individuals receiving inpatient care with a learning disability and/or autism diagnosis, so increasing the baseline against which reductions are tracked

The Long Term plan focuses on three main areas:

- Identification and recording;
- Health promotion and screening;
- Personalised support, including moving care closer to home.

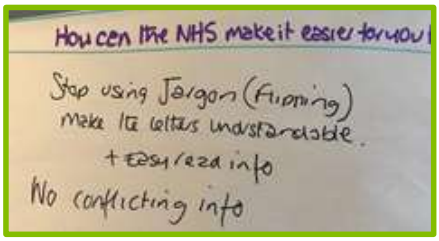
Questionnaire Respondents

Learning Disabilities
In the questionnaire about NHS support for specific conditions 19 people, ten from Shropshire and nine from Telford & Wrekin, told us about their experiences of support for learning disabilities.

Autism
In the questionnaire about NHS support for specific conditions 11 people, three from Shropshire and eight from Telford & Wrekin, told us about their experiences of support for autism.

Focus Groups

Taking Part, the Independent Service for people with Health and Social Care needs in Shropshire and Telford & Wrekin, facilitated focus groups across both areas. They spoke to 58 people, 48 in focus groups and ten in one to one sessions. Of the 48 people in the groups, there were 42 people with learning disabilities, four with autism and two with both. Eighteen people reported having other long-term conditions.

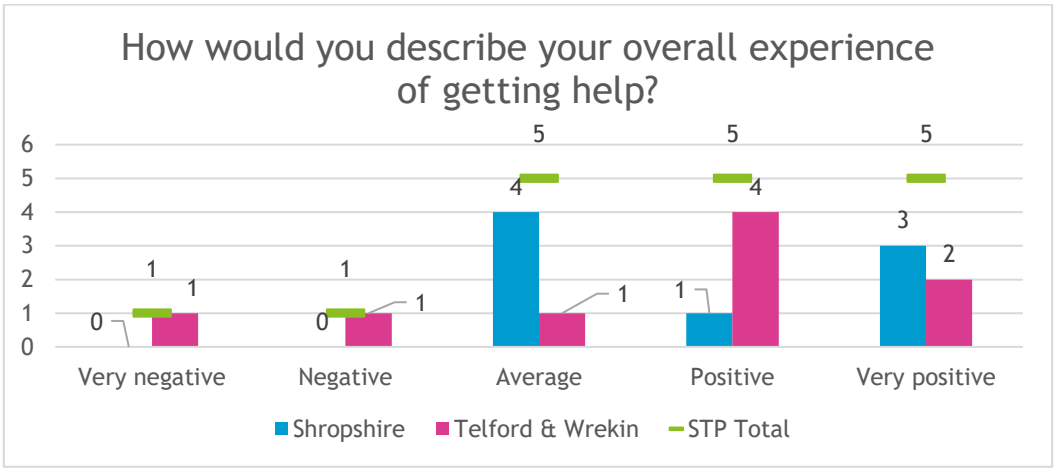


Overall Experiences

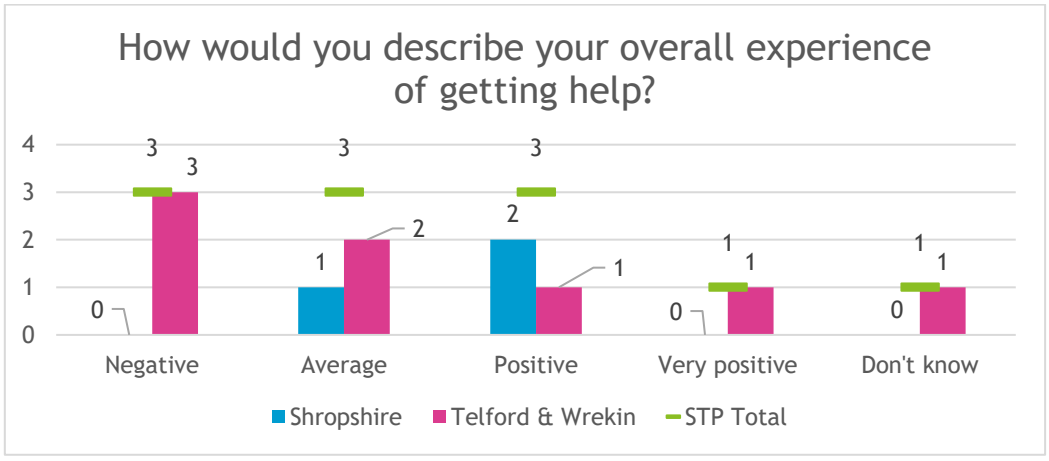
Getting Help

Questionnaire respondents

Learning Disabilities



Autism



Communication

Learning Disabilities

When asked if people received timely and consistent communication seven of 17 respondents felt they did, five they did 'somewhat' and five that they did not.

The Expert by Experience focus group outlined the need for clear communication:

- Don't assume I understand because I say I do, reflect /check.
- Better training for health workers.
- Use easy read information, letters and leaflets.
    - "Both times they spoke to my Mum more rather than me"
    - "Problems understanding him because of his accent, but he repeated himself"
    - "Understand that we can't always read/understand side effects" [of medical treatment]
    - "Easy read information is so important"
    - "No conflicting information"
    - "Stop using jargon"
    - "Health people need training…train more doctors on awareness" [of disabilities]
    - "Reception at hospital needs to be better- needs better training"
    - "Train medical people about MCA. They don't understand it properly"

Autism

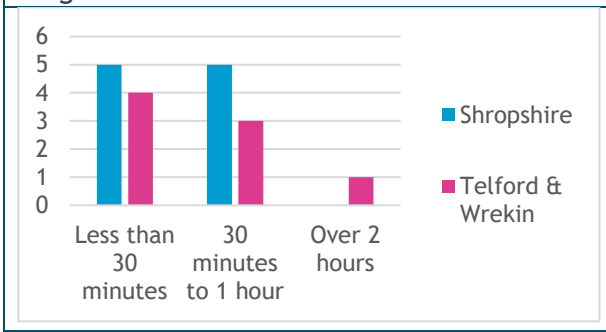
When asked if people received timely and consistent communication four people felt they did, four they did 'somewhat' and one that they did not.

Transport and Travel

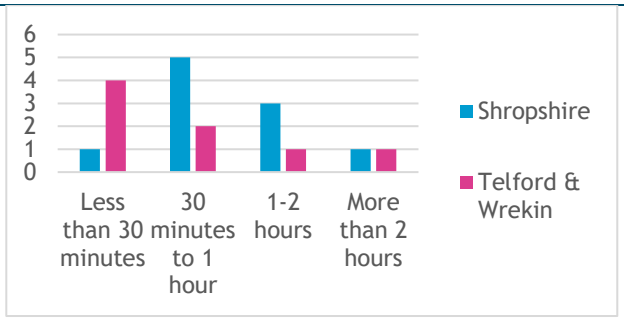
Learning Disabilities

All respondents main means of transport was their own or somebody else's car.

How much time would you be willing to travel for to receive a quick and accurate diagnosis?

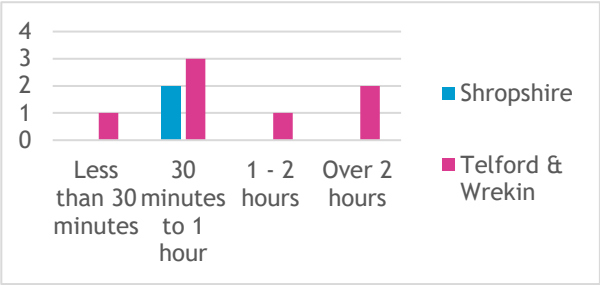
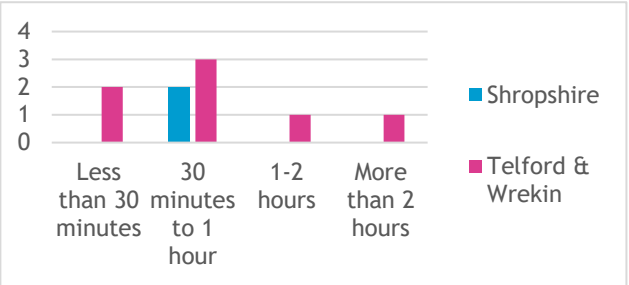


How much time would you be willing to travel to receive specialist treatment or support?



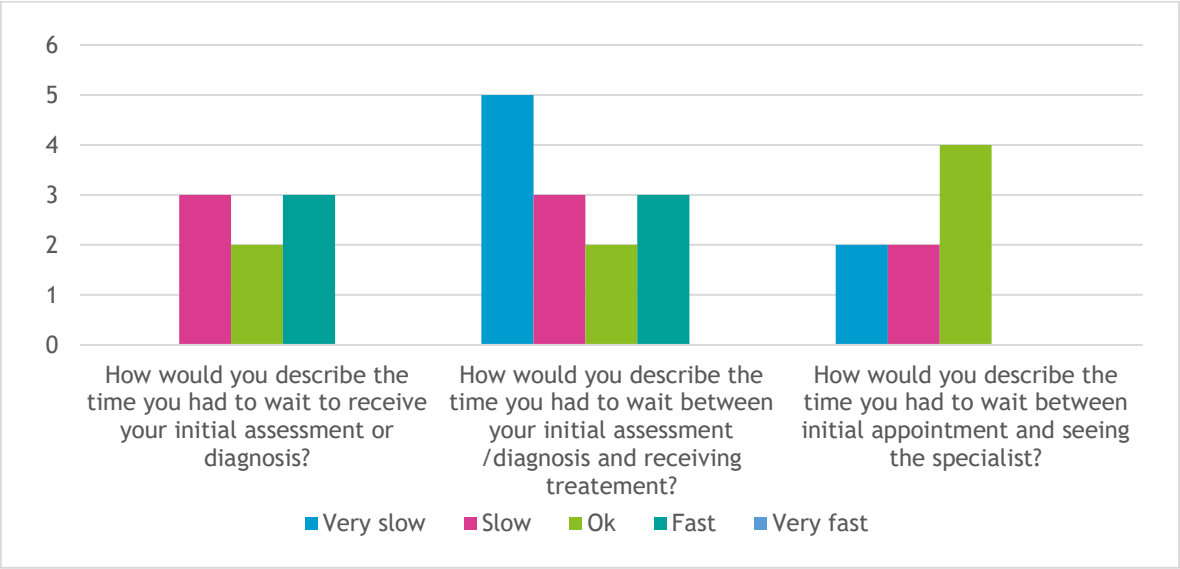
Autism

Most respondents main means of transport was their own or somebody else's car, one person used a taxi.

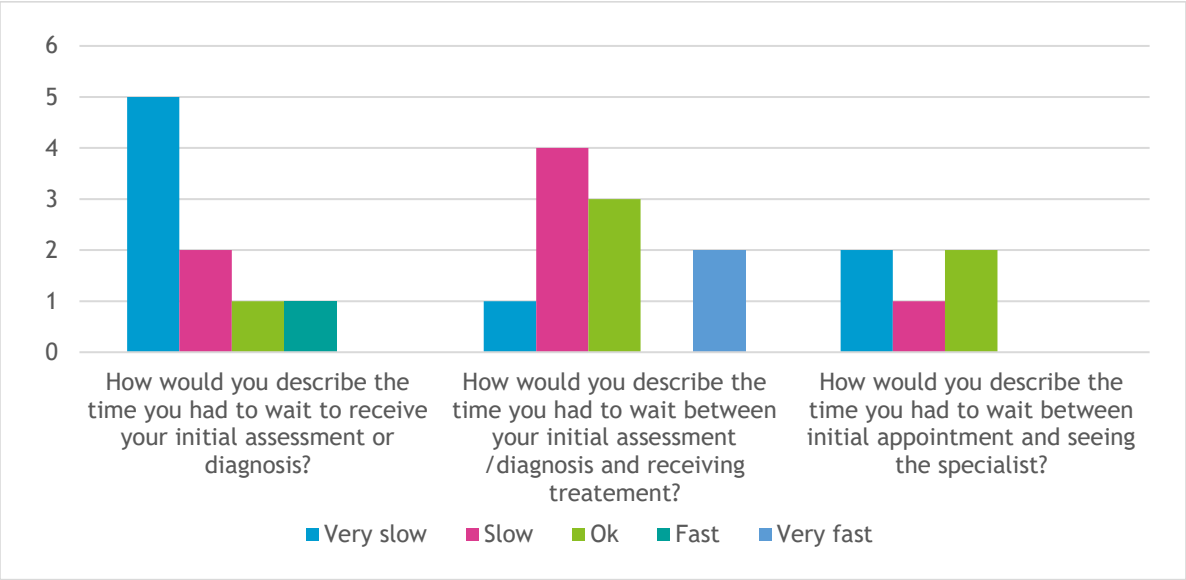
How much time would you be willing to travel for to receive a quick and accurate diagnosis?	How much time would you be willing to travel to receive specialist treatment or support?
	

How would you describe the time you had to wait?

Learning Disabilities



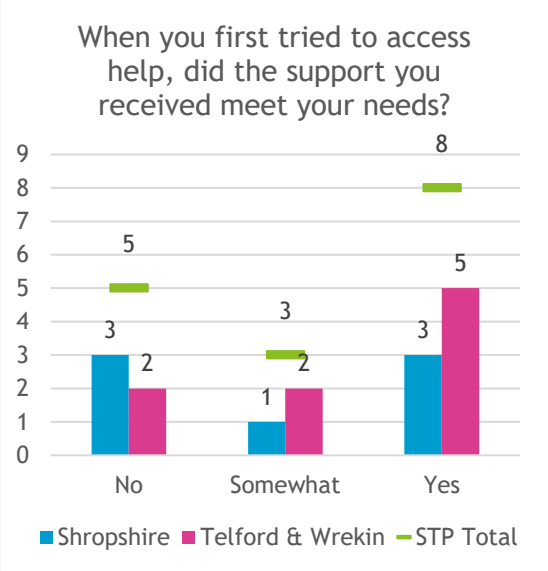
Autism



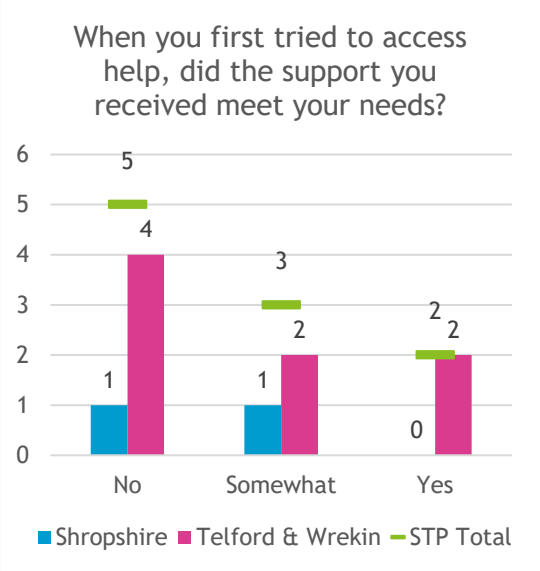
Assessment, diagnosis and treatment

Questionnaire respondents

Learning Disabilities



Autism



Focus group findings

As well as the need for clear communication the Expert by Experience focus groups outlined these key elements:

- **Consistency, access to the same doctor** is vital. Know me well; know me when I feel well, know what's normal for me. Parity across the county with Annual Health Checks.

- "I have had to wait 1 ½ hrs (waiting time) for my doctor, but they are good if I can have my own doctor."
- "I don't get to see my same GP every time, and that's not good."

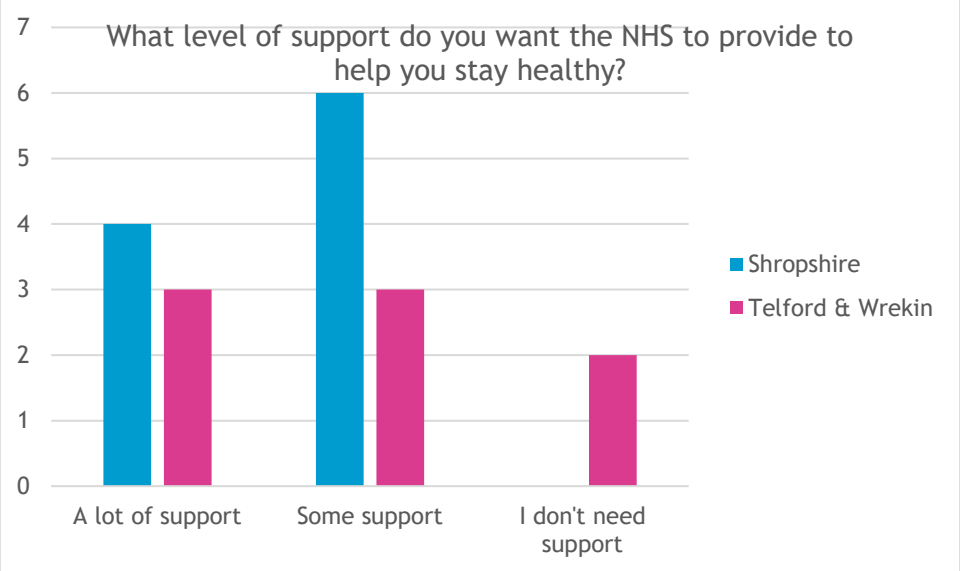
- **Compassion**, understand that I am a person not a 'condition' and do not let my disability overshadow other potential conditions.
  - "Sometimes the receptionists ask too much [personal info]
  - "They [medical staff] do things automatically; we need things done step by step, makes it less scary."
  - "If you don't understand our conditions, please research it first"
  - "Don't think [assume] we all can use computers"
  - "We'd need a lot of support with this" [accessing/managing care planning and online appointments etc.]
  - "Keep us informed"
  - "Come to us" [come into their world Day Services etc. when talking about prevention work check-ups/training/awareness work etc.]

The provision of ongoing care and support

Questionnaire responses

What level of support do you want the NHS to provide to help you stay healthy?

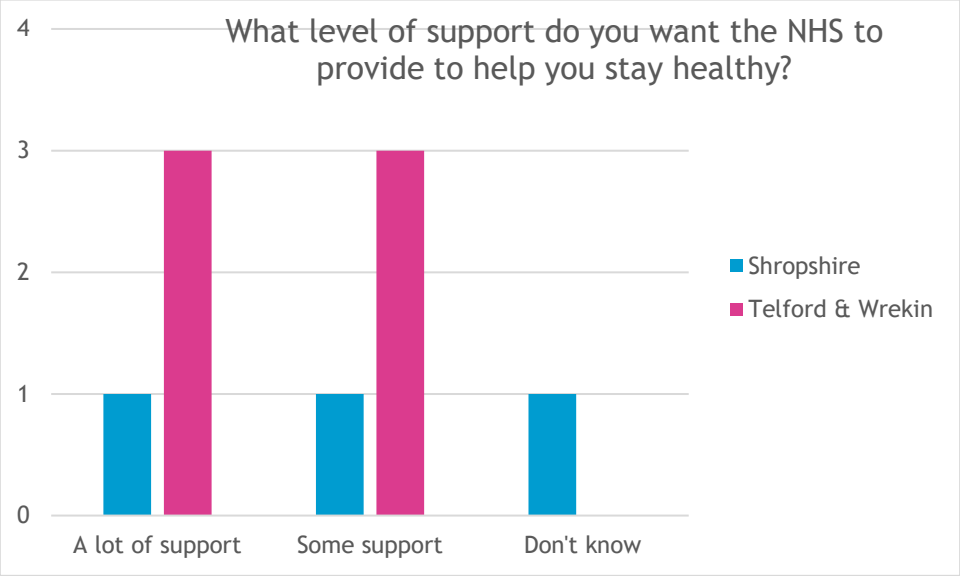
Learning Disabilities



After diagnosis three people found it Easy or Very easy to access on-going support, three found it Difficult or Very Difficult and five said it was OK.

When asked if the support options offered met expectations, eight people replied that it did, two replied 'somewhat' and four replied that it did not.

Autism



After diagnosis one person found it Easy or Very easy to access on-going support, two found it Difficult or Very Difficult and four said it was OK.

When asked if the support options offered met expectations, three people replied that it did, two replied 'somewhat' and four replied that it did not.

Common themes

The responses to questions around the quality of support that respondents had experienced, what they felt could be improved and what they felt the NHS could provide showed some common themes. These themes have been collated to indicate the areas of support that respondents commented on most. A full count of the themes is in Appendix 2 along with the question answers on which they are based (questions 6b, 13, 14, 18b, 19b, 25, 26).

Learning Disabilities

Themes identified included:

- **Communication with the patient** – Four people identified this as important, e.g. "Good thorough H Check at the doctors, [they] are good, they sign, I can understand / they take time", "Keep checking up on me. Make sure I am ok"
- **Information and advice** – Four people mentioned this, e.g. "My son got a diagnosis and that was it I have no idea what to expect or what help we can get", "More specialist advice"

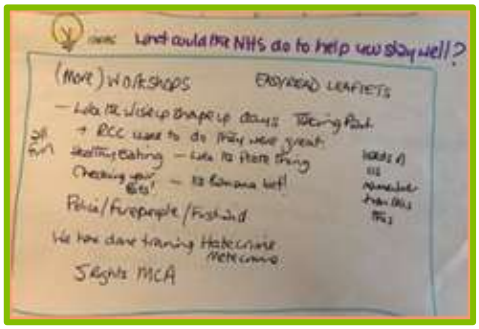
Autism

Themes identified included:

- **Information and advice** – four people told us how important this is, e.g. "We spoke to our health visitor about it and she gave us lots of information and places to reach out too", "Learning help about dangers, road safety. Maybe workshops for carers/parents. Expert help on foods with sensory issues."

- **Access to specialist service** – three people highlighted this importance of speak to the right person at the right time, e.g. "Felt like I was passed around from person to person", "I had many appointments before being given support. I saw so many different people"

Focus group findings



Appointments

The focus groups highlighted the difficulty in making appointments with doctors, having to call at a certain time and not being able to get through to the surgery. Only a few people are able to deal with this, with carers going to the doctors to book appointment in person.

- "Making appointments is difficult, you have to ring, say at 8 o'clock and you can't get through, it's hard to get an emergency appointment"
- "Not easy to get an appointment, the set time to ring is stupid, you can't get through, it needs to be sorted"
- "My carer goes down [to the surgery] it's the only way [to book an appointment in the end]"

Carers

The importance of carers was apparent from the focus groups feedback. Vital for people to be able to access health services, most people need ongoing support from a person that they trust for practical reasons, i.e. travel, following directions, reading letters etc. Also for emotional support and help with understanding processes and choice making.

- "Even now I am constantly misunderstood by [medical staff]" [This comment, when talking about why having someone like a carer with you is vital, someone who the person can trust and knows well]
- "After my experience [of the doctors] I felt I had to take someone with me the next time"
- "It's hard to go to my doctors on my own" [Even independent people said they wouldn't go alone]
- "We need to get supported to go to things like doctors"
- "It's most important for us to have carers with us, someone we can trust; talk to my carer so they can help to explain to me, but talk/explain to me too."

Most people spoken to in the focus groups 'do not differentiate health care services, the NHS including primary care is one thing, you are ill/had an accident you need help to get better, who the people work for (that are helping you) are not so important or relevant.'

	Do you get good support from your doctors?			Do you get good support when you go into hospital?			Do you get good support when you see a specialist?		
	✓	–	✘	✓	–	✘	✓	–	✘
Shropshire	9	8	3	5	2	1	2	2	1
Telford and Wrekin	14	1	1	4	1	1			
Total numbers	23	9	4	9	3	2	2	2	1

When people could identify that they had been to a specialist they said:

- "Got support from my family"
- "The specialist explained the whole condition to me"
- "Yes they told me what was going to happen"

The provision of ongoing care and support	As you get older is it important to stay in your own home?			Your family get good help to support you?			Is it important to get easy ways to travel?			Your family get support when you come to the end of your life?		
	✓	–	✘	✓	–	✘	✓	–	✘	✓	–	X
Shropshire	28			28			28			28		
Telford and Wrekin	12	2		14			14			14		
Total numbers	40	2		40			40			40		

The provision of ongoing care and support	Is important to see the same doctor?			To get appointments easily?			Do you feel you have enough time talking with the doctors or nurses?			Do you want test results sent to your home?		
	✓	–	✗	✓	–	✗	✓	–	✗	✓	–	✗
Shropshire	28			28			18	8	4	28		
Telford and Wrekin	20			20			12	6	2	20		
Total numbers	48			48			30	14	6	48		

Multiple Conditions

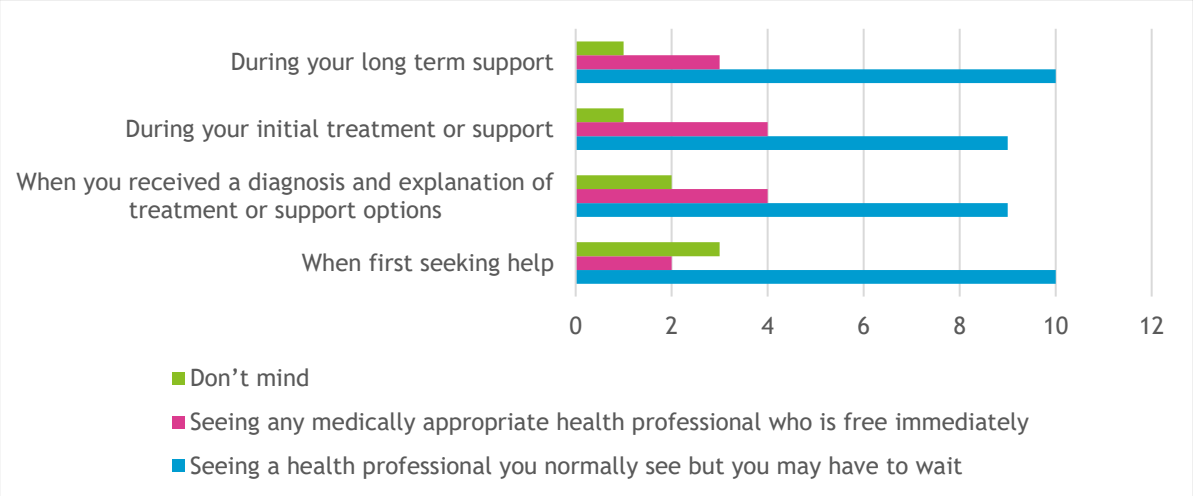
Some people who completed the questionnaire identified themselves as also having other conditions:

Learning Disabilities
Seven people had additional conditions and six of those felt that it made getting support harder, and one thought it made no difference.

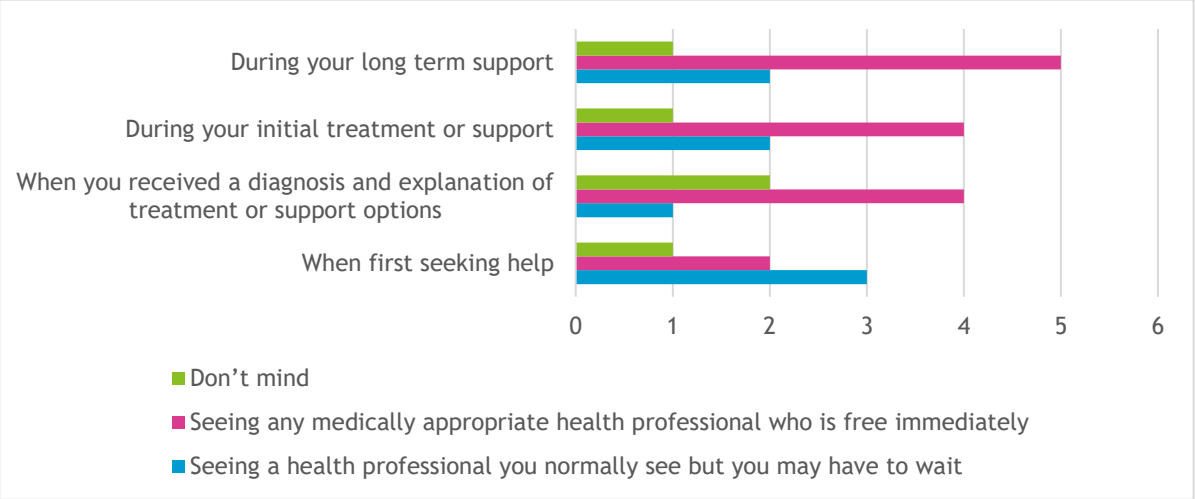
Autism
Three people had additional conditions and two of those felt that it made getting support harder, and one thought it made no difference.

What is most important to you at each stage of your care?

Learning disabilities



Autism



Prevention and/or early intervention

Questionnaire responses

Learning Disabilities
When asked about the time people had to wait for their initial assessment or diagnosis five people described it as fast or very fast, two as Ok and three as slow or very slow.

Autism
When asked about the time people had to wait for their initial assessment or diagnosis three people described it as fast or very fast, one as Ok and seven as slow or very slow.

"Young people with Autism, if very severe, will often get help but if less severe or high functioning, then no service is available.

There also continues to be a huge difference between young people transitioning from children to adult services. Prevention and early intervention were identified for young people as a key factor. Putting in services earlier may helped prevent young people becoming an adult with more complex mental health problems."

Unmet Needs in Telford and Wrekin, Initial Review Healthwatch Telford & Wrekin

Focus group findings

- *'What could the NHS do to help you stay well?'*

The focus groups highlighted the need for:

- Easy read information
- The importance of the annual health check
- Health workers communicating in an understandable way

Making it easier to make appointments was part of the feedback as was the value of workshops to raise not only health awareness but also awareness of other safety issues, for example crime and fire prevention.

'Taking Part' added that "the Expert by Experience (Shropshire) group have fed-back their concerns, which are echoed by their peers in Telford & Wrekin, consistently on health service matters many times in the last few years. Through for example:

- the annual Shropshire, Telford and Wrekin Health and Social care self-assessment Framework
- Government Green papers, e.g. Making Lives Better
- co-production for the Patient Passports and easy read information
- events and campaigns including Health Heart Humour and Hats Off/Ask the Question.

None of the people we spoke with could navigate all the health service processes without significant help/support, even for people who are very independent (i.e. do not have formal health or social care packages of support around them). There is a reliance on informal support, families and friends, but crucially also advocacy groups, peer groups and where available housing associations. As cuts, tighter budgets and contacting criteria impacts there is decreasing support.

So the Experts by Experience wonder and would like to say to the NHS,

"You already have the answers please act upon them.

- Rather than all these expensive surveys and reports use the money to support/maintain and develop the support mechanisms around people with needs, this will have better outcomes for us.
- Help to make sure that our carers are supported and keeping themselves healthy.
- Keep supporting groups and organisations like Taking Part who help many people formally with issue-based and citizen advocacy support. All the staff help informally; we can rely on them for help e.g. reading/understanding letters from doctors/hospitals. Very importantly around prevention work they have helped people to understand the benefits of healthy eating, to having a patient passport, to supporting expert by experiences to represent their peers on important groups such as the LeDeR (NHS England Learning Disability Mortality Review) programme steering group and many things in between.

Work like this is getting lost and must be the same all over the UK, the EE group feel that they are being forgotten often lumped together with people who are autistic or have mental health issues."

Summary

Our findings show that what matters most to people in Shropshire, Telford & Wrekin who have learning disabilities and autism is:

- **Clear communication with health workers**, including easy read information.
- **Consistency of health care professional** e.g. the same doctor

    - This was highlighted by all members of the focus groups, both those with learning disabilities and those with autism. However, those with autism who filled out the questionnaire indicated that it was less of an important factor in the various stages of their support.

- **Compassion**, understand that I am a person not a 'condition' and do not let my disability overshadow other potential conditions.
- **Easy access to appointments**
- **Carers who I know and I can trust**
- **Timely, on-going, reliable information and advice for carers**
- **The importance of the Annual Health Check**

A theme raised by respondents with autism indicated the importance of seeing a specialist at the initial stages of assessment.

Supporting people with long term conditions (e.g. diabetes, arthritis)

Overview

Many people are affected by having long-term conditions – which will impact on their physical and / or mental health - with some people facing the challenges of dealing with two or more conditions at the same time. Research by the Health Foundation found that around one in 12 people have four or more conditions – an estimated 4.7 million people in England.

For example, low back and neck pain is the greatest cause of years lost to disability, with chronic joint pain or osteoarthritis affecting over 8.75 million people in the UK. **Over 30 million working days are lost due to musculoskeletal (MSK) conditions every year in the UK and they account for 30% of GP consultations in England.** 1.7 million children have longstanding illnesses, including asthma, epilepsy and diabetes, and England lags behind international comparators in some important aspects of child health.

Compared with the general patient population, **patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease** and make more use of urgent and emergency care.

Over the coming decade, the NHS will inevitably need to look after more people, with greater needs, as a result of our growing and ageing population. For example, **the number of people over 85 is projected to increase from 1.3 million to 2 million** and they will need appropriate support. The growth in average costs with age is projected to increase at a faster rate, due to the growing number of long-term conditions and particularly multiple conditions.

The Long Term Plan identifies a number of inter-related approaches:

- Use of digital technology;
- Service redesign (the right care at the right time in the optimal setting);
- Supporting independence and self-care.

Some of the approaches relate to specific conditions whereas others will be applied more generally.

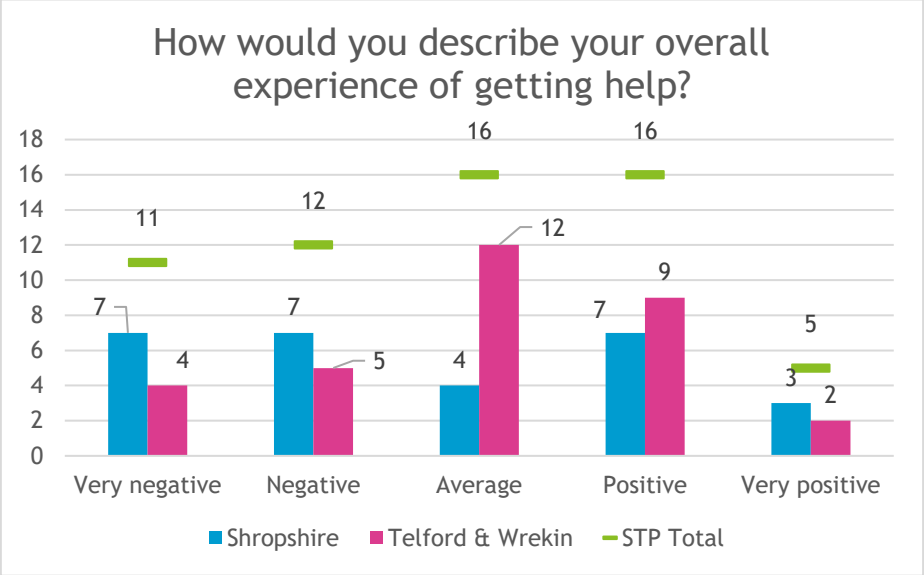
Long Term Condition Questionnaire

Respondents

In the questionnaire about NHS support for specific conditions 62 people, 29 from Shropshire and 33 from Telford & Wrekin, told us about their experiences of services for their long-term condition.

Overall Experiences

Getting Help



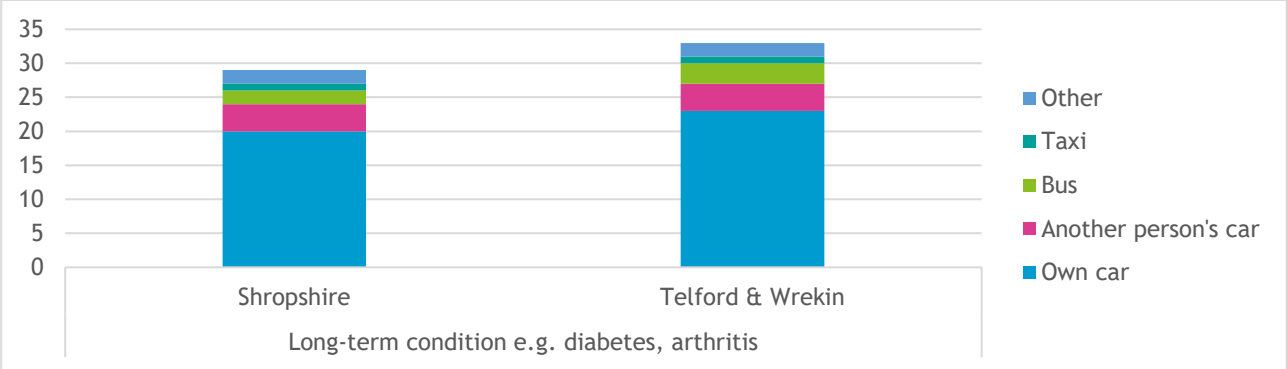
"The Shropshire Enablement team's help was invaluable as it provided many insights in how to manage the condition in practical ways as well as how to cope with the situation mentally. They also, at a later date, gave me help to learn how to use a computer in a way I could manage as I'm unable to concentrate for the length of time needed in ordinary classes. Sadly the Team no longer exists I understand…"

Communications

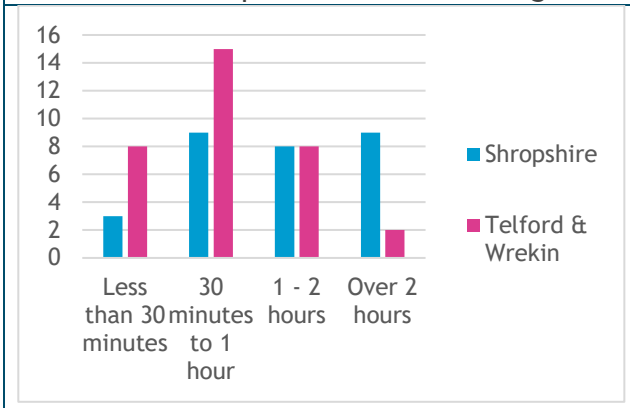
When asked if people received timely and consistent communication 12 (19%) of respondents felt they did, 12 (19%) they did 'somewhat' and 34 (55%) that they did not, four did not answer.

Transport and Travel

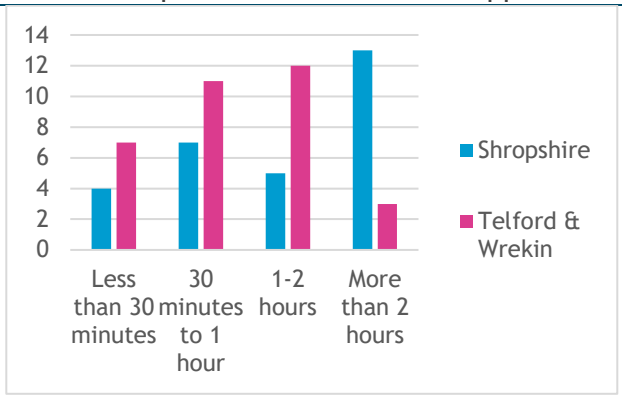
Main means of transport



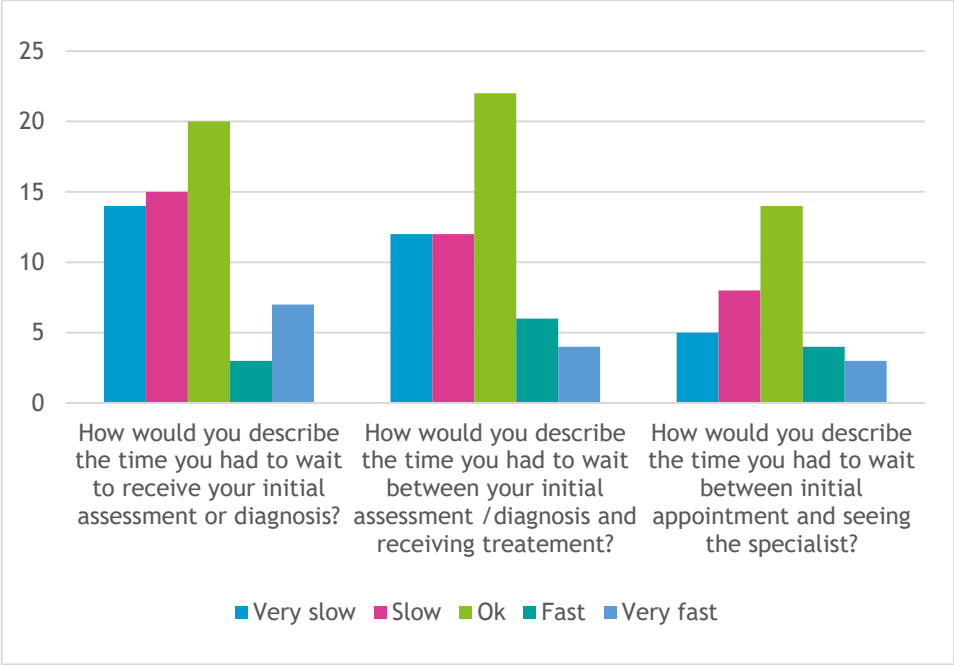
How much time would you be willing to travel for to receive a quick and accurate diagnosis?



How much time would you be willing to travel to receive specialist treatment or support?

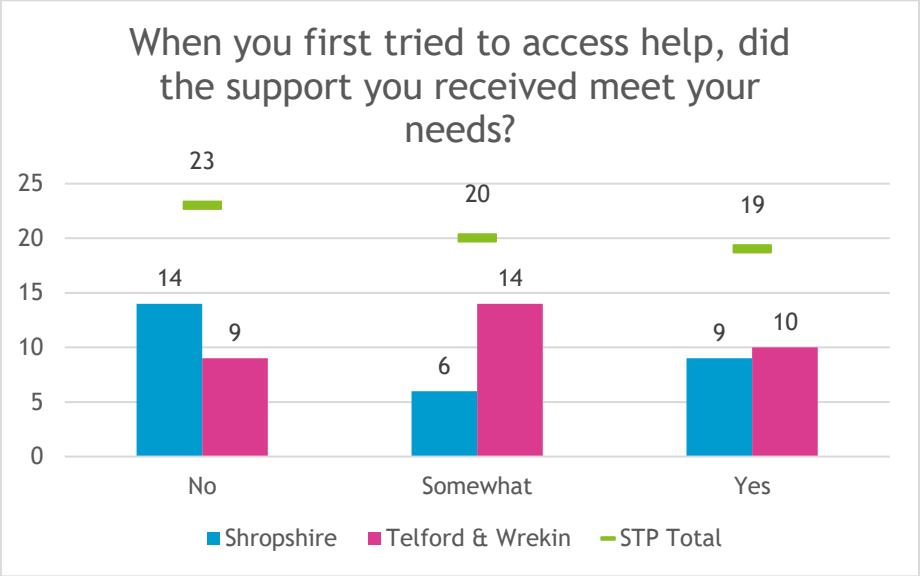


How would you describe the time you had to wait?



"Very quick follow up, due to the diagnosis of diabetes, but this was essential as we had a huge amount to learn in a very short time."

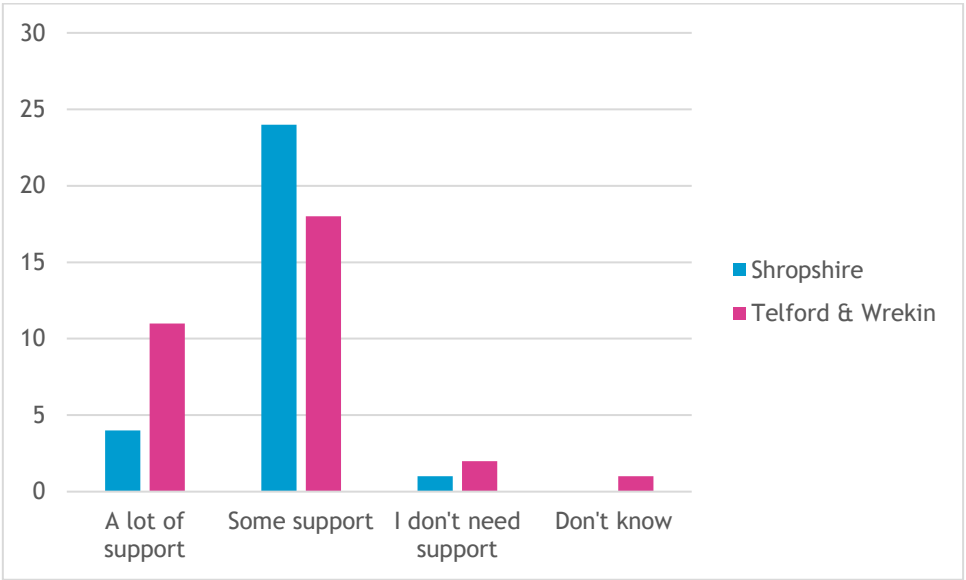
Assessment, diagnosis and treatment



"It could have been improved by more communication, not having to chase for answers and diagnosis. Going through 4 different doctors was pretty frustrating."

The provision of ongoing care and support

- What level of support do you want the NHS to provide to help you stay healthy?



After diagnosis 10 people found it 'Easy' or 'Very easy' to access on-going support, 28 found it 'Difficult' or 'Very Difficult' and 13 said it was 'OK'.

When asked if the support options offered met expectations, 16 people replied that it did, 11 replied 'somewhat' and 28 replied that it did not.

"Home visits where necessary from GP nurses who understand the condition. (and are your regular ones). Liaise with social services to help with food, cleaning etc."

Common themes

The responses to questions around the quality of support that respondents had experienced, what they felt could be improved and what they felt the NHS could provide showed some common themes. These themes have been collated to indicate the areas of support that respondents commented on most. A full count of the themes is in Appendix 2 along with the question answers on which they are based (questions 6b, 13, 14, 18b, 19b, 25, 26).

The top five themes were:

1. **Listen to me** (13 respondents), e.g. "GP could and should have paid more attention to what I was saying", "The rheumatologist I saw didn't listen and talked over me", Felt like no one believed me"
2. **Access to specialist services** (11 respondents), e.g. "Replace the missing Parkinson's nurse", "Provide more specialists in Shropshire for specialist conditions", "I had an infection in a joint where my RA was bad but on arriving there [A&E] there was not a Rheumatologist to see only an MSK consultant who had no idea about my condition at all"
3. **Communication with the patient** (10 respondents), e.g. "Shropshire must be the worst authority for lack of communication and care.", "Sometimes I get letters with results of tests and such and sometimes I don't. It is very inconsistent. I have no "care plan" as such and have no idea how things tie up with one another."
4. **Continuity of staff** (9 respondents), e.g. "Please can patients with complex long-term conditions be seen by one person so they get to know the person and are quick to notice changes", "It would be good if you could see the same clinician each time you need advice"
5. **Information and advice** (7 respondents), e.g. "Information on support services / groups would have been useful", "Education on long term conditions and impact on families", "I was not told what to expect with on-going condition"

Other themes included: Communication between staff / services and condition review / monitoring.

Neurology 'Hot Topic'

In September 2017 we focused our engagement efforts to try to understand the patient experience of neurology services in Shropshire. This resulted in the collection of 97 experiences.

The majority of the feedback came from patients with long-term conditions:

- Parkinson's
- Multiple Sclerosis
- Motor Neurone Disease.

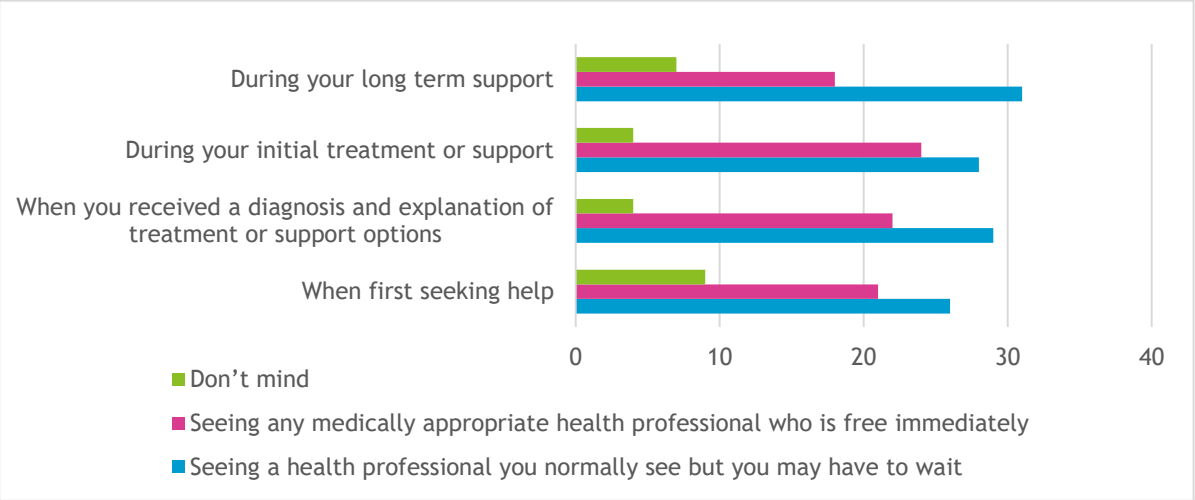
Many of the themes that came through this engagement were the same as those raised in the table above.

Read More

Multiple Conditions

Just over half, 33, of the people had additional conditions and 19 of those felt that it made getting support harder, six thought it made no difference and three thought it made it easier.

What is most important to you at each stage of your care?



Prevention and/or early intervention

When asked about the time people had to wait for their initial assessment or diagnosis 10 people described it as fast or very fast, 20 as Ok and 29 as slow or very slow.

Summary

Although this group had a larger cohort size it was a very varied 'catch all' group and therefore difficult to generalize and therefore summarize findings. However, what is noticeable for people in Shropshire, Telford & Wrekin who are living with long-term conditions is:

- In Shropshire there is a general negative reporting of the overall experience of getting help with most people answering average to very negative. The picture in Telford and Wrekin appears slightly more positive with the majority reporting average to positive experiences. The responses from Telford & Wrekin appear consistently slightly more positive throughout many of the quantitative data answers.
- Difficulties around communication is strong within the free text comments; difficulties with inter- service communication also between the person and professionals helping them. The need for access to specialist services is also high in the free text responses.
- In all phases of support and treatment this group identified it was important to see a health professional that you would normally see.
- The free text comments indicated that a leading theme was that people felt they were not listened to, especially when first seek help.

Improving mental health support

Overview

Mental health problems often develop early and, **between the ages of 5-15, one in every nine children has a mental condition**. Half of all mental health problems are established by the age of 14, with three quarters established by 24 years of age. Prompt access to appropriate support enables children and young people experiencing difficulties to maximise their prospects for a healthy and happy life. While the latest prevalence survey has shown only a modest increase in diagnosable problems since 2004 – from 10.1% to 11.2% – this overall figure includes **concerning rates of mental distress particularly amongst late teenage girls**.

Mental health support features prominently in the NHS Long Term Plan and talks about it being central to the concept of **triple integration:**

Primary/community care / specialist care

Physical health / mental health

Adults' services / children's services

The NHS Long Term Plan builds on the work done in the Five Year Forward View but sets some important new ambitions and targets.

Importantly it states that there will be investment to support this - **with mental health budgets set to grow faster than the overall NHS budget**, and children and young people's mental health services to grow even faster.

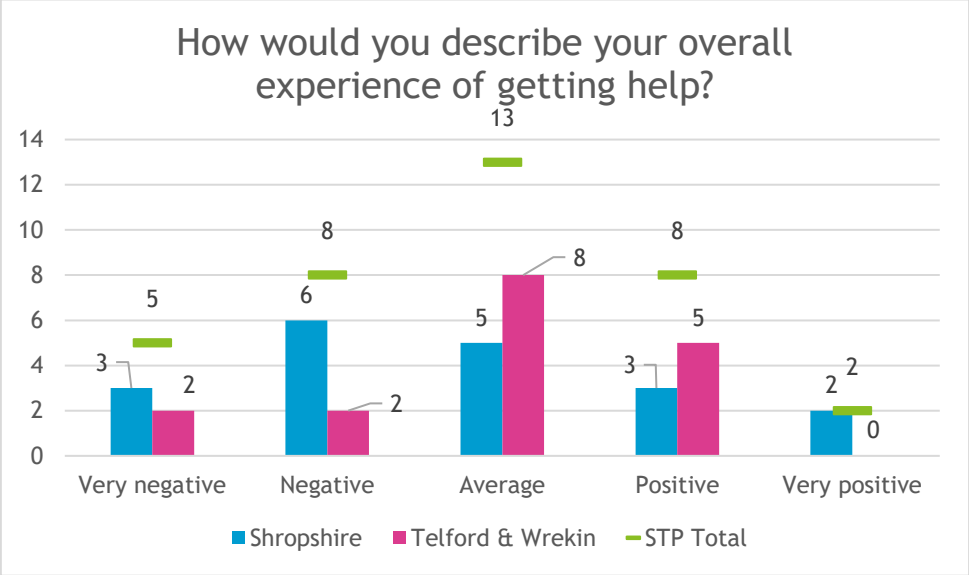
Long Term Condition Questionnaire

Respondents

In the questionnaire about NHS support for specific conditions 36 people, 19 from Shropshire and 17 from Telford & Wrekin, told us about their experiences of mental health support.

Overall Experiences

Getting Help

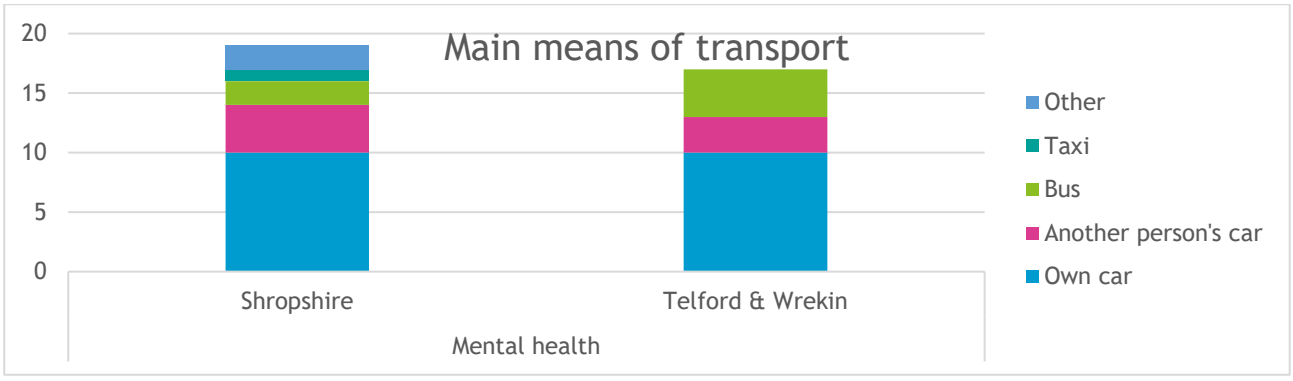


Communications

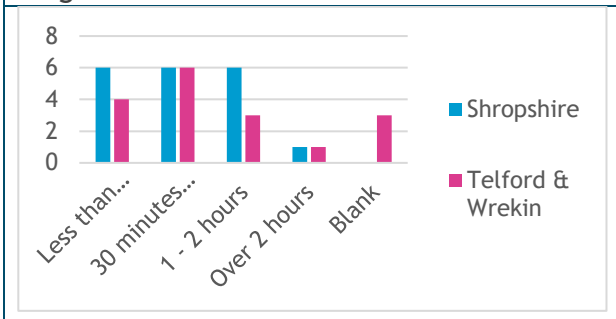
When asked if people received timely and consistent communication 11 of respondents felt they did, nine they did 'somewhat' and 15 that they did not.

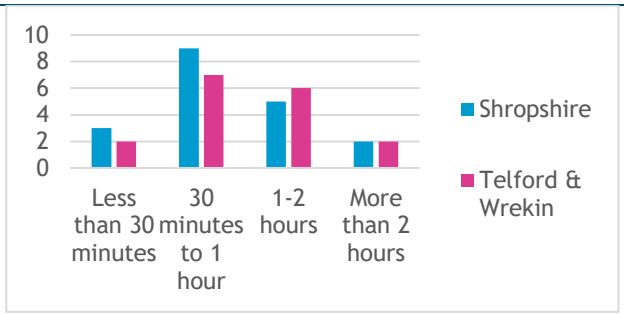
> "A lot of mixed communications between professionals. Support offered was wrong and made me worse and was judged."

Transport and Travel

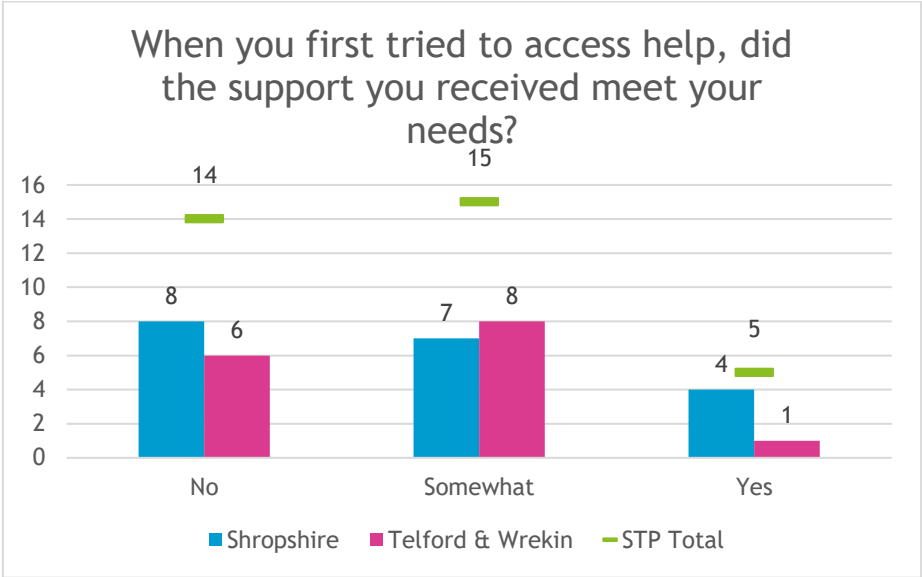


How much time would you be willing to travel for to receive a quick and accurate diagnosis?	How much time would you be willing to travel to receive specialist treatment or support?



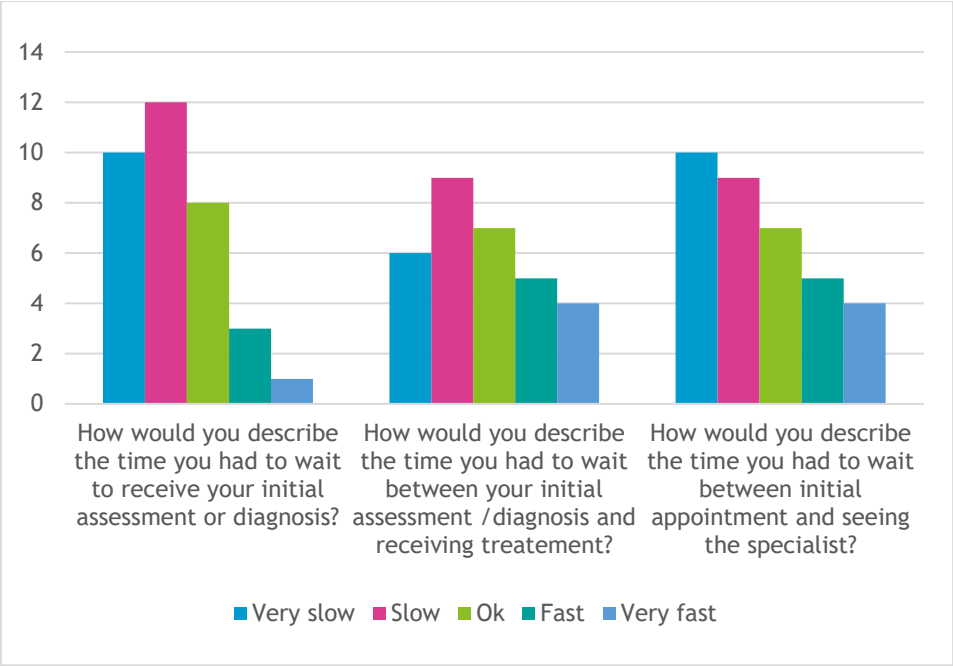


Assessment, diagnosis and treatment



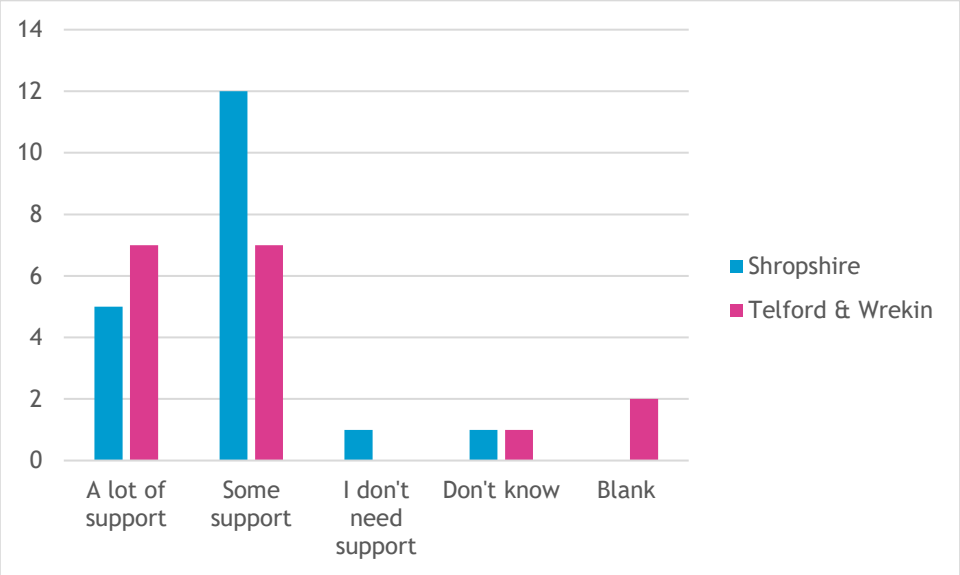
"I attended 1:1 CBT and was not offered any other kinds of support. It would have been good if there was a free App that I could have been recommended or a free book"

How would you describe the time you had to wait?



The provision of ongoing care and support

What level of support do you want the NHS to provide to help you stay healthy?



After diagnosis seven people (23%) found it 'Easy' or 'Very easy' to access on-going support, 15 (48%) found it Difficult or Very Difficult and nine (29%) said it was OK.

When asked if the support options offered met expectations, six people (17%) replied that it did, 14 (39%) replied 'somewhat' and 16 (44%) replied that it did not.

Common themes

The responses to questions around the quality of support that respondents had experienced, what they felt could be improved and what they felt the NHS could provide showed some common themes. These themes have been collated to indicate the areas of support that respondents commented on most. A full count of the themes is in Appendix 2 along with the question answers on which they are based (questions 6b, 13, 14, 18b, 19b, 25, 26).

The top themes were:

1. **Access to specialist services (5)**, e.g. "There needs to be a central task force who connect all the services and provisions together. Someone central that the families can access at all times", "I had telephone support while I waited for the help", "Face to face contact with a specialist"
2. **Information and advice (4)** e.g. "Clear information and advice that goes into the right amount of detail for the individual", "Better information and drop-in points"

Each of the following themes were commented on by three respondents:

3. **Communication with patient**, e.g. "Better communication!! I think that as so many "back office" staff have either been removed and outsourced, (e.g. appointments services) it is not unknown to receive the letter AFTER the actual appointment time!"
   Continuity of staff e.g. "See the same practitioner who is familiar with my progress."
   Access to services out-of-hours, e.g. "My friend attended counselling but found it hard to make appointments with working full time and appointments only being offered during office hours"
   Communication between staff/services, e.g. "A lot of mixed communications between professionals."
   Condition review/monitoring, e.g. "Regular three or four months check-up just to make sure all is well, so not to relapse."
   Support in the community, e.g. "GPs need to refer people to the available support groups can offer in the community."

"There is a big gap in support before people reach acute stage.

There is a real lack of services for people who are not acute but have severe problems resulting in their needs being left unmet. If they are suicidal the people can get help from Mental Health services, but this is time limited."

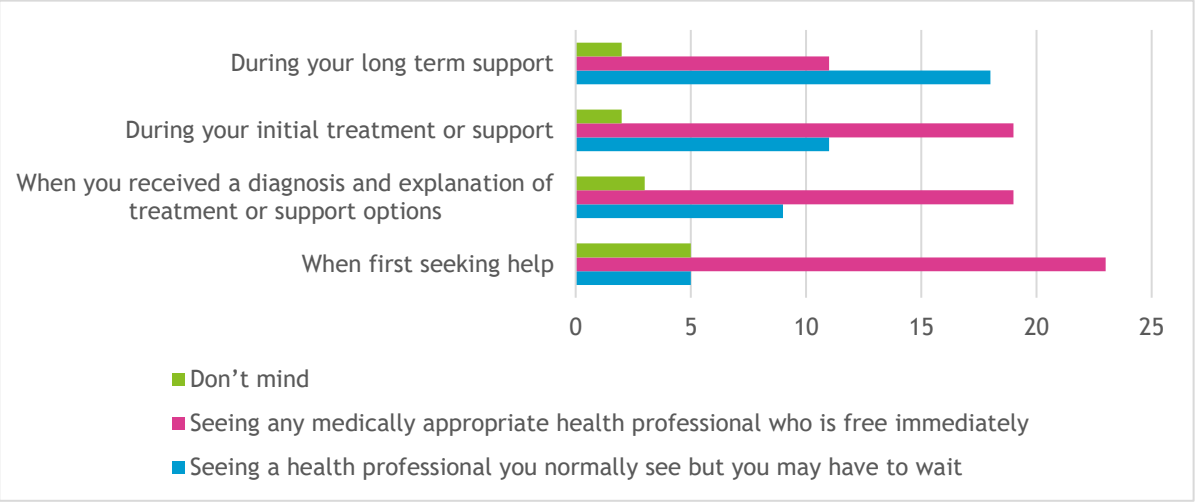
Unmet Needs in Telford and Wrekin, Initial Review Healthwatch Telford & Wrekin

Multiple Conditions

Seventeen people had additional conditions and 12 of those felt that it made getting support harder, one thought it made no difference and two thought it made it easier.

"…as a carer for a mental health patient who has a long and very complex medical/psychiatric history, I would like my needs to be taken into account when deciding my partner's treatment plan. When she is ill it puts a lot of strain on me as I have heart, bowel and other health problems which are totally ignored by the mental health services"

What is most important to you at each stage of your care?



Prevention and/or early intervention

When asked about the time people had to wait for their initial assessment or diagnosis five people (11%) described it as fast or very fast, eight (27%) as Ok and 22 (57%) as slow or very slow. Two (5%) were unsure.

Summary

With a small number of respondents, it is difficult to generalize and therefore summarize findings. However, what is noticeable for people in Shropshire, Telford & Wrekin who are living with mental health needs:

- There is a general negative experience of the overall experience and quality of treatment possible due to difficulty accessing initial help, long waiting times, poor communication, and difficulties with accessing on-going support.
- The level of perceived on going help and need of support to stay healthy is high with the majority identifying 'some' to 'a lot' of support required.
- It is important to see any appropriate health professional when first seeking help, receiving a diagnosis and initial treatment. It was only during the long-term support phase that seeing a health professional you normally see becomes important.

"I think it would be helpful if services understood that many people with mental health issues also work full-time. Having to take time off to attend appointments in the day can add to the pressure you are under (e.g. as a teacher where time off is much frowned upon) and cause you to disengage before treatment is complete or you have attended the recommended number of sessions"

Implementing cancer health and care services

Overview

Survival rates for cancer are the highest they have ever been. For patients diagnosed in 2015, one year survival was 72% – over 11 percentage points higher than in 2000.

Actions in the plan can largely be grouped into four areas:

- Prevention;
- Diagnosis;
- Treatment;
- Patient experience.

The strongest emphasis is on diagnosis as this can have the greatest impact on improving outcomes.

The NHS Long Term Plan sets a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients meaning that 5,000 more people each year will survive their cancer for at least five years after diagnosis.

The plan identifies specific activities around children's cancers because although survival rates for children with cancer have doubled over the past 40 years, mortality has fallen for other conditions and cancer is now the biggest cause of premature death among children and young people aged 5-14 years.

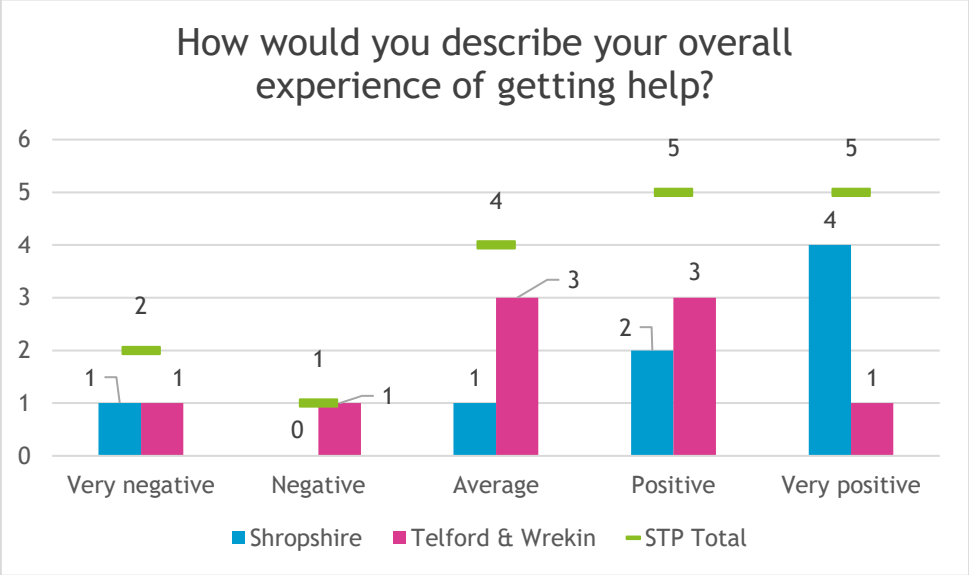
Long Term Condition Questionnaire

Respondents

In the questionnaire about NHS support for specific conditions 17 people, eight from Shropshire and nine from Telford & Wrekin, told us about their experiences of Cancer services.

Overall Experiences

Getting Help



Communications

When asked if people received timely and consistent communication ten of the 17 respondents felt they did, five that they did 'somewhat' and two that they did not.

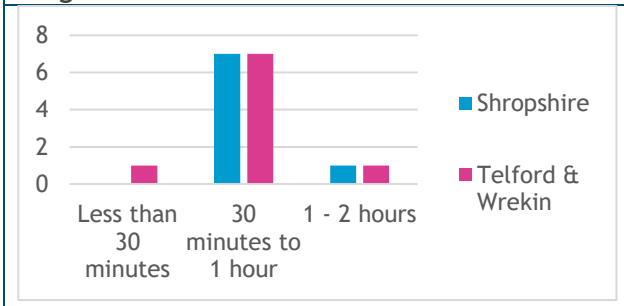
Three people commented on problems with communication. Examples:

- "Initial diagnosis was not provided carefully enough"
- "At the time was completely overwhelmed by the professional jargon"

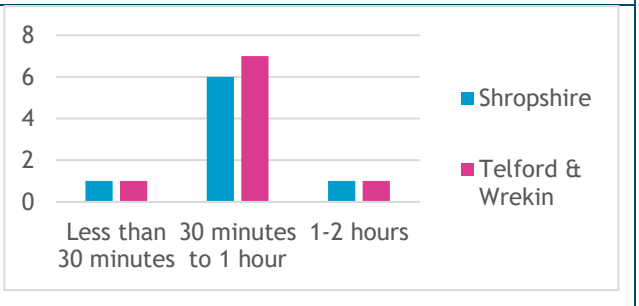
Transport and Travel

All respondents main means of transport was their own or somebody else's car.

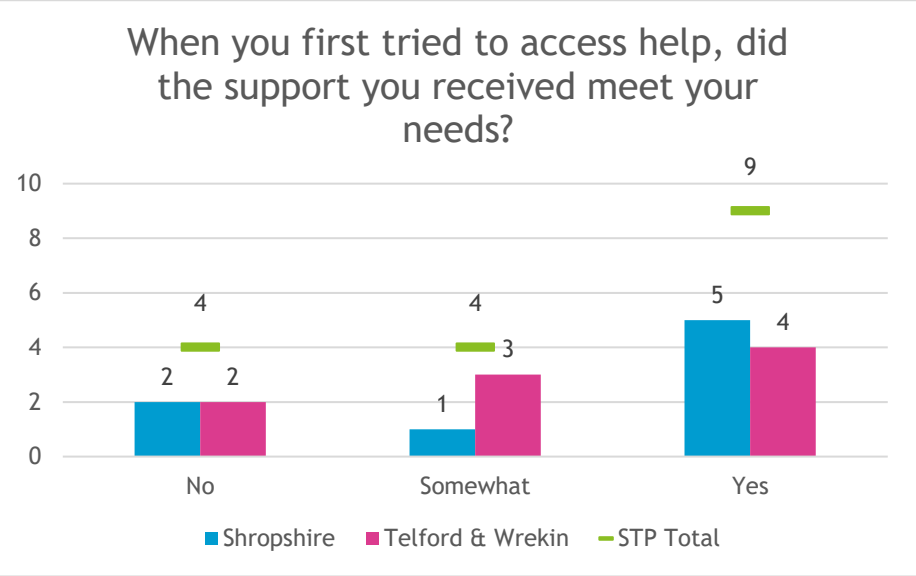
How much time would you be willing to travel for to receive a quick and accurate diagnosis?



How much time would you be willing to travel to receive specialist treatment or support?

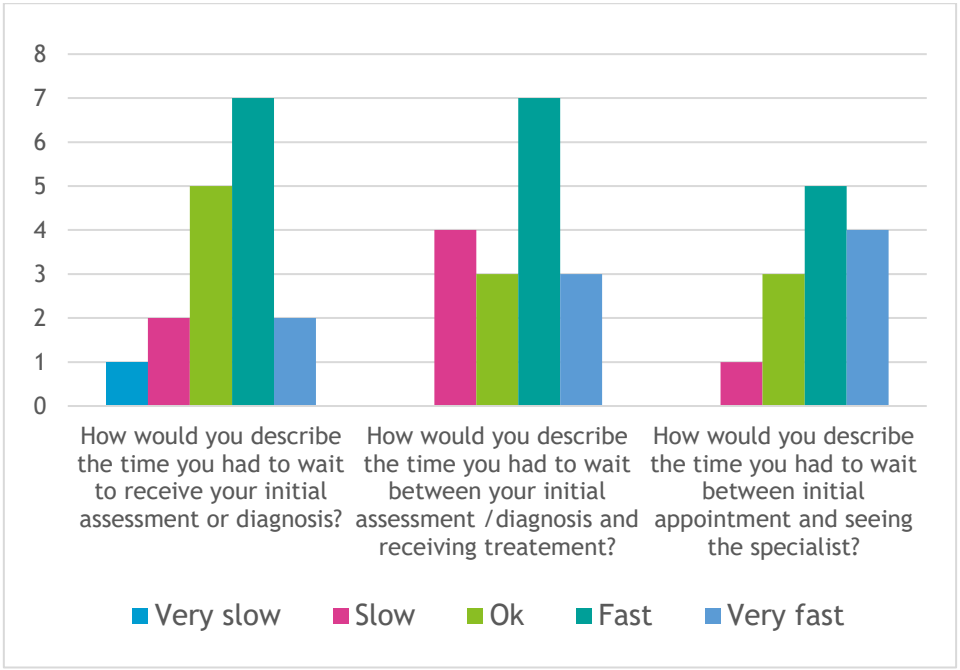


Assessment, diagnosis and treatment



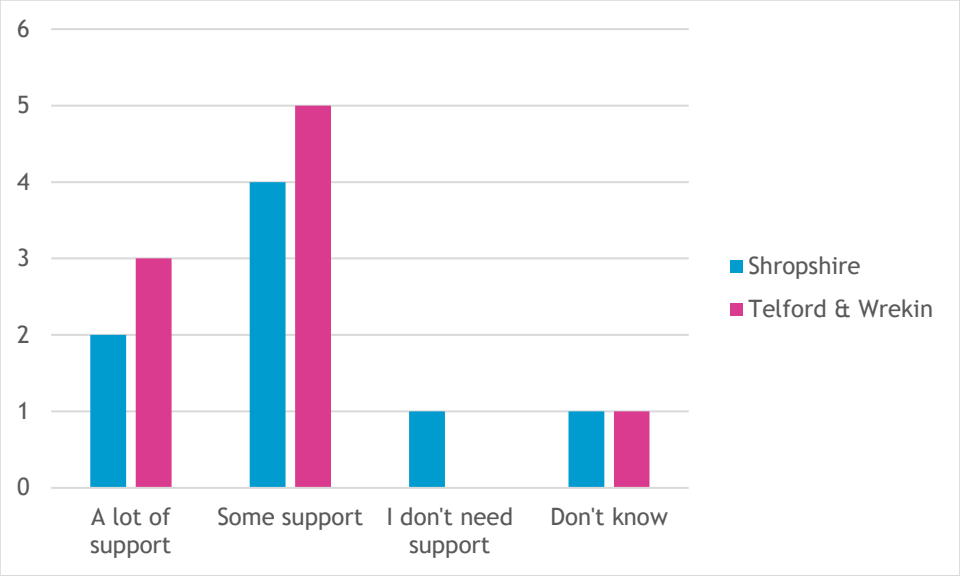
"Brilliant fast acting appointments with referrals biopsies maybe just a phone call from a clinical nurse just asking how we are after everything would be appreciated!!"

How would you describe the time you had to wait?



The provision of ongoing care and support

What level of support do you want the NHS to provide to help you stay healthy?



After diagnosis seven people found it 'Easy' or 'Very easy' to access on-going support, five found it 'Difficult' or 'Very Difficult' and three said it was 'OK'.

When asked if the support options offered met expectations, eight people replied that it did, four replied 'somewhat' and four replied that it did not.

> "Advice and guidance, reliable information in different formats, access to health professionals when needed but not necessarily a doctor"

Common themes

The responses to questions around the quality of support that respondents had experienced, what they felt could be improved and what they felt the NHS could provide showed some common themes. These themes have been collated to indicate the areas of support that respondents commented on most. A full count of the themes is in Appendix 2 along with the question answers on which they are based (questions 6b, 13, 14, 18b, 19b, 25, 26).

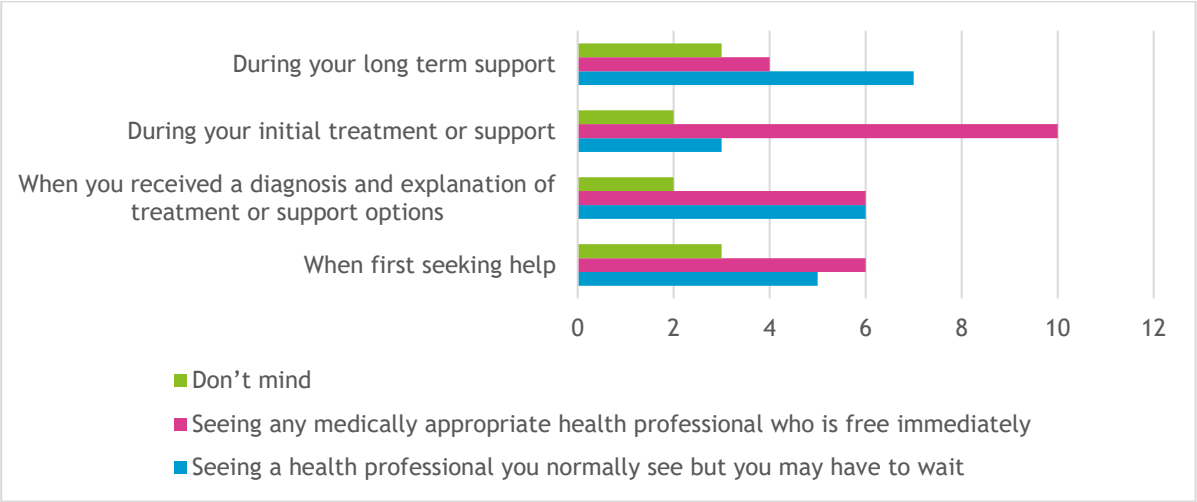
Some main themes identified were:

1. **Access to specialist services (4 respondents)**, e.g. "Only improvement in my case would be more local to where I live, closer hospitals with gynaecologist should be able to see me through recovery instead of having to travel so far [Stoke]", "Clinical nurses need to follow up, get in touch, just ask how we are doing!!!"
2. **Information and advice (2)**, e.g. "Advice and guidance, reliable information in different formats" [would help me stay healthy and manage my condition]
3. **GP access (2)**, e.g. "Make access to GP easier and be able to see the same GP."

Multiple Conditions

Eight people had additional conditions and five of those felt that it made getting support harder; one thought it made no difference and one thought it made it easier.

What is most important to you at each stage of your care?



Prevention and/or early intervention

When asked about the time people had to wait for their initial assessment or diagnosis 9 people described it as 'fast' or 'very fast', five as 'Ok' and three as 'slow' or 'very slow'.

Summary

With a small number of respondents it is difficult to generalize and therefore summarize findings. However, what is noticeable as important for people in Shropshire, Telford & Wrekin who are living with Cancer is:

- To be seen quickly by any appropriate health professional during the initial treatment and support phase. The preference for longer-term support, however, is to be seen by a health professional you would normally see.
- Multiple conditions appear to make it more difficult for most people to gain the help they need, however most respondents were satisfied with the overall experience of help.
- Greater access to specialist services.

"It was assumed I was aware of what stage I was in, how my mental health would be effected was not mentioned. Everything felt like it was taken out of my hands to be dealt with by professionals who knew best (of course I understand that but still feel like I was almost rushed through diagnosis and treatment) . I concur they do know best but some self-knowledge and minor input would have been appreciated."

Heart and lung diseases - prevention, diagnosis and treatment

Overview

Heart and circulatory disease, also known as cardiovascular disease (CVD), causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years. CVD is largely preventable, through lifestyle changes and a combination of public health and NHS action on smoking and tobacco addiction, obesity, tackling alcohol misuse and food reformulation.

Respiratory disease affects one in five people in England, and is the third biggest cause of death. Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally and remain a major factor in the winter pressures faced by the NHS.

Incidence and mortality rates for those with respiratory disease are higher in disadvantaged groups and areas of social deprivation, where there is often higher smoking incidence, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.

Enabling more people with heart and lung disease to complete a programme of education and exercise based rehabilitation will result in improved exercise capacity and quality of life in up to 90% of patients.

The approach to these issues can be seen broadly in terms of:

- Prevention
- Diagnosis
- Early treatment
- Rehabilitation

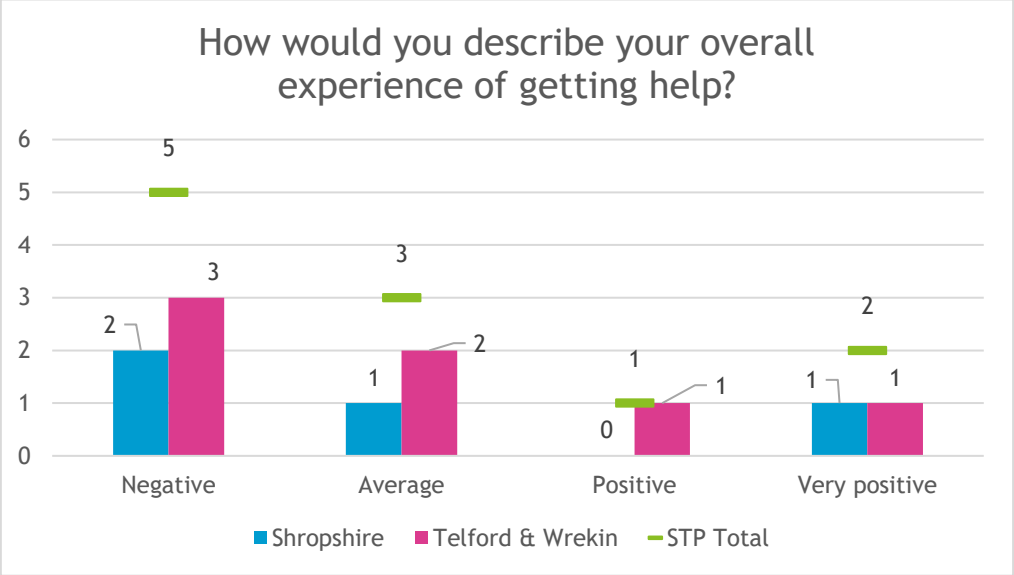
Long Term Condition Questionnaire

Respondents

In the questionnaire about NHS support for specific conditions 11 people, four from Shropshire and seven from Telford & Wrekin, told us about their experiences of Heart and lung disease services.

Overall Experiences

Getting Help



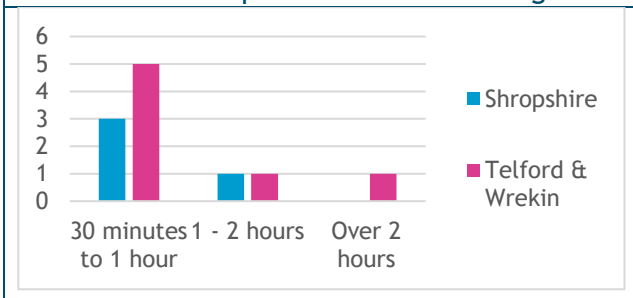
Communications

When asked if people received timely and consistent communication one of the respondents felt they did, six they did 'somewhat' and four that they did not.

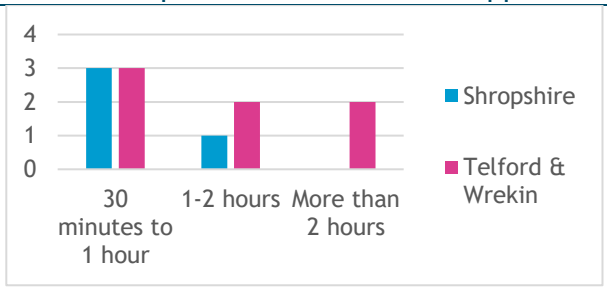
Transport and Travel

Nine respondents main means of transport was their own or somebody else's car, for one person it was the bus and one the train.

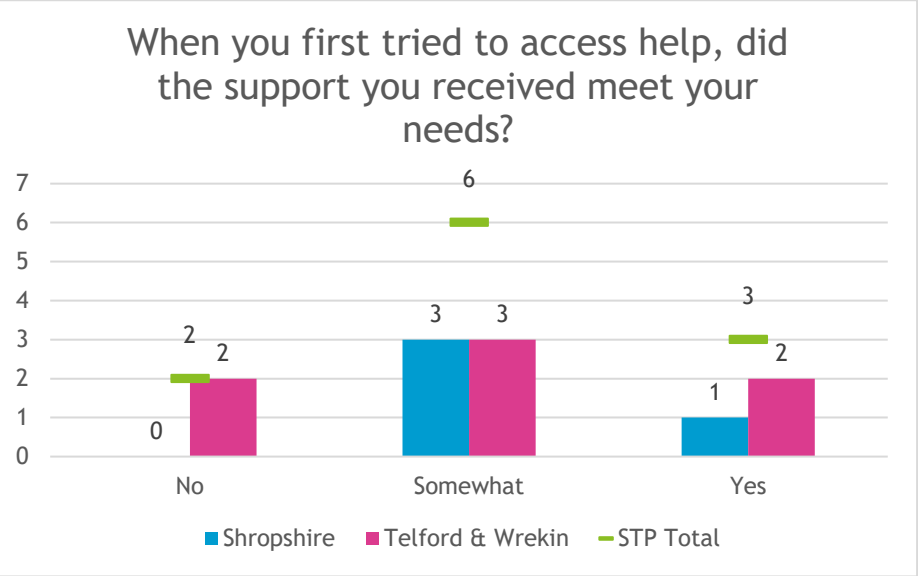
How much time would you be willing to travel for to receive a quick and accurate diagnosis?



How much time would you be willing to travel to receive specialist treatment or support?

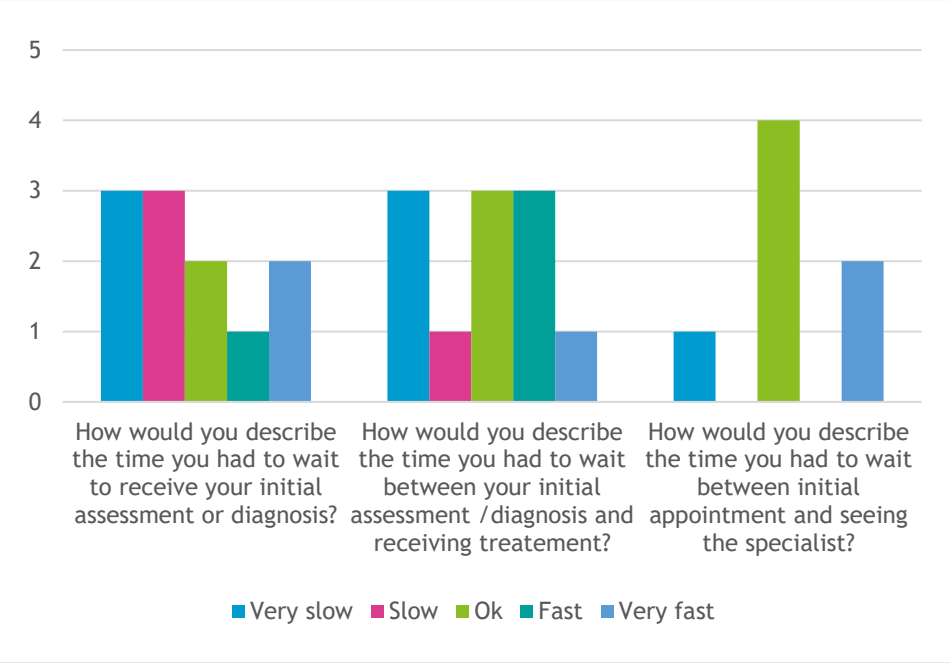


Assessment, diagnosis and treatment



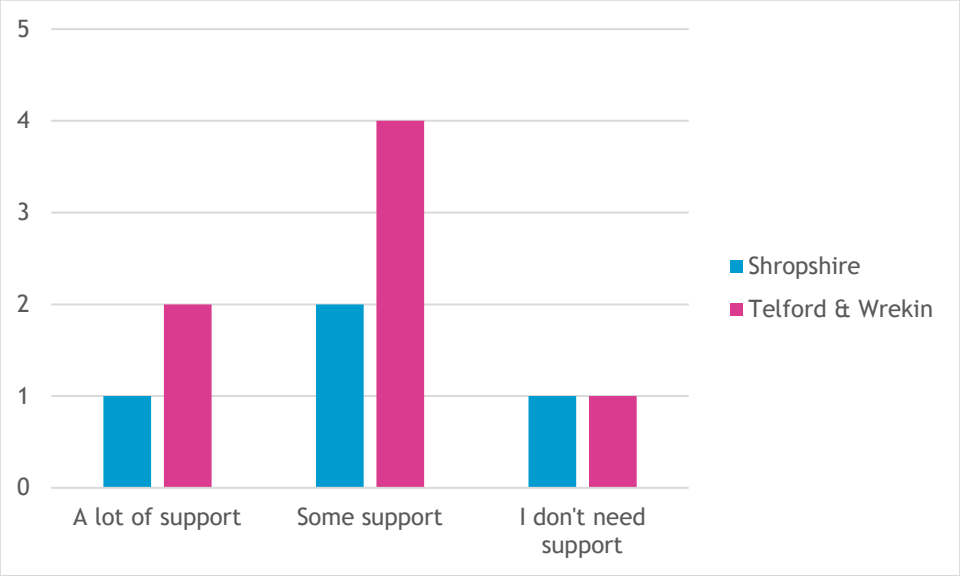
"I underwent tests very quickly saw the Consultant quickly several times. Gave me advice and we agreed along term treatment plan which was acceptable to me and is still working."

How would you describe the time you had to wait?



The provision of ongoing care and support

What level of support do you want the NHS to provide to help you stay healthy?



After diagnosis three people found it ‘Easy’ or ‘Very easy’ to access on-going support, three found it ‘Difficult’ or ‘Very Difficult’ and three said it was ‘OK’.

When asked if the support options offered met expectations, four people replied that it did, five replied ‘somewhat’ and two replied that it did not.

> “Reasonably quick access to my GP, access to local cardiac specialists, enough GPs so we don't have to wait so long for GP appointments, yearly MOT with cardiac professionals, yearly general health MOT with GP.”

Common themes

The responses to questions around the quality of support that respondents had experienced, what they felt could be improved and what they felt the NHS could provide showed some common themes. In particular:

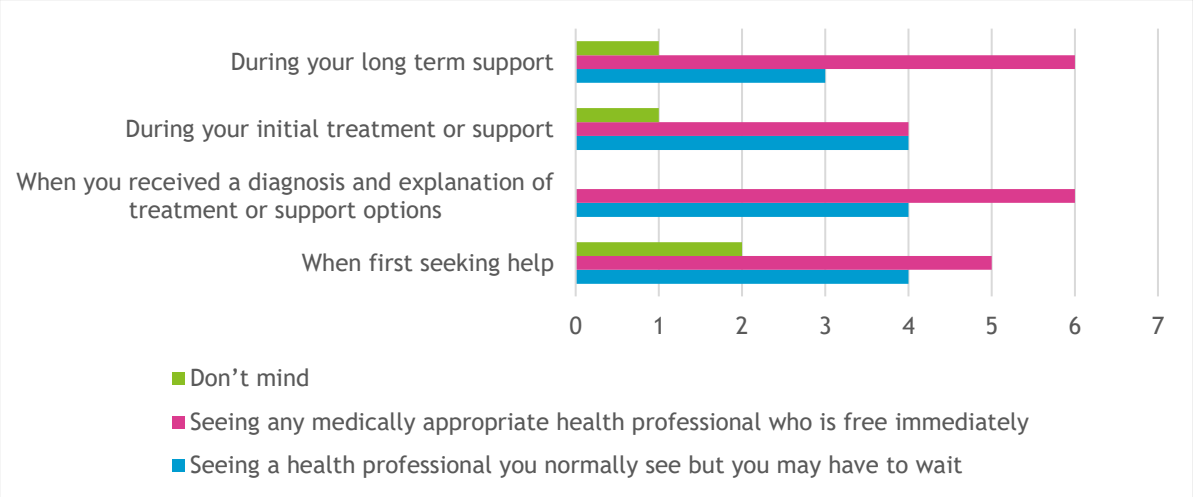
- **Communication with patients** – Three respondents identified this as an issue, e.g. “Shrewsbury [SaTH] communication non-existent”

A full count of the themes is in Appendix 2 along with the question answers on which they are based (questions 6b, 13, 14, 18b, 19b, 25, 26).

Multiple Conditions

Nine people had additional conditions and of those five felt that it made getting support harder, three thought it made no difference.

What is most important to you at each stage of your care?



Prevention and/or early intervention

When asked about the time people had to wait for their initial assessment or diagnosis three people described it as 'fast' or 'very fast', two as 'Ok' and six as 'slow' or 'very slow'.

Summary

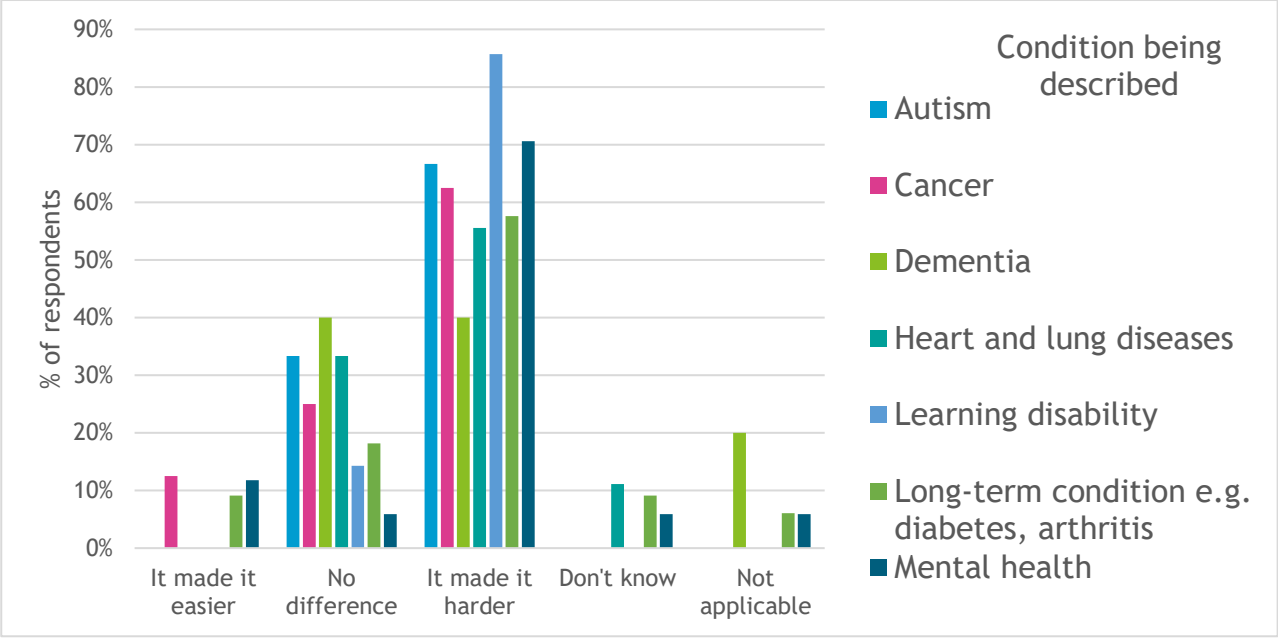
With a small number of respondents, it is difficult to generalize and therefore summarize findings. However, what is noticeable for people in Shropshire, Telford & Wrekin who are living with heart and lung disease:

- There is a general negative experience of the overall experience and quality of treatment possible due to difficulty accessing initial help and Ok to poor waiting times in all phases of treatment.
- Multiple conditions appear to make it more difficult for most people to gain the help they need
- Although a small number of respondents many raised communication as being of importance

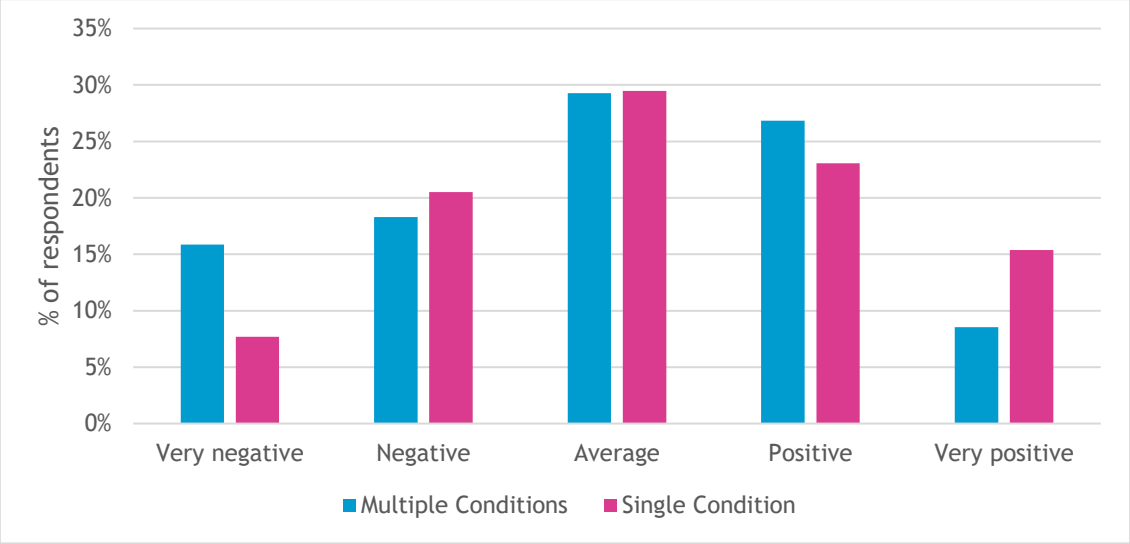
"Maintain funding for specialist centres and education to the public, that to maintain high standards and competences, sometimes traveling a distance to a service is in their interest to get the best treatment and support."

Overview of the experience of those with multiple long term conditions

Those with multiple conditions described the experience of seeking support for more than one condition at a time as follows:

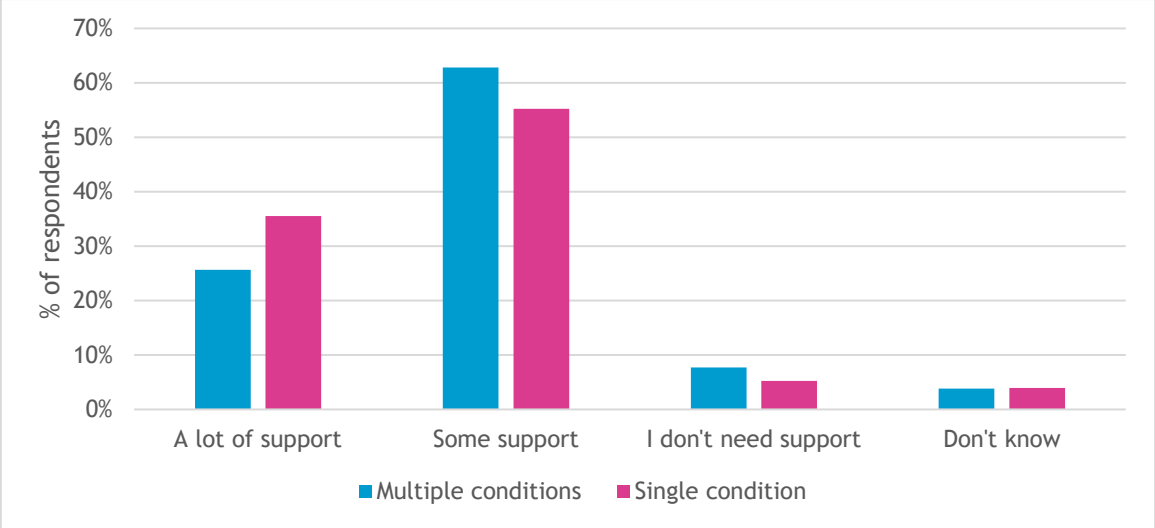


How would you describe your overall experience of getting help?



The significant difference between these two groups appears between the numbers who found the experience very negative or very positive.

What level of support do you want the NHS to provide to help you stay healthy?



Engaging people in health service design and delivery

Healthwatch Shropshire and Healthwatch Telford & Wrekin did not directly ask people how they would like to be engaged in health and care service transformation going forward. We did ask people for their feedback on our approach to this piece of work, e.g. the engagement methods. A representative from Sight Loss Shropshire asked the STP to conduct further focus groups with people with a sensory impairment to ensure their views and ideas are considered when producing the local Long Term Plan.

Feedback regarding the 'What would you do?' public events was overwhelmingly positive with 13 people from Telford & Wrekin giving their feedback and 12 people from Shropshire. All 13 respondents from Telford and Wrekin either 'agreed' or 'strongly agreed' that they found the presentations interesting and the table discussions good. The 12 respondents from Shropshire gave a greater range of response, however nine (75%) either 'agreed' or 'strongly agreed' that the presentations were good and 11 (92%) said the discussions were good and they had enough opportunities to participate. Twenty people across both events 'agreed' or 'strongly agreed' that it had helped them to understand the local issues.

One attendee at the Shropshire event told us:

- "I found it useful to speak to fellow attendees who in their various ways all had concerns about what's happening to services and the ability of primary and community healthcare services to cope with demand – however 'differently' 'they are able to work. The key message that emerged from our group was the need for 'honest' communications from healthcare commissioners and providers"

Comments from attendees at the Telford & Wrekin event included:

- "The talk was interesting – I await the action"
- "Table discussions – everyone on my table actively took part and made contributions. It was a good relaxed atmosphere."
- "Good to see Shropshire and Telford & Wrekin Healthwatch working so well together"

Limitations of this piece of work

The questionnaires

Comments received by both Healthwatch about the questionnaire and its limitations will be shared with Healthwatch England as part of the review process, e.g.

- "Every question in this survey is a 'leading' question. It does not suggest that the survey was piloted very well!"
- "This survey form became confusing once the question regarding more than one condition had been answered"

We also received feedback regarding the Easy Read versions of the questionnaires.

Attendance at the public events

In this STP area there has been a range of public engagement over the last few years, in particular regarding the reconfiguration of the acute hospital Trust under 'Future Fit'. This may have impacted on the limited response from the press to our press releases to promote the public events.

Healthwatch also believe that the previous experiences some people have had of being asked their views on services and their redesign directly impacted on the number of people willing to respond to this piece of work, in particular the on-line questionnaires and public events. Some people have expressed their frustration to both Healthwatch that in the past that they have shared their views with services and commissioners and then they have not seen any evidence that they have been acted upon or the services they have used, valued and given feedback on, have been changed or cut anyway.

Methodology

General Questionnaire Qualitative Data

Analysis of the response to the following questions:

- Q3b) If there was one more thing that would help you live a healthy life, what would it be?
- Q4b) If there was one more thing that would help you manage and choose how the NHS support you, what would it be?
- Q5b) If there was one more thing that would help you retain your independence and live healthily for as long as possible, what would it be?
- Q6b) If there was one more thing that you think needs to change to help you to successfully manage your health and care, what would it be?

Three members from Healthwatch (2 Telford & Wrekin and 1 Shropshire) worked together to order the comments into themes. Themes were developed as the data was read, titles to describe the theme and it's parameters remained flexible until all data was considered and discussed. Some themes had sub-categories where there was a strong similarity between particular issues mentioned. Data within each theme was then reconsidered as a final check that it sat correctly within the allotted theme.

Numbers of comments from Telford & Wrekin (T&W) and Shropshire (S) within each theme were recorded. The overall numbers of data strings within each theme were counted allowing a ranking of the most mentioned themes.

LTC Questionnaire Qualitative Data

A similar approach was taken with the qualitative data in questionnaire 2 however the questions asking for contextual information were quite similar so there was less distinction between the answers to each question. To reduce the recording of repetition the answers to questions 6b, 13, 14, 18b, 19b, 25 and 26 were considered together.

Acknowledgements

Healthwatch Shropshire and Healthwatch Telford & Wrekin would like to thank

- Taking Part for their work on the section concerning the support for people with learning disabilities and autism
- Chair, Shropshire, Telford and Wrekin Dementia Action Alliance
- Shropshire, Telford & Wrekin STP Communication and Engagement Team
- Telford Carer's Centre
- Age UK
- Alzheimer's Society
- Mayfair Centre
- Highley Dementia Football Group
- Midlands Partnership Foundation Trust Memory Service

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NHS
Shropshire
Clinical Commissioning Group

Agenda Item: GB-2020-07.084
Shropshire Clinical Commissioning Committee meeting: 8.07.2020

Title of the report:	Update on the Special Educational Needs and Disability (SEND) Local Area Inspection
Responsible Director:	Claire Parker, Director of Partnerships
Author of the report:	Claire Parker, Director of Partnerships (updated from a previous report from Helen Bayley, Head of Quality)
Presenter:	Claire Parker

Purpose of the report:

- To provide the Governing Body with a regular update on the outcome of the joint SEND CQC and Ofsted Inspection carried out in Shropshire between 27 January and 31 January 2020,
- To provide the Governing Body with an outline of the key work streams and actions currently in progress
- To provide the Governing Body with an outline of the key challenges and risks to delivery of the plan

Key issues or points to note:

Special Education Needs and Disability (SEND) is a statutory requirement under the Children and Families Act 2014. It requires local partners to work together to deliver a coordinated and simplified offer to children and young people (aged 0 – 25).

The CCG works in partnership with the local authority on the SEND agenda.

A joint, SEND CQC and Ofsted Inspection took place in Shropshire across health, social care and education between 27 January and 31 January 2020. The outcome of the inspection was first shared with the CCG and LA on 25th March. The final letter was published on 6 May 2020.

As a result of the findings of this inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, the Chief Inspector determined that a Written Statement of Action is required because of the areas for improvement identified. The Written Statement of Action is due to be published on 25th September 2020.

Actions required by Governing Body Members:

To note:

- To note the actions identified.
- To continue to monitor the implementation of SEND within Shropshire.
- To identify a clinical Governing Body Champion for SEND

Monitoring form:
Agenda Item: GB-2020-07.084

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications	**Yes**
	Telford and Wrekin DCO is covering across Shropshire on an interim basis. Claire Parker, is identified as the new executive Lead. Administration support is provided on an ad hoc basis from the Shropshire commissioning team. Consideration to commissioning input needs to be addressed.	
2	Health inequalities	**Yes**
	Children with Special Needs and disabilities experience a range of health and social care inequalities. A robust EHC process should assist with improving the co-ordination of services and enhancing their life chances	
3	Human Rights, equality and diversity requirements	**Yes**
	Disability is one of recognized characteristics of the Equality Act 2010	
4	Clinical engagement	**Yes**
	DCO has links with clinical teams, MPFT staff have received awareness training. Links to the Learning Disabilities and Autism partnership (formerly Transforming Care) and Transformation directorate have been reviewed and a project proposal submitted to NHSE/I.	
5	Patient and public engagement	**Yes**
	Patient and public engagement is a key component of the SEND guidance. Significant further work is needed to ensure the CCG, in partnership with the local authority, embeds the voices of children, young people, parents and carers into the implementation of SEND. DCO and Strategic lead are working with the parent and carer group to move forward with current concerns re progress of Health and SEND.	
6	Risk to financial and clinical sustainability	**Yes**
	Reforms require significant increased work from clinical teams around provision of assessment and ongoing review. Capacity and demand for therapies, neuro developmental services and managing expectations of families	

NHS Shropshire CCG

Special Educational Needs and Disability Update
July 2020

1. Executive Summary and Actions Required

Special Educational Needs and Disability (SEND) was introduced in 2014 and placed requirement on local authorities and CCG's to work together to implement Education, Health and Care Plan (EHCP) to children and young people with special needs and/or disabilities up to the age of 25.

Currently within Shropshire the implementation is overseen by the SEND Strategic Board, which feeds into the Health and Wellbeing Board.

A joint SEND CQC and Ofsted Inspection took place in Shropshire across health, social care and education between 27 January and 31 January 2020. The outcome of the inspection was first shared with the CCG and LA on 25th March. The final letter was published on 6 May 2020.

As a result of the findings of this inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, the Chief Inspector determined that a Written Statement of Action is required because of the areas for improvement identified. Ofsted have agreed via a joint meeting with LA and CCG meeting that the date of publication of the Written Statement of Action is September 25th 2020.

The inspectors acknowledged that the LA and CCG were aware of what the areas for improvement were; they acknowledged that a clear plan of how to improve the gaps had been identified, but there was reduced confidence in the system's ability to deliver at pace on the actions required due to the other pressures within the system, particularly around the healthcare system.

A workshop (face to face) jointly presented by the LA and CCG took place on 23rd June 2020. This workshop initiated the joint Written Statement of Action (WSoA). Encouragingly providers also attended the workshop.

A refresh of the governance arrangements will form part of the discussions, but a regular meeting at executive level has already been put into place to ensure senior over sight and accountability will be maintained through the SEND partnership board.

2. The inspection

The inspection was led by one of Her Majesty's Inspectors (HMIs) from Ofsted, with a team of inspectors including an HMI and a Children's Services Inspector from the CQC.

3. Key Findings during the Inspection:

Areas for improvement and any actions already undertaken:

3.1 Health specific improvements:

- Inconsistent leadership for SEND- the Director of Partnerships has responsibility for SEND and is working with the Director of Children's Service at Shropshire Council to develop the WSoA jointly with other partners.
- In-effective pathway for specialist assessment of autism spectrum disorder (ASD) for children over the age of five. Commissioners are working on the pathway as a matter of urgency although funding streams remain an issue.
- Significant waits for speech and language assessment and treatment- the Director of Partnerships has arrange to meet with the director lead for Shropshire Community NHS Trust to discuss the changes and proposals for reducing waiting times for speech and language therapy. Shropshire Community NHS Trust are attending the initial workshop to support development of the WSoA. Significant progress and review of the SaLT waiting list has been undertaken and a new way of working has been developed and will be implemented through restore and recovery.
- Waiting times for CYP accessing intervention once assessed by Bee-U service is too long. This needs to be addressed.
- The number of young people leaving care who have received a health passport is low. A plan needs to be developed to improve this and will form part of the WSoA.
- Therapy services do not proactively work with local early help services to share information and provide a joined up approach for families who are receiving support from both teams. A joint approach is being developed and will be overseen through the SEND Partnership Board.
- Several health services do not seek feedback from parents, carers and young people about the service being delivered. The Director of Partnerships has had an initial meeting with the Chair and Trustee of the Parent and Carers Council (PaCC) in Shropshire.
- Lack of inclusion of health services input into the area's SEND action plan. This will be addressed through joint partnership working and an immediate action to review the health chapter of the SEND strategy has been commenced.

3.2 System improvements:

- Inconsistent input from partners into EHC plans. This has been agreed to be an action within the WSoA but needs further development.
- Knowledge of the SEND reforms and EHC assessment and planning processes across services is inconsistent. An immediate action to ensure consistent training jointly, is undertaken to ensure all partners understand the revised SEND framework and the implications for both strategic decision making and delivery of services.
- Co-production of services, to continue to be developed and be a integral part of the SEND strategic board and Partnership Board.
- Support of specialised practitioners within specialist schools is inadequate- this needs to be addressed.

- No SEND-specific joint strategic needs assessment. The Local Authority are leading on this as an action with support and input from partners and will be incorporated into the WSoA.
- The rates of exclusion for children and young people with an EHC plan in primary, secondary and special schools are significantly above the national average. An immediate action to review and present the data on school exclusions and understanding the issues has commenced.
- Not enough two year olds have their needs assessed by the health visiting service- there has been an initial discussion with the lead for this service and Director of Partnerships. A further meeting to develop is planned, this will also be in context of the Covid 19 recovery plan.
- EHC plans are not updated in a timely way following an annual review. This will an action within the WSoA and will need a review of training and oversight of plans.

3.3 Good Practice:

There were many areas of good practice identified within the report. Below are some examples of this good practice:

- The service offered by Beam has a good uptake and has been able to support more than double the anticipated number of children and young people.
- Improvements have been made to the ASD diagnostic pathway for under-fives. Further work on the older age groups is being undertaken following a workshop with partners.
- Children and Young people with severe speech and language impairment benefit from intensive SALT and specialist teacher input, with joint care assessments and care planning.
- The public health nursing team has dedicated SEND practitioners who help.
- The children's community nursing team respite service help s to reduce anxiety for parents of children with acute and/or complex needs
- There is effective joined up working between the occupational therapists provided by health and LA services. A trusted assessor agreement is in place.
- There is good support from education, health and social care professionals at key transition points. Therapists take a proactive approach to transition planning.
- Area leaders continually look for ways to develop and improve the local offer.
- The percentage of 17 year olds receiving SEND support who were in education, employment or training is above the national average.

4. Ongoing actions:

- The ASD Pathway has been mapped and agreed, funding is still to be confirmed. This needs to be understood and taken forward as a matter of urgency.
- The SALT Service specification has been reviewed by the CCG and provider and some immediate actions have been addressed, this needs to be understood in the context of Covid 19 recovery and in ensure sustainability for the future.
- The Self Evaluation Framework (SEF) has been completed between health and SEND lead.

- Working closely with MPFT to improve understanding and engagement in SEND, for example: contributions to EHCP's, advice giving; appropriateness of recommendations; data collection; information required for the local offer; working with other participating agencies.
- BeeU waiting times have significantly improved within last 12 months – there are now no waits for initial assessments. Data is now reported and monitored more robustly through CRM on internal waits, which remain a concern.
- T&W's JSNA is ready to go live. Shropshire has attended the joint JSNA workshop and the CCG children's commissioner has shared data in preparation for completion of the Shropshire JSNA. This was taken as an immediate action from the SEND workshop on 23rd June.
- Representation of the CCG at operational and strategic meetings has continued with good working relationships with LA and partners. Partners now report improved confidence in discussions with CCG staff in place to provide consistency and clarity in approach. Executive leadership is in place and a strategic board for SEND is in the process of being commenced.
- Working relationships with PACC is improving and plans to continue to work together in developing true co-production of services. Very positive and constructive discussions have been held.
- The strategic SEND Board have an agreed SEND statement of Intent highlighting the need to reduce health inequalities as requested by parent group, which has been signed up to by all partners involved. A key set of principles adopted and agreed by all partners is to be developed as an action from the workshop.
- The three work streams are: Joint Commissioning, Preparing for Adulthood and Inclusion. Impact & monitoring of these groups is through the SEND strategic Board.
- Local Offer has been relaunched and continues to be developed further following feedback from the inspection and following the workshop.
- Developing revised health action plan in preparation for the WSoA.
- Quality processes to improve EHCP's continues and is embedded as business as usual. Improvements have been noted.
- Senior partnership working has improved significantly.

5. Challenges:

- Commissioning capacity for children's and young people's services may be an issue during restoration and recovery phase.
- Securing funding to ensure commitment to the improvements is required, including development of Learning Disability, and Autism services.
- The pace of developing joint commissioning with the council and other parties needs a clearer sense of direction and commitment from all partners.

Recommendations:

- Governing Body continue to have regular oversight and assurance of the actions and monitor the implementation of SEND within Shropshire
- To note and acknowledge the concerns and challenges within the report.

- Identify a clinical champion for SEND.
- Note the date for publication of the Written Statement of Action as 25th September 2020

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.085
Shropshire CCG Governing Body meeting: 8 July 2020

Title of the report:	Report from Audit Committee 24 June 2020
Responsible Director:	Alison Smith, Director of Corporate Affairs Claire Skidmore, Executive Director of Finance
Author of the report:	Keith Timmis, Lay Member – Governance & Audit
Presenter:	Keith Timmis, Lay Member – Governance & Audit

Purpose of the report: To highlight to the Governing Body key issues arising from the 24 June 2020 Audit Committee meeting and to agree any actions that result.

Key issues or points to note:

1. We received the final papers for the annual accounts and annual report, together with the related reports from the internal and external auditors. External audit gave an "unqualified opinion" on the financial statements and noted the quality of the supporting working papers and significantly reduced number of issues raised. Their overall comment was that the accounts were "a huge achievement". The Committee commended the work of all in the CCG and external bodies for the high standards achieved in these difficult circumstances. External audit's concerns about the CCG's financial performance meant that we again received an "Adverse" Value for Money Conclusion.
2. Internal audit have concluded in the final version of their Head of Internal Audit Opinion that our arrangements provide "Moderate Assurance".
3. Counter Fraud presented their annual report for 2019/20 and their plan for 2020/21. There were no issues of concern and the Committee agreed the work plan for the current year.
4. We have finally been given permission to share the results of the Mental Health Investment Standard report from 2018/19. This had been delayed, pending a national decision on the release of the results of the work. External audit concluded that our Compliance Statement was "properly prepared".

Actions required by Governing Body Members:

- Note the content of the report.

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	No
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the clinical engagement*	No
5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	No
6	Risk to financial and clinical sustainability *If yes how will this be mitigated* *External audit reported on the scale of the CCG's financial problems. They concluded that the CCG does not have adequate arrangements in place to secure "Sustainable resource deployment". The CCG responded as follows:* *"We have agreed with NHSEI that an updated CCG financial strategy will be drafted ready for consideration in Autumn 2020.This will incorporate any emerging guidance on restoration and recovery planning and will be constructed as part of our system view of financial recovery."*	Yes

NHS Shropshire CCG Audit Committee Report 24 June 2020
Keith Timmis: Lay Member – Governance & Audit

Matters arising

1 The Committee met to discuss the outcome of the annual audit exercises slightly later than normal on 24 June. This reflected the change to the national timetable for the preparation and auditing of accounts.

2 We anticipate returning to a more normal cycle and content of meetings from September and will catch up with outstanding work within a revised timetable. Planned work will be reevaluated throughout the year to ensure we maintain appropriate oversight of governance, while minimising the impact on the organisation as we move on from the current pandemic.

Governing Body Assurance Framework

3 We discussed the current version of the GBAF including a new risk for the covid pandemic. We agreed with all the revised content but asked for more specific wording on the covid risk to include the issues associated with the recovery from the pandemic and the potential consequences for patients from the emergency actions the CCG has taken. Overall, the Committee is happy the GBAF covers the key risks and actions.

Annual Report

4 We received the final version of the CCG annual report. The Committee praised the work of those involved in the drafting and collating of the report. Internal audit had updated their section to include the results of their final piece of work for 2019/20.

Annual accounts

5 The Committee heard a very positive summary of the external audit work and judgements on our financial statements. Grant Thornton gave an “unqualified opinion” on the financial statements and noted the quality of the supporting working papers and significantly reduced number of issues raised this year. The overall comment was that the accounts were “a huge achievement”.

6 However, external audit were critical about the CCG’s arrangements for ensuring value for money. Although our arrangements for monitoring quality and working in partnership were judged to be satisfactory they remain concerned about our finances. Their concerns about the CCG’s financial performance meant that overall we again received an “Adverse” Value for Money Conclusion.

7 We also had our regularity opinion qualified because we spent £47m more than specified in directions and breached our administration resource allocation.

8 Grant Thornton concluded they do not consider the financial position is sustainable for either the CCG or the Shropshire health system.Therefore on the 26 May they issued written recommendations to the CCG under section 24 of the Local Audit and Accountability Act 2014. The CCG responded to this and will provide an update on progress, initially to the Audit Committee, this Autumn.

Internal audit

9 Internal audit formally presented their updated plan for 2020/21. We also received the final report from 2019/20. This was on primary care commissioning. They concluded our arrangements provided “significant assurance”.

10 The Annual Internal Audit Report and Head of Internal Audit Opinion concluded that overall they can give the CCG “Moderate assurance”.

Maintaining financial control during covid 19

11 We received a report on the arrangements in place to ensure we maintain control of financial transactions during the covid 19 pandemic. The Committee considered the arrangements were appropriate and looked forward to the results of internal audit work on a sample of transactions that will be completed over the next quarter.

Counter Fraud

12 The Committee received the annual Counter Fraud report for 2019/20 and the plan for 2020/21. There were no issues of concern and the Committee agreed the work plan for the current year.

Other matters

13 The Committee is keen for the CCG to revert to the normal level of governance and meetings within the CCG as soon as possible. The current thinking is for this to happen from September and the Committee supports this approach.

14 The Executive Director of Finance outlined the approach she is taking to consider the arrangements for internal and external audit we will need from April 2021 when we expect to formally move to a single CCG for Shropshire Telford & Wrekin.

15 Shortly after the Committee met we received an update on an old piece of audit work. We have finally been given permission to share the results of the Mental Health Investment Standard report from 2018/19. This had been delayed from October 2019, pending a national decision on the release of the results of the work. External audit concluded that our Compliance Statement was “properly prepared”. The full details will be published on 9 July.

Next meeting

16 The next Audit Committee was due to be held on 26 August 2020. This will now be rearranged for a date in September as we establish a new cycle of meeting dates on a “committees in common” approach for the new shared governance arrangements with Telford and Wrekin CCG.

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-07.087
Shropshire CCG Governing Body meeting: 8.07.2020

Title of the report:	**Single Strategic Commissioner for Shropshire & Telford and Wrekin – Update Report**
Responsible Director:	**David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG**
Author of the report:	**Alison Smith, Director of Corporate Affairs, NHS Shropshire CCG and NHS Telford and Wrekin CCG**
Presenter:	**David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG**

Purpose of the report:

The purpose of this report is to provide:

1) an update on the application process for creating a single strategic commissioner across Shropshire and Telford and Wrekin.

Key issues or points to note:

To note that the application for dissolution of the two existing CCGs and proposal to create a single CCG from April 2021 was made on 30th April 2020.

A Regional Panel meeting was held on 3rd June 2020 where our application was formally presented and scrutinised by colleagues in the NHS England/NGS Improvement Regional Team.

The Regional Panel following the application presentation on 3rd June 2020, has formally recommended to the National Committee that has the formal decision making powers to accept or reject applications to approve the NHS Shropshire CCG and NHS Telford and Wrekin CCG application with a number of conditions to be determined.

Actions required by Governing Body Members:

For information only.

The Governing Body is asked to:

- Note the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin.

Monitoring form
Agenda Item: GB-2020-07.087

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *Future working arrangements will impact on future resources required by the CCG's*	Yes
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *The CCGs have commissioned Equality Impact Assessments on both the workforce of both CCGs and of the populations the CCGs serve.*	Yes
4	Clinical engagement *Clinical engagement will be key in moving forward with and shaping future working arrangements*	Yes
5	Patient and public engagement *Public engagement forms part of the Communications and Engagement Plan for the programme.*	Yes
6	Risk to financial and clinical sustainability *Future working arrangements are a key consideration in the financial and clinical sustainability of the CCG's going forwards*	Yes

NHS Shropshire CCG Governing Body Meeting 15th July 2020

Single Strategic Commissioner for Shropshire & Telford & Wrekin – Update Report

David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG

1. Introduction

1.1 At its meeting held on 14th May 2019, the Governing Body agreed to support the dissolution of both CCGs and the formation of a single strategic commissioning organisation for the Shropshire, Telford & Wrekin footprint. It also supported recruitment of a single Accountable Officer across both CCGs and the establishment of a single management team, whether an early application to NHS England for establishment of a single CCG was accepted or not.

1.2 On September 17th both CCG memberships supported this proposal and an application was formally made to NHS England/NHS Improvement on 30th September to dissolve the two existing CCGs with a view to creating a single CCG from April 2020.

1.3 An NHS England panel meeting was convened by the regional team to consider the application in more detail on 11th October 2019 with the outcome that the application was unsuccessful, mainly due to lack of time to develop some of the key evidence to a sufficient level, to satisfy the criteria used to judge the application by NHS England.

1.4 Since October 2019 the CCGs have undertaken significant work on developing the proposal to create a single CCG culminating in the Governing Body's support to make another application on 30 April 2020, with a view to a single CCG being created in April 2021. This report seeks to provide the Governing Body with a further update on progress in moving towards becoming a single strategic commissioner with NHS Telford and Wrekin CCG and in making a re-application to NHS England/Improvement on 30th April 2020.

2. Report on progress of the programme

2.1 The NHS England/NHS Improvement have supported the CCGs to make a further application earlier than the normal deadline of September 2020, as they believe our application can be enhanced to meet the 10 application criteria in full, if we continue to work at pace. We have agreed with NHS England the following new timescale for re-application and the programme timelines have been amended accordingly:

- Final submission of revised application evidence - 30th April 2020
- Regional NHS England/NHS Improvement panel – early June 2020
- National NHS England/NHS Improvement Committee – July 2020
- Creation of a new single CCG – April 2021

2.2 The Regional Panel meeting was held on 3rd June 2020 where our application was formally presented and scrutinised by colleagues in the NHS England/NGS Improvement Regional Team. Informal feedback has been positive, clearly with some work still to be completed over the coming months. As the Shropshire, Telford and Wrekin health system is considered high risk by NHS England/NHS Improvement due to the financial deficit across the whole system and significant quality issues in the main provider Trust, the Regional Panel following the application presentation on 3rd June 2020, has formally recommended to the National Committee that has the formal decision making powers to accept or reject applications for high risk systems, to approve the NHS Shropshire CCG and NHS Telford and Wrekin CCG application with a number of conditions, still to be determined. The National Committee was due to be held sometime in July but due to the impact of Covid 19 NHS England/NHS Improvement had signaled that the decision may be taken as late as the Autumn. Work will continue on the programme despite any possible delays to the decision.

2.3 The management of change process to create one single staffing structure for senior managers and staff had started with Directors appointed in December 2019. However, due to the Covid 19 response both CCGs have placed the staff management of change process, which had begun on hold, until earliest September 2020. The Executive Team are currently reviewing the proposed management of change process in light of three new Directors being appointed since the original plan was developed and agreed.

2.4 Following the last Governing Body meeting in May, we are now awaiting formal ratification by NHS England/NHS Improvement of the new Constitution for the CCG that will align with a similarly drafted Constitution for Telford and Wrekin. The timeframe for this to take place is by mid July 2020.

2.5 The CCGs are nearing completion of a management of change process for existing Governing Body members which began in April and is due to be completed by the end of July. An election process of shared Governing Body members; the six Joint GP/Healthcare Professionals and subsequently the Joint Chair took place in May and June with the following joint appointments made to both CCGs:

1) Three Jointly appointed GP/Health Care Professional Governing Body Members from Shropshire CCG Membership; Dr Michael Matthee, Dr John Pepper and Dr Julian Povey

2) Three jointly appointed GP/Health Care Professional Governing Body Members from Telford and Wrekin CCG Membership; Mrs Rachael Bryceland (ANP), Ms Fiona Smith (ANP) and Dr Adam Pringle

3) Joint CCG Chair; Dr Julian Povey

2.6 This has been followed by recruitment of other jointly appointed Governing Body members in June and July 2020 which is currently ongoing; Secondary Care Doctor, Registered Nurse, Lay Member PPI and Lay Member Primary Care, with a view to

having newly appointed Governing Bodies for both CCGs by the end of July. The CCGs have also begun an election process for the chairs of their respective membership engagement forums, which again is due to be completed by the end of July.

2.7 The highest risks to the programme are currently;

- developing a commissioning strategy and then a finance plan which aligns with it;
- developing a financial plan that will meet the NHS England criteria for the application process;
- the continuing impact of Covid 19 and the delay in proceeding with the planned staff management of change process.
- ratification by NHS England/NHS Improvement of the newly adopted Constitution; and
- successful appointment of new Governing Body members by the end of July 2020.

3. Recommendations

The Governing Body is asked to:

- Note the actions taken to date and the risks of creating a single strategic commissioner for Shropshire and Telford and Wrekin.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.088
Shropshire CCG Governing Body meeting: 8.07.20

Committee Meeting Summary Sheet	
Name of Committee:	Finance and Performance Committee
Date of Meeting:	25/3/2020
Chair:	Kevin Morris

Key issues or points to note:

- Holding fast on the budget for 19/20
- Draft budget to sign off in May for 20/21
- Uncertainty around assumptions in the plan
- Deterioration in RTT and 52 week waits

Actions required by Governing Body Members:

- To note contents of the report

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF THE FINANCE & PERFORMANCE COMMITTEE HELD VIA CONFERENCE CALL ON WEDNESDAY 25 MARCH 2020 AT 11.00AM

Present

Mr Kevin Morris (Chair)	GP Practice Board Representative
Mr Keith Timmis	Lay Member – Governance & Audit
Mrs Claire Skidmore	Executive Director of Finance
Dr Julie Davies	Director of Performance
Ms Sarah Porter	Lay Member – Transformation
Mr Meredith Vivian	Lay Member – Patient & Public Engagement
Mrs Laura Clare	Deputy Chief Finance Officer
Ms Kate Owen	Head of PMO
Dr Michael Matthee	North Locality Chair

Apologies

None

In Attendance

Mrs Faye Harrison	Personal Assistant (minute taker)

FPC-2020.03.026 - Apologies

1.1 No apologies were received.

FPC-2020.03.027 - Members' Declaration of Interests

2.1 No Declarations of Interest were noted.

FPC-2020.03.028 - Minutes of Previous Meeting held on 26 February 2020

3.1 The minutes were discussed and the following amendments were required:

- Paragraph 9.3 – Spelling mistake, should read *'External Audit'*
- Paragraph 6.4 – the following addition to be made '*We are in a worse position this year than the previous 4 years, we haven't got enough schemes to deliver the target for 20/21 and the pressures are now greater. We also noted average delivery of QIPP is approximately 75% and more schemes than just the QIPP target are needed if we are expected to deliver the financial target for the CCG as a whole'*
- Paragraph 7.1 – Delete second sentence

After these amendments have been made the minutes were agreed as being a true and accurate record of the meeting held on 26 February 2020.

FPC-2020.03.029 - Matters Arising/ Action Tracker

4.1 The Action Tracker was discussed and updated as appropriate

- FPC-2020.02.019 - Quality, Innovation, Productivity & Prevention (QIPP) Report - Julie Davies to bring update on Rightcare Data to next Meeting
  Dr Davies gave the following update: *A meeting is being held later today for further discussion. The BI function is being prioritised and is currently set up and working well remotely. The Rightcare data will need to be scrutinised for*

potential QIPP savings. This will revisited when the current COVID-19 situation is under control. Dr Davies will give further update following the meeting later today.

FPC-2020.03.030 - Quality, Innovation, Productivity & Prevention (QIPP) Report

5.1 Mrs Skidmore updated members that at Month 11 there was a forecasting delivery of £16.6m however the risk adjusted position is now at £16.1m. The 2 areas of risk to note regarding the £500k are areas which are included in the year end deal with SaTH so this will not impact on the year end financial position. This is an improvement on last months risk adjusted forecast however there has been deterioration in the individual commissioning forecast which is predominantly down to capacity and staffing issues.

5.2 There is a level of unidentified risk within the pipeline schemes and plan with around £3.5m being attributed to Shropshire CCG. There is work on going in the background to address this however due to the current COVID-19 situation this has become a challenge as this is impacting on delivery of the schemes on a daily basis. This has been flagged as a risk in the report.

5.3 The COVID-19 situation was discussed further and guidance from NHSE/I is expected to detail a relaxation of expectation around Q1 delivery of QIPP plans. Plans later in the year which are reliant on Q1 activities have not yet been discussed.

5.4 The impact of COVID-19 on Care Closer to Home and MSK was discussed. It was felt that there would be opportunities created around the key priorities to achieve targeted savings. The outpatient QIPP will be accelerated and managed in a different way; a sub-group of the LHRP will be looking at this going forward. This will need to be continues post COVID-19. Community staff may need to be redeployed and demand will be modeled accordingly. Concern was raised as to what will happen when isolation is relaxed and what the impact will be however this may be opportunity to start afresh and put new practices into place for a better way of working to make further savings.

5.5 Further insight into the Individual Commissioning figures was requested as the costs appear to be going up but not in proportion to the numbers in the system. It was reported that not having a secure baseline within Broadcare was causing an impact along with capacity and staffing issues. Brief discussion was held around this.

FPC-2020.03.031 – STP Finance Report (for information)

6.1 This report was not available when the papers were circulated and had only just been received therefore Mrs Skidmore would share with members following the meeting.

Action: Mrs Skidmore to circulate STP Finance Report to members

FPC-2020.03.032 – 2020/21 Finance Plan

7.1 Mrs Skidmore reported that the Accountable Officers met with Julian Kelly recently and the feedback given was that the system needed to improve the position that was presented although no target or trajectory was given. The main area of focus would be the activity assumptions at SaTH and reducing the pre-QIPP growth to 4%. SaTH have since agreed to do this in the planning but will still need to commit to the block contract arrangements. SaTH have also requested that the CCG add in a risk the difference in the adjustment. Triangulation of the numbers with SaTH is awaited

however it is expected that this impact be around £2.8m which will improve the deficit.

7.2 The Finance Team have been doing some work around modelling assumptions and some Kings Fund information around benchmarking for prescribing growth has been received and applied to the model which results in around £500k being taken out. A risk may be noted around this. Other areas where this may be reduced include Better Care Fund and Care Closer to Home. New NICE guidance received enables being able to get more from the reserves for the providers.

7.3 After these measures have been put into place it is hoped to reduce the deficit from £55m to £50m; this is without stopping the Mental Health Investment and without stripping out any challenging schemes. Reducing the plan to £50m will mean that figures are only £500k away from the underlying recurrent exit position. Members commented that the report would need to be made clearer when it is taken to the Governing Body.

7.4 SaTH have also revised their numbers alongside both CCGs and it is hoped that as a system around £10m will be taken out of the position and this will be submitted to NHSE/I on 27 March.

7.5 Next steps will be to set operational budgets for managers based on the latest position; this will be heavily caveated that this is a draft working position subject to review and re-budgeting if necessary when the position is finalised. Members agreed with this proposal.

7.6 Block contracts were discussed as to whether they can still be signed when the impact on the activity levels due to the elective cancellations is unknown. Mrs Skidmore reported that guidance is awaited but the key message is that all providers will receive payment from their lead commissioner; the payment value will be calculated centrally. There is an expectation that a settling up process will be put in to place. However regarding the contracts it is not entirely sure how this will go forward given the current situation. It is not yet known what will or will not be signed although the agreement for block contracts is already in place. National guidance is awaited.

7.7 The possibility of having an Extra-Ordinary Governing Body to in April to confirm the plan was briefly discussed and whether it was still appropriate for this to go ahead or whether to postpone the plan sign off until May. Members agreed to wait until May and to recommend that Governing Body Members sign off the draft budget however if anything changes in the meantime Mrs Skidmore would contact Mr Morris for further discussion.

7.8 The Statutory Recommendations Report from Grant Thornton was discussed as it could potentially cause issues around the financial position.

Monthly Monitoring for Finance and Performance

FPC-2020.03.033 – Finance & Contracting Report

8.1 Mrs Skidmore gave the good news summary that the forecast had held for another month however it is very tight due to the issues with individual commissioning and landing month 12 will be challenging.

8.2 All spending relating to COVID-19 can be reclaimed so this is being closely monitored. Jon Cooke is leading on this data collection and monitoring grip and

control around the spend processes. A QIPP update will be taken to the Audit Committee in April.

8.3 PWC are continuing with the desk top review; this is being paid for by NHSE/I.

8.4 There is an extension to the deadline for Year End and Final Accounts due to the COVID-19 situation, however it is hoped the team will be able to hit the original deadlines.

FPC-2020.03.034 – Performance Report

9.1 Dr Davies reported that the team are currently working remotely where possible and will continue to report as long as the data flow is coming through. However it is expected that the performance requirements will change as there is the possibility of a COVID-19 dashboard which will need to be complied with.

9.2 There has been a reduction in the emergency and ambulance activity and due to the impact of COVID-19 with an improvement in ambulance handovers although this may change significantly in the coming weeks.

9.3 The impact on RTT waits will be severely impacted by COVID-19 due to the suspension of elective activity which will increase the number of 52 week breeches going forward. A national piece of work is on going on how to utilise capacity to meet the needs of non-ventilated support for COVID-19 patients and also for urgent and cancer activity based on clinical urgency. A sub-group of the LHRP has been set up to help manage demand due to referrals still being received from Primary Care.

9.4 Cancer performance continues to improve and it is hoped that impact is minimal going forward.

9.5 The underreporting regarding failure to apply on mixed sex accommodation on ITU was discussed and it was confirmed that this work is on going around this and Dr Davies is linking in with Maggie Bayley regarding this. Further update will be provided to the next meeting.

Action: Dr Davies to bring update on failure to apply underreporting to next meeting

FPC-2020.03.035 – Key Messages to the Governing Body

- Holding fast on the budget
- Draft budget to sign off in May
- Uncertainty around assumptions in the plan
- Deterioration in RTT and 52 week waits

FPC-2020.03.036 - Any Other Business

10.1 There were no items of Any Other Business

Date and Time of Next Meeting

Wednesday 29 April 2020, 11am – 1pm via conference call

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.089
Shropshire CCG Governing Body meeting: 8.07.2020

Committee Meeting Summary Sheet	
Name of Committee:	Quality Committee
Date of Meeting:	25th March 2020
Chair:	Meredith Vivian, Lay Member, Patient and Public Involvement

Key issues or points to note:

- The Quality Team is currently supporting the Director of Planning with the CCG's response and co-ordination of Covid 19 (Coronavirus).

- Workforce remains a significant challenge for SaTH with a high number of vacancies across both nursing and medical specialties. In particular there is a shortage of Paediatric trained nurses within the Emergency Department.

- The Committee heard that at the February Risk Summit, to respond to the ongoing drive to improve quality and safety at SaTH, support had been agreed in relation to a number of workstreams including IT, Peer Support & Mentoring, Workforce, Training for ED nurses in Paediatric competencies, sharing of learning from peers on Sepsis, as well as additional staff to support the ED, work to review and support the frailty pathway, and service configuration. Twice weekly system calls have taken place with NHSE/I and the weekly Safe Today calls with SaTH continue.

- The Mental Health Wellbeing provider has been commissioned to address the waiting list backlog of 12+ months and continues to work closely with MPFT.

- Ofsted and CQC carried out a joint CCG / Local Authority area inspection for SEND. A draft report is now with the CCG for factual accuracy and development of an action plan.

- The Committee heard that since CQC had highlighted issues within Maternity the SaTH Maternity Department had put a recovery plan in place and have been reporting progress weekly to CQC and the CCG. Feedback received was that handover, organisation of the department, and staff morale, had seen positive changes for staff and mothers and their families.

- There is currently one Never Event at Robert Jones Agnes Hunt Orthopaedic Hospital (RJAH). There are currently two Never Events at Shrewsbury and Telford Hospitals NHS Trust (SaTH). Full details are awaited.

- The Committee heard that in response to the Covid 19 outbreak, a local Health Resilience Forum has been set up, co-chaired by Sam Tilley (CCG Director of Planning) and Rachel Robinson (Director of Public Health at Shropshire Council). As part of that group a series of Task & Finish groups have been established to ensure that the work being done meets all the needs of patients, carers and providers. Specific COVID Workgroups include Mental Health and Learning Disability in Children, Comms, Infection Prevention & Control, the Care Sector, Primary Care, Excess Deaths, Human Resources and Care Pathways. Work is also being done around transport, Local Authority community resilience, and a cross-border weekly call also takes place.

Actions required by Governing Body Members:

- To note.

Shropshire Clinical Commissioning Group

MINUTES OF THE QUALITY COMMITTEE
HELD BY TELECONFERENCE AT 2.00PM ON WEDNESDAY 25 MARCH 2020

Present

Mr Meredith Vivian	Lay Member for Patient & Public Involvement
Mr Keith Timmis	Lay Member for Audit & Governance
Miss Maggie Bayley	Interim Executive Director of Quality & Nursing
Mrs Sarah Porter	Lay Member for Transformation
Dr Julie Davies	Director of Performance, Shropshire CCG
Dr Alan Leaman	Secondary Care Consultant, Shropshire CCG
Dr Jessica Sokolov	Executive Director of Transformation; Medical Director
Mr Brian Rapson	HealthWatch, Shropshire
Mrs Helen Bayley	Strategic Lead for Quality and Care Improvement Team
Mrs Chris Billingham	Personal Assistant; Minute Taker

QC-2020-03.024 (Agenda Item 1) - Apologies
Mr Vivian welcomed members to the meeting.

Apologies were received from Mr Joe Allan, and Ms Lynn Cawley.

QC-2020-03.025 (Agenda Item 2) - Members' Declaration of Interests
There were no declarations of interest.

QC-2020-03.026 (Agenda Item 3) – Minutes/Actions of Previous Meeting Held on 26 February 2020 and Action Log
The Committee requested that the following amendments are made to the minutes of the previous meeting:

Page 2, Provider Exception Report
The action point states that "Mrs Helen Bayley was to provide an update to a future Committee on the Action Plan for workforce retention at SaTH".

This should be amended to reflect the fact that an invitation was to be extended to SaTH to attend a future Quality Committee to update the meeting on their workforce retention plan.

Page 4, Patient Experience - Final Paragraph
"Mr Timmis commented that the CCG must consider what steps they should be taking to improve discharge arrangements. Only then would Quality Committee consider submitting the report to the Governing Body as a patient experience".

This comment was not made by Mr Timmis, but by Mrs Jane Blay.

The Action Tracker was updated as appropriate.

QC-2020-03.027 (Agenda Item 4) – Provider Exception Report
The report was taken as read. Mrs Helen Bayley drew the following key issues to the attention of the Committee:

- The Quality Team is currently supporting the Director of Planning with the CCG's response and co-ordination of Covid 19 (Coronavirus). This involves working with partners in health and social care.

- SaTH was rated inadequate by Care Quality Commission (CQC) following an inspection in September 2018. Prior to publication of the CQC report, NHS Improvement placed the Trust into Special Measures.
- Workforce remains a significant challenge for SaTH with a high number of vacancies across both nursing and medical specialties. In particular there is a shortage of Paediatric trained nurses within the Emergency Department.
- The Mental Health Wellbeing provider has been commissioned to address the waiting list backlog of 12+months and continues to work closely with MPFT.
- Ofsted and CQC carried out a joint CCG / Local Authority area inspection for SEND. A draft report is now with the CCG for factual accuracy and development of an action plan.
- The CCG has formally raised concerns relating to poor engagement from WMAS.

Helen Bayley referred to workforce and advised that SaTH had been overwhelmed by the number of retired medical staff who had contacted them to offer to return to work. The biggest challenge for SaTH at the moment is the administration involved, e.g. DBS checks, an interview process, etc. and Helen Bayley is involved with SaTH to support the process and help reduce the backlog of staff who have offered to return to work.

Mr Vivian referred to the greatly reduced number of 12 hour trolley breaches in February and queried the reason for this. Helen Bayley replied that the reduction was partly due to the reduction in admissions. In addition, work has been done to triangulate some of the admissions who, it was felt, should not have been in the department or those for whom it had taken a considerable length of time to review medically in order to get them out of the department.

Mrs Porter referred to Point 7 of the report – Midlands Partnership NHS Foundation Trust (MPFT) - and the neurodevelopmental pathway that had been agreed but for which financial approval was awaited. She asked where the approval was coming from, how long the approval would take, and whether there was any risk that it would not be granted. Dr Davies advised that, because of the current position the CCG found itself in, it was unable initially to plan its own expenditure and was subject to the CCG compiling an appropriate financial recovery plan. However, because of Covid 19, no resources are to be allocated for the time being and all decisions relating to future investment are on hold. Dr Davies has raised the risk associated with this situation at Exec Team, and it will be continually monitored until such time as it can be agreed.

Mr Vivian highlighted Page 4 of the report and comments relating to Maternity services which referred to a "wide number of initiatives in place to improve quality".

Maggie Bayley advised that since the CQC report highlighted issues within Maternity, the team have had a plan in place and have been reporting on a weekly basis to CQC and the CCG progress on a number of actions and initiatives to address performance in relation to how they respond and provide support in terms of the service delivered. Feedback received was that in terms of handover, organisation of the department, and staff morale, there had been a positive change in terms of how the staff felt and how the women and their partners felt about the care that had been delivered to them. Maggie Bayley wished it to be noted that, when the CQC visit took place, she was working within the organisation. There had been a change of leadership and therefore a change of focus in terms of expectations in terms of delivery. The CCG, through the weekly reporting to CQC, receive a copy of progress against the actions that have been put in place and also evidence that there has been continuous improvement in terms of how women are looked after including, for example, triage.

The Trust has now received the latest CQC report which, it is anticipated, will be made published in the next two weeks.

Dr Leaman was of the opinion that the CCG should have been able to identify shortfalls in provision of the Maternity service by noting certain Key Performance Indicators (KPI's). MB confirmed that internally the CCG were reviewing the timeline of events that had occurred within maternity and actions taken by the CCG once this is collated a board briefing is planned to take place. Until this background work has been completed Maggie Bayley felt that she could not comment further until she had the opportunity to link into that information and try to understand whether anything could have been done differently.

QC-2020-03.028 (Agenda Item 5) – Never Event Report

There is currently one Never Event at Robert Jones Agnes Hunt Orthopaedic Hospital (RJAH).

There are currently two Never Events at Shrewsbury and Telford Hospitals NHS Trust (SaTH).

Dr Davies referred to the incident at RJAH and the practice whereby two different types of implants were placed on the same tray. Although there is a suspension of routine elective activity they are maintaining urgent and cancer surgery, and there is a potential for this error to be repeated. It was noted that the investigation into the incidents is not yet complete and once the full root cause analysis's (RCA's) are received a much better level of detail will be available.

Since compilation of the Quality Committee report another Never Event has been reported at SaTH. Details are not yet known and an update will be provided to the next Committee.

ACTION: Maggie Bayley confirmed that issues involved in the Never Events at SaTH would be followed up.

QC-2020-03.029 (Agenda Item 6) – Coronavirus Update and Planning

Maggie Bayley provided the Committee with a verbal update on Covid 19 on behalf of Sam Tilley.

- At the beginning of the Covid 19 outbreak, a local Health Resilience Forum was set up, co-chaired by Sam Tilley and Rachel Robinson. As part of that group a series of Task & Finish groups have been established to ensure that the work being done meets all the needs of patients, carers and providers.

- Workgroups include Mental Health Learning Disability in Children, Comms, Infection Prevention & Control, Care Sector, Primary Care, Excess Deaths, Human Resources and Care Pathways. Work is also being done around transport, Local Authority community resilience, and a cross-border weekly call also takes place.

- Daily national Covid calls take place. These include multiple calls that the entire system is involved in; and a national weekly Covid briefing with Professor Keith Willetts, the Emergency Covid Planning Lead at NHSE/I.

- In addition, there are weekly or bi-weekly professional calls involving various groups, e.g. Chief Nursing Officers. All organisations within Shropshire are implementing their Business Continuity Plans and within the context of that the CCG is following national guidance around how it works and operates.

- As many staff of the CCG as possible are working from home. Essential work must continue and the Executive Team have been working through priorities and essential work over the last few weeks to streamline and focus priorities for teams. Biggest concerns and biggest areas of work have been Prescription Ordering Direct (POD), Referral Assessment Service (RAS), and TRAC, the online recruitment system.

- The POD team normally receives 2,000 calls a week but for several weeks have been taking an exponential rise and up to 15,000 calls a day. Consideration is being given as to how they can be supported by identifying all staff who can work on the front line, and all admin staff who could be re-trained to support POD and other essential areas of work.

- Frequency of all meetings and Committees has been reviewed by the Executive Team and further discussions will take place to enable the Accountable Officer to discuss with the Chairs of the two CCG's plans in terms of work over the next few months.

- New national guidance was issued week commencing 16 March 2020 in relation to Continuing Healthcare payments and the normal processes have been suspended; discharge has fallen to the providers. Case management of patients will continue by the team.

- A Covid Bill is currently being passed which will allow creation of an Emergency Register for retired nurses. Third year student nurses in the last six months of their placement will be able to voluntarily join the emergency register to work as Registered Nurses. Work is also taking place in relation to first and second year students in relation to them working as Healthcare Assistants on a voluntary basis if they choose to.

- NHS England has taken over the powers of all CCGs in terms of purchasing private hospital beds.

- A Tactical Control Group has now been set up for the whole system and Sam Tilley is currently working through the requirements of other organisations to participate in that Group with our partners in the Local Authority and Police to deliver that system oversight.

- We have been clearly briefed that we are 2-3 weeks behind Italy and within our area we are very clear as to what needs to be done by our providers to get us in a position to try to do our best to cope and care for patients in the best possible way.

- Guidance is to be issued in relation to Critical Care. The number of Critical Care beds that will be required for patients is exponential, and 4,000 such beds have been created at the Nightingale Hospital in London.

- Concerns have been received from various areas regarding Personal Protective Equipment (PPE). A massive amount of work is being carried out nationally and locally to ensure that the PPE required by teams is available.

The Chair invited questions.

Mr Vivian asked if PPE was reaching Care Homes. Maggie Bayley replied that providers had been issued with supplies at the weekend and Infection Prevention & Control (IPC) have checked with providers that they currently have sufficient supplies and equipment. Reporting will take place on a regular basis and Maggie Bayley has agreed to be the Executve lead for the IPC task and finish group that group to be involved in supporting the maintenance of an adequate service. New guidance is to be issued on PPE nationally. However, some PPE was being used inappropriately and the IPC team are helping to manage this issue.

The Committee discussed redeployment of staff, and Maggie Bayley advised that this is included in Business Continuity Plans which each of the organisations are currently implementing. Clinicians are making decisions regarding patients and which treatments will continue, although these will be very minimal. Specific conditions will be clearly reviewed to avoid harm to patients, and the CCG will ensure that a specific risk stratification process is in place via the Clinical Pathways Group. Dr Davies reassured the Committee that, as well as Covid 19, clinical urgency will be managed.

Mr Rapson advised the Committee that Healthwatch had received reports of social workers experiencing difficulties in communicating with MPFT.

Dr Davies had spoken to Cathy Riley, MPFT Lead in Shropshire, who advised that MPFT are experiencing an unprecedented impact of Covid 19. Staff absences are high and they also have a considerable number of Covid 19-positive patients within their inpatient setting. They have admitted that currently communication is challenging. Cathy Riley has agreed to join Dr Davies' Care Pathway overarching group and any mental health related issues that are picked up in the sub-group will be escalated to Ms Riley to deal with. Dr Davies asked to be advised of any specific issues that she could assist with.

ACTION: Brian Rapson to send details of any Covid-related issues received by Healthwatch to Mrs Billingham to circulate to the appropriate Manager.

Mr Timmis requested clarification regarding the 4,000 bed unit which had been created at Excel and asked if a similar facility was being created in the Midlands. He also wished to know if the Excel beds were a critical care facility or general medicine beds. Maggie Bayley replied that they are 4,000 critical care beds, and a plan was currently being worked up regarding extra care beds in the Midlands. No further information was available as the detail was still being worked upon.

Dr Leaman expressed his concern once again that the CCGs had a very fragile A&E service in their areas and he was concerned that central guidance will be based on the idea of a well-staffed, robust A&E department, which did not exist in Shropshire. He believed that additional steps should be taken to protect the department and its staff from contracting Coronavirus. He believed that exceptional measures need to be taken to protect the very fragile A&E service that exists in the County. He was of the opinion that patients with respiratory symptoms should not be going through the A&E department - they should either be seen in a community care setting or go to a designated ward. If the A&E department *should* go down, then there would not be a Trauma Unit for Shropshire and Powys. Maggie Bayley agreed with Dr Leaman that such patients should not be dealt with in A&E department and Mrs H Bayley advised that the department has been separated into red and green zones to manage patients as a pragmatic approach to ensure that patients and staff are protected going forward. The Shropshire Care Closer to Home service is temporarily suspended for the next three months or so to ensure that the right capacity is in the right place at the right time during the Covid emergency.

QC-2020-03.030 (Agenda Item 7) – SaTH Follow Up Risk Summit
Maggie Bayley referred to her written report and advised that the minutes of the Risk Summit are confidential, therefore her report consisted only of high level summary information which she was in a position to share.

At the last Risk Summit held in February support had been agreed in relation to a number of workstreams including Digital & IT, Peer Support & Mentoring, Workforce, Training for ED nurses in Paediatric competencies, sharing of work in relation to Sepsis by Sherwood Forest Hospital and action plan to address similar issues raised within, and additional staffing to support the ED from external organisations, work to review and support the frailty pathway, and service configuration.

A huge amount of work was carried out to look at how teams could be supported. However, all plans have now been superseded by Covid 19.

In terms of maintaining assurance, twice weekly system calls have taken place with NHSE/I and the weekly Safe Today calls with SaTH continue on a Friday. Joe Allan will be in the Emergency Department three days a week on a clinical basis for the foreseeable future and potentially, once crisis point is reached, full time.

It has been agreed with NHSE/I that one assurance call per week will take place in order to ensure that relevant information is received regarding maintaining safety in the department. A follow up call will potentially take place in 4 weeks' time depending on the situation with the Covid crisis nationally by then.

QC-2020-03.031 (Agenda Item 8) – Healthwatch
Mrs Cawley's report was taken as read.

Mr Rapson, who attended the meeting on Mrs Cawley's behalf, advised that Healthwatch Shropshire are continuing to work with communities where English is not the first language. However, they have been advised against directing them towards using Google Translate as it does not translate reliably. The NHS has issued translations of the guidance around Covid, and Healthwatch are also using another service called "Doctors of the World.org" a group of doctors in this country who translate information into a wider range of languages.

In response to a question from Dr Davies, Mr Rapson confirmed that Healthwatch is a member of the Comms Sub Group linked to the Local Health Resilience Partnership (LHRP) and are capturing the experiences of the public in relation to the service being provided across the County.

ACTION: Dr Davies will discuss with Sam Tilley as to where feedback received by Healthwatch should be directed.

QC-2020-03.032 (Agenda Item 9) – Points to Escalate to CCG Board
The Committee were asked to note and escalate to the Board the fact that the Risk Summits were continuing, as would the assurance process around SaTH.

QC-2020-03.033 (Agenda Item 10) – Any Other Business
There was no other business.

As this was Dr Sokolov's last Quality Committee before she took up her new appointment as Medical Director – System Improvement & Professional Standards at NHSE/I, the Chair thanked her for her contribution to the Committee over the last 3 years and wished her every success in her new role.

QC-2020-03.034 (Agenda Item 11) – Date and Time of Next Meeting
The date and time of the next meeting is Wednesday 27 May 2020.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.090
Shropshire CCG Governing Body meeting: 8 July 2020

Committee Meeting Summary Sheet	
Name of Committee:	North Locality Board Meeting
Date of Meeting:	27 February 2020
Chair:	Dr Katy Lewis

Key issues or points to note:

PLT – Discussion took place about plans and arrangements for the PLT sessions and options for covering these and suggested topics.

CCG Chair Update – Dr Julian Povey gave an update about work ongoing to align the constitutions of Shropshire CCG and Telford and Wrekin CCG and membership vote needed for this. An update was given about management of change processes at the CCGs. Information was also given about CCG finances.

Ultrasound Guidance - Dr Leah Farrell, Consultant Radiologist from SaTH attended the meeting to talk through a guidance document that had been put together to clarify what could be referred and answered questions from Members about this.

ADHD/Autism Pathway – Cathy Davis attended the meeting to talk about the pathways and ASD waiting list initiative.

NDPP – The new providers of the National Diabetes Prevention Programme (Living Well Taking Control) attended the meeting to introduce themselves and talk about the service and answer questions.

Medicines Management – there was a presentation to Members about self-care. Members also discussed issues around Hydroxychloroquine and eye screening.

Palpitations Pathways – the approved pathways were provided that had been developed following a workshop held in the Shrewsbury and Atcham Locality.

Actions required by Governing Body Members:

- No actions required

Minutes of the

North Locality Board Meeting

Thursday 27 February 2020

The Venue at Park Hall, Oswestry

NHS Shropshire Clinical Commissioning Group

Member Name	Practice	Attendance
Dr Adam Booth	Baschurch – Prescott Surgery	*Apologies*
Nicolas Storey	Baschurch – Prescott Surgery	Attended
Dr Tim Lyttle	Churchmere Medical Group	Attended
Jenny Davies	Churchmere Medical Group	Attended
Dr Anna Schur	Clive Medical Practice	Attended
Zoe Bishop	Clive Medical Practice	*Apologies*
Dr James Mehta	Hodnet Medical Centre	Attended
Ros Mehta	Hodnet Medical Centre	Attended
Dr Jonathan Davis	Knockin Medical Centre	*Apologies*
Mary Herbert	Knockin Medical Centre	*Apologies*
Dr Mike Matthee	Market Drayton – Drayton Medical Practice	Attended
Michele Matthee	Market Drayton – Drayton Medical Practice	Attended
Dr Santiago Eslava	Oswestry - Cambrian Medical Centre	*Apologies*
Kevin Morris	Oswestry - Cambrian Medical Centre	Attended
Dr Stefan Lachowicz	Oswestry – The Caxton Surgery	Attended
James Bradbury	Oswestry – The Caxton Surgery	Attended
Dr Yvonne Vibhishanan	Oswestry - Plas Ffynnon Medical Centre	Attended
Sarah Williams	Oswestry - Plas Ffynnon Medical Centre	Attended
Dr Alistair C W Clark	Shawbury Medical Practice	*Apologies*
Kirsty Arkinstall	Shawbury Medical Practice	Attended
Dr Catherine Rogers	Wem & Prees Medical Practice	Attended
Caroline Morris	Wem & Prees Medical Practice	*Apologies*
Dr Katy Lewis (Chair)	Westbury Medical Centre	Attended
Helen Bowkett	Westbury Medical Centre	Attended
Dr Ruth Clayton	Whitchurch – Dodington Surgery	Attended
Elaine Ashley	Whitchurch – Dodington Surgery	*Apologies*
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Chair	Attended
David Evans	CCG Accountable Officer	*Apologies*
Nicky Wilde	CCG Director of Primary Care	*Apologies*
Janet Gittins	CCG North Locality Manager	Attended
Heather Clark (Minutes)	CCG Personal Assistant	Attended
Amanda Laing	CCG North Locality Pharmacist	*Apologies*
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	Attended
Claire Hand	CCG Project Lead Pharmacy Technician	Attended
Dr Leah Farrell	SaTH Consultant Radiologist	Attended
Cathy Davis	CCG Mental Health Commissioning Lead	Attended
Stuart Brown	Service Manager, Living Well Taking Control	Attended

Minute No NLB-2020-02.014 [Item 1] - Welcome & Apologies

1.1 Dr Katy Lewis welcomed those present for attending; apologies were recorded as above.

Minute No NLB-2020-02.015 [Item 2] - Members' Declarations of Interests

2.1 There were no further interests declared for items included on the agenda.

Minute No NLB-2020-02.016 [Item 3] - Minutes of Meeting held on 23 January 2020

3.1 The minutes of the meeting held on 23 January 2020 were approved as an accurate record of the meeting and were signed by the Chair.

Minute No NLB-2020-02.017 [Item 4] - Matters Arising from Previous Meeting

4.1 Minute No NLB-2020-01.009 – PLT (Protected Learning Time) – Dr Lewis advised that Shropdoc were not able to provide cover for the first PLT session which was planned to be an in-house PLT. The two later dates would be covered by Shropdoc. Dr Povey explained that the Shrewsbury Locality had made a suggestion that their PCN could cover their PLT session. The CCG were also looking into the possibility of 111 taking calls and booking appointments, with urgent appointments being made available by the practice later in the day. A discussion took place about the options for covering this and it was suggested that the Locality could just have two PLT sessions with one being in-house as these were more useful to practices. Suggested topics were common childhood problems (such as sleep disorders and constipation), cancer guidelines/pathways and mental health (particularly self-harm and suicidal ideation in teenagers). A discussion took place about advice and guidance, the letters that are sent out and how these referrals go through RAS (Referral Assessment Service). Proposed PLT dates were confirmed as 13 May 2020, 1 July 2020 and 22 October 2020. Members agreed to think about the first PLT date and how this could be covered and send ideas back to Janet Gittins.

ACTION: Janet Gittins to confirm Advice & Guidance pathways/processes through RAS including letters that are sent out.

Members to send ideas about how to cover the first PLT date to Janet Gittins.

Minute No NLB-2020-02.018 [Item 5] – CCG Chair Update

5.1 Dr Julian Povey explained that Shropshire CCG and Telford and Wrekin CCG were still on track in the formation of a single CCG from April 2021. Work was ongoing to align the two constitutions in time for 1 August 2020 and looking at having joint committees or committees in common. A draft of the new constitution would be sent out and a joint Membership meeting had been arranged for the evening of Tuesday 24 March 2020. There would then be an electronic vote on the constitution for Shropshire Members.

5.2 The plan would also include changes to the CCG Boards so that the same people were shared by both Boards such as the Executive Directors, Secondary Chair Doctor and Lay Members, with 3 GPs from each CCG on the Board as was previously agreed. There would be a need to go through the management of change process for the Boards and Chairs of the CCG. The CCGs Executive Director team had already gone through this process and roles had been appointed to, with vacancies remaining in the Quality and Partnerships roles. Dr Sokolov would also be leaving the CCG at the end of April to take up a post as a Medical Director for NHS England/Improvement. This means there will also be a vacancy for the Executive Director of Transformation role. GPs on the new Board would not be involved in any programme design work, only strategy and assurance. This means there would still need to be medical input into the CCG and this was still being designed.

5.3 The whole process had been driven by the NHS England direction to have a single CCG per STP (Sustainability and Transformation Partnership) and to reduce running costs by 20%. Executive Directors were still in the process of designing their directorate structures, and staff would have to go through a management of change process in the near future. It was likely that a MARS (Mutually Agreed Resignation Scheme) would be on offer to staff, with a period of consultation on the new structure following this. Dr Povey noted that this was a very difficult and stressful time for CCG staff and for Members to be aware of this.

5.4 Dr Povey advised that the CQC (Care Quality Commission) went back into SaTH (Shrewsbury and Telford Hospital NHS Trust) accident and emergency department last week and found the same problems as before (9 and 18 months ago). There was now major pressure in the system about quality issues. A risk summit took place with the regional NHS England team and hospitals in the region, but there had been no further news following this yet.

5.5 CCG finances were still challenging, but as of next year the system will be looked at as a whole. There was now a system plan in place for 2020/2021 which showed an aim to end the year with a deficit of £76m as a system (compared to a £90m deficit this year). This was £40m more than the target set by NHS England and discussions were ongoing about how to close the gap. A question was asked about other STP performance; Dr Povey advised that Shropshire Telford and Wrekin STP was one of 10 STPs (out of 40) that were at level 4. A discussion took place about whether there was enough money in systems as there were so many not performing well.

5.6 A discussion took place about finance, staffing and quality issues at SaTH and how this could be improved. There were also concerns about work coming from Secondary Care to other areas such as Primary Care. Dr Lyttle asked if 111 had made an impact on this; Dr Povey explained that there were more 12 hour breaches this year compared to the previous year even though the numbers of patients attending were fewer; it was more to do with the flow through the hospital.

Minute No NLB-2020-02.019 [Item 6] – Locality Chair Update

6.1 Dr Lewis explained that the locality chair update that had been circulated had been completed by Dr Deborah Shepherd, Chair of the Shrewsbury and Atcham Locality. There were no further questions about this. Dr Lewis added that the Director of Public Health had attended the Clinical Commissioning Committee Working Group to discuss development of smoking cessation and weight management services. Public Health was in the process of completing a needs assessment, but there were no further updates about this.

Minute No NLB-2020-02.020 [Item 7] – Ultrasound Guidance

7.1 Dr Leah Farrell, Consultant Radiologist from SaTH, attended the meeting to talk about GP Ultrasound. Dr Farrell explained that there had been a steady increase in referrals and therefore a guidance document had been put together to clarify what could be referred as there were quite a few inappropriate referrals received which had created long waiting times. Dr Farrell talked through some of the guidelines for justification of ultrasound requests and information about the current waiting times.

7.2 Dr Farrell explained that the main thing that was needed was more clinical detail on referrals. She added that the information presented in the guidance was also available on iRefer. Dr Povey explained that this was still available and the CCG had just renewed the subscription. Members asked that if referrals were sent back to GPs via a letter, that the original referral was included with the information sent back so that the GP could see what information they included on the referral form, this was not always stored on GP systems.

7.3 A discussion took place about the outsourcing of work from radiology to Everlight. Dr Farrell advised that GPs could ring the team for advice if they received referrals back from Everlight and were not sure what to do next, or had any other issues. Members reported that they found it difficult to speak to consultants within the radiology team and would get through to the answer phone quite a lot. Dr Farrell stated that the secretaries in the team would put GPs through to someone to speak to. There was also an advice and guidance service set up and Dr Farrell would reissue the numbers. Members also advised that amended reports received from Everlight were very confusing as they also sent back the original report and it was not always clear which report was the new version. Dr Farrell thought that this may be due to a legal reason.

ACTION: Dr Farrell to send the phone numbers for the radiology team and advice and guidance service to Janet Gittins.

7.4 Dr Mehta asked about CT scanning and amount of radiation for patients. Dr Farrell advised that this was why all referrals were always checked and patients only have scans when needed and justified. The new equipment and technology also gave out a lower dose of radiation.

7.5 Dr Matthee asked about patients with diabetes that become dramatically unstable and whether it would still be ok to request a scan of the pancreas. Dr Farrell advised that this had been queried at a meeting she had attended recently and there was a mixed response as there was not enough evidence to support it. Dr Matthee also asked about abdominal distension; Dr Farrell advised that IBS (Irritable Bowel Syndrome) would have to be ruled out first and IBS does not require imaging.

7.6 Members stated that they found the new chest x-ray reporting to be a lot quicker. Dr Lewis advised that she had two chest x-ray requests sent back to her recently querying possible infections, to treat the patients and refer back again in six weeks. Both times after referring back the x-rays showed malignancies, and the time delay for this was quite significant. Dr Farrell advised that a lot of work was ongoing with issues and feedback that had been received and there had been many improvements made; she asked Members to continue reporting any issues like this to the team.

7.7 Dr Vibhishanan asked about communication with RJAH (The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust) and problems with images received from them by SaTH as she had been told that SaTH could not access the images. Dr Farrell advised that the images could be seen but were sent through a separate system that would need a log in, but that from a safety perspective it was better to have scans on PACS (Picture Archive and Communications System). Members raised concerns about this due to patients having to attend for two scans. Dr Povey advised that he would raise this issue at CQRM (Clinical Quality Review Meeting).

ACTION: Dr Povey to raise issue at CQRM of consultants viewing scans at SaTH that are sent from RJAH – patients are having to attend for another scan when images are already available if a separate log-in is used.

7.8 Dr Lewis mentioned a significant event that happened in the past when a patient was seen at SaTH for a CT scan which a SaTH Radiologist reported as showing a pancreatic tumour. The patient was referred to Stoke; they insisted on completing another scan as they thought the SaTH images were not good enough and didn't agree with the diagnosis. The Stoke Radiology thought that the new images showed the patient had chronic pancreatitis. SaTH completed another CT scan, as the patient was deteriorating. Dr Lewis was involved in the investigation which came up with the recommendation that if two consultants had conflicting opinions a third should be involved – Dr Lewis queried whether this process was now in place. Dr Farrell advised that she was not part of these processes but was aware that MDT (Multi-Disciplinary Team) meetings took place which involved a number of people when patients were transferred.

Minute No NLB-2020-02.021 [Item 8] – ADHD/Autism Pathway

8.1 Cathy Davis attended the meeting to talk about the ADHD (Attention Deficit Hyperactivity Disorder) and Autism Pathways. She advised that the ADHD pathway was up and running and was a straight forward referral into BeeU, although there was a wait for this service.

8.2 At a previous meeting it was explained that for ASD (Autism Spectrum Disorder) there was a review completed and a waiting list initiative was set up for children waiting for over 12 months as at the end of October 2019. All other referrals and new referrals were still on a waiting list. The children on the waiting list initiative (around 120) had been split; with the under 11 years being seen by BeeU and the over 11 years being seen by a private provider call Mental Health and Wellbeing. All families in this cohort had been written to and explained they could accept to go to the alternative provider or decide to stay with BeeU. All that responded accepted to go to the new provider, with 22 not responding – these families had been contacted a further three times. Assessments were expected to be completed by June 2020.

8.3 A business case had been agreed in principal to develop a sustainable ASD pathway, though there was still no agreed funding for this as the long term plan for mental health had not yet been agreed. For adult ASD a contract was now in place with Cheshire and Wirral Partnership Trust, this had taken a while to be signed off but they were now able to offer regular monthly slots. The team had a small capacity so there would be a wait. Patients could be referred through RAS but the preferred route for referral was through Autism for You who could help while patients were waiting and help them with pre-assessment work; this was through self-referral via phone to make an appointment.

8.4 A question was asked about what the plan was for the other children on the waiting list (approx. 180 children). Cathy Davis advised that these patients would still be referred to BeeU but would be on a waiting list. Dr Lewis asked about the new pathway for referrals from school to an MDT that would assess the needs of the child and if this was still in place. Cathy advised that this had been running in Telford for 3-4 months but the process had not been as smooth in Shropshire and it had only just been

agreed by Shropshire Locality Authority to pilot this. The feedback from Telford was that it worked well. It was confirmed that new referrals now should be referred through schools and if an assessment was needed the child would be placed onto a waiting list. There was not currently a service in place to assess children on this waiting list. There was a block contract in place but there was not enough resource to cover the demand, unfortunately the contract was not very robust to challenge them on this.

8.5 Dr Lachowicz asked about children being referred that might not have ASD but the parents need some help, and if support would be offered to them. Cathy Davis advised that the autism hub could provide practical support to families even without a diagnosis.

ACTION: Cathy Davis to send details for the autism hub to Janet Gittins/Heather Clark to circulate.

Cathy Davis to share draft ASD pathway for Members to comment on.

8.6 Dr Clayton mentioned a problem with the perinatal team having no consultant in place and receiving requests to prescribe medication without consultant advice. Dr Povey advised that this was a regionally commissioned service and was not commissioned by the CCG, and it was still worthwhile to have part of the service in place rather than no service at all. Cathy Davis confirmed that the team in place were still supporting mothers that didn't need consultant input.

8.7 Cathy Davis explained that Simon Frayer had been appointed to help with severe and enduring mental health physical health checks and had requested that any practices that he had not yet visited get in touch to arrange a visit. A letter had been sent out twice to all practices and would be sent out again.

ACTION: Practices to get in touch with Simon Frayer if he had not yet visited (for help with severe and enduring mental health physical health checks).

Minute No NLB-2020-02.022 [Item 9] – NDPP (National Diabetes Prevention Programme) New Provider

9.1 Stuart Brown from Living Well Taking Control (LWTC) attended the meeting to introduce the service as the new provider for the NDPP from 1st April 2020. Mr Brown explained that LWTC was a partnership between a Midlands-based social enterprise and a south west charity. The service had been delivered by LWTC in 24 localities across England, including rural and urban areas. The eligibility criteria for the service and referral pathways would remain the same, and the referral template would be uploaded to clinical systems and switched over week commencing 23 March 2020. LWTC would be willing to engage with practices and help with contacting patients on the practices behalf, permitting that consent and data sharing agreements were in place beforehand.

9.2 LWTC were committed to ensuring patient outcomes were sent back to practices, but didn't want to overload GPs with information so would welcome feedback on how regular this feedback was needed. The service was very open to closer working relationships with primary care and felt that it would be ideal to deliver within practices if there was spare accommodation. If this was not available the service would still be delivered in local community venues.

ACTION: Members to advise if they have any accommodation for LWTC to deliver NDPP within practices.

9.3 All materials for the programme conform to easy read and accessible standards. Non-English speakers could also get extra support and access to translation services. Sessions would be available for workers at more accommodating times in the evenings or at weekends.

9.4 Mr Brown advised that he had attended a locality meeting the previous week and there was a lot of interest in the evidence base for NDPP. In a recent journal article from January 2020 which stated that for people who completed the programme with a baseline weight of 82.4kg a mean weight change of 3.3kg was achieved overall, 37% of participants lost more than 5% of their body weight. In the article it stated that 25% of participants completed the 9 month course. The evidence showed that the longer people attended the more weight reduction and blood sugar level reductions were achieved.

9.5 Mr Brown explained that the service aimed to have 15-20 participants to start a group, but could start a group with 8 people in rural areas where needed. It was aimed to deliver the programme as locally as possible and it was hoped that there would not be a wait for the groups any longer than two weeks. Contact would be made within 5 working days of referral. Sessions would start off at a fortnightly basis and then every three weeks. To keep participants engaged there would also be automated messages and other services to keep them occupied.

9.6 Dr Lyttle asked about the obstacles in getting significant reductions. Mr Brown advised that this was primarily retention; the initial version of the programme was all face to face, but there was now a digital remote service which would improve retention.

Minute No NLB-2020-02.023 [Item 10] – Medicines Management Update

10.1 Claire Hand and Clare Michell-Harding attended the meeting and gave a presentation about Self-Care which included the following information:

- Costing information as a CCG compared to other CCGs in England showed that Shropshire CCG was performing well; compared to 10 similar CCGs Shropshire CCG was in the middle.
- Figures showed that dispensing practices in Shropshire were spending more than non-dispensing practices. It was thought this was due to not having access locally to buy over the counter medication in rural areas.
- NHS England set a savings target for Shropshire CCG of £270k, Shropshire CCG set a target to achieve £100k. The actual savings achieved were only £3200 between April 2019 and December 2019.
- Information about high cost conditions – Members reported problems with other services telling patients they could go to their GP for a prescription for these high costs conditions e.g. prescribing vitamin D. The Medicines Management Team were working through each condition and working on schemes with secondary care and other services.
- Information on campaigns in Shropshire and patient awareness/expectations - Members agreed that patient education also needed a more national focus with national campaigns. There was a slight improvement nationally when the self-care initiative started but this progress was now stagnant.

10.2 Dr Lyttle asked about Hydroxychloroquine, he had decided not to prescribe as there was no shared care document in place and was sending requests back to RJAH. Clare Michell-Harding advised that the shared care document was a separate issue from the eye screening, the reason it was done like this historically was that NHS England guidance was to do this by condition-specific and not drug-specific. The recent guidance from the Regional Medicines Optimisation Committee which was also in conjunction with NHS England was now to go back to drug-specific guidance and therefore there was now a need for there to be an individual shared care agreement for Hydroxychloroquine. The CCG had been in consultation with RJAH and they will be updating this document imminently.

10.3 The eye screening was a slightly separate issue. In 2018 the Royal College of Opthalmology published new recommendations on monitoring requirements, mostly around additional eye screening and more frequency for higher risk patients. The guidance suggested that there was a gold standard assessment for patients, but the type of test the guidance suggested was not available. The new guidance was written following a study in America, it was confirmed that the level of evidence the guidance is written from is low and was not an essential test, just a gold standard test. The test could be done in hospital and the CCG were in discussions with SaTH about this. Dr Lyttle advised that Leighton Hospital in Crewe were providing the additional eye tests. At the moment it was recommended that Members follow what was in the SPC and British Society of Rheumatology guidance.

Minute No NLB-2020-02.024 [Item 11] – Palpitations Pathways

11.1 Dr Lewis advised that the palpitations pathways had been approved and were now available on the CCG website. She asked practices to discuss these and email any comments back to her.

ACTION: Members to send any comments about the Palpitations Pathways back to Dr Katy Lewis.

Minute No NLB-2020-02.025 [Item 12] – Primary Care Update

12.1 The Primary Care update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No NLB-2020-02.026 [Item 13] – Commissioning Update

13.1 The Commissioning update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No NLB-2020-02.027 [Item 14] – Any Other Business

14.1 There were no other items raised for discussion.

Minute No NLB-2020-02-028 [Item 15] - Date of Next Meeting

15.1 The next meeting will take place on: **Thursday 26 March 2020** at **Drayton Medical Practice, Market Drayton** commencing at **2.30pm.**

A provider session will take place before the Locality Board from 1.30 – 2.30pm.

Future Meeting Dates

- Thursday 23 April 2020 – Venue to be confirmed
- Wednesday 13 May 2020 – Possible in-house PLT date
- Thursday 21 May 2020 – Drayton Medical Practice (may be cancelled if PLT above goes ahead)
- Thursday 25 June 2020 – Venue to be confirmed
- Wednesday 1 July 2020 – PLT
- Thursday 30 July 2020 – Drayton Medical Practice
- Thursday 24 September 2020 – Venue to be confirmed
- Thursday 22 October 2020 – PLT
- Thursday 26 November 2020 – Drayton Medical Practice
- Thursday 28 January 2021 – Venue to be confirmed
- Thursday 25 February 2021 – Drayton Medical Practice
- Thursday 25 March 2021 – Venue to be confirmed

Signed: ……..... **Date:** ……

Dr Katy Lewis, Joint North Locality Chair

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-07.091
Shropshire CCG Governing Body meeting: 8 July 2020

Committee Meeting Summary Sheet	
Name of Committee:	South Locality Board Meeting
Date of Meeting:	5 March 2020
Chair:	Dr Matthew Bird, Chair, South Locality Board

Key issues or points to note:

CCG Chair Update – an update was given about the plan to align the constitutions of both Shropshire and Telford and Wrekin CCGs and Membership vote to approve this, and an update was given about the management of change process at the CCGs. An update was also given about the coronavirus FAQ document.

Locality Chair Update – Members were advised that a PLT planning meeting had taken place and discussion took place about the arrangements for these sessions and different proposals.

Palpitations Pathways – the approved pathways were provided for the Members and it was explained these had been developed following a workshop held in the Shrewsbury and Atcham Locality.

Medicines Management – there was a presentation to Members about self-care.

NDPP – The new providers of the National Diabetes Prevention Programme (Living Well Taking Control) attended the meeting to introduce themselves and talk about the service and answer questions.

Shropshire Care Closer to Home – Dr Finola Lynch attended the meeting to give an update on this programme.

Actions required by Governing Body Members:

- No actions required

Minutes of the

South Locality Board Meeting

Thursday 5 March 2020
Mayfair Community Centre, Church Stretton

NHS Shropshire Clinical Commissioning Group

Member Name	Practice	Attendance
Dr Matthew Bird (Chair)	Albrighton	Attended
Val Eastup	Albrighton	Attended
Dr Dale Abbotts	Alveley	*Apologies*
Lindsey Clark	Alveley	Attended
Dr Paul Gardner	Bishop's Castle	Attended
Sarah Bevan	Bishop's Castle	*Apologies*
Dr Gwen Potter	Bridgnorth	Attended
Sandra Sutton	Bridgnorth	*Apologies*
Dr Mathai Babu	Broseley	Attended
Nina Wakenell	Broseley	Attended
Dr Bill Bassett	Brown Clee	*Apologies*
Vicki Brassington	Brown Clee	*Apologies*
Dr Alex Chamberlain	Church Stretton	Attended
Emma Kay	Church Stretton	Attended
Dr Paul Thompson	Cleobury Mortimer	Attended
Mark Dodds	Cleobury Mortimer	*Apologies*
Dr Juliet Bennett	Clun	Attended
Peter Allen	Clun	Attended
Dr Mark Carter	Craven Arms	Attended
Susan Mellor-Palmer	Craven Arms	Attended
Dr Shailendra Allen	Highley	*Apologies*
Sudhanshu Consul	Highley	*Apologies*
Dr Catherine Beanland	Ludlow – Portcullis	*Apologies*
Rachel Shields	Ludlow – Portcullis	Attended
Dr Graham Cook	Ludlow - Station Drive	Attended
Jodie Billinge	Ludlow - Station Drive	*Apologies*
Dr Jim Wentel	Much Wenlock & Cressage	Attended
Sarah Hope	Much Wenlock & Cressage	Attended
Dr Philip Leigh	Shifnal & Priorslee	Attended
Theresa Dolman	Shifnal & Priorslee	*Apologies*
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Clinical Chair	Attended
David Evans	CCG Accountable Officer	*Apologies*
Nicky Wilde	CCG Director of Primary Care	*Apologies*
Tom Brettell	CCG South Locality Manager	Attended
Heather Clark (Minute Taker)	CCG Personal Assistant	Attended
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	*Apologies*
Shola Olowosale	CCG Locality Pharmacist	Attended
Stuart Brown	Living Well Taking Control, Service Manager	Attended
Dr Finola Lynch	CCG GP Governing Body Member	Attended

Minute No SLB-2020-03.013: Item 1 – Welcome & Apologies

1.1 Dr Matthew Bird, Locality Chair, welcomed and thanked Members for attending and introductions were made. Apologies received were recorded as above.

Minute No SLB-2020-03.0014: Item 2 – Members' Declaration of Interests

2.1 Members were reminded of the requirement to complete a new Declaration of Interests form annually. No new declarations of interest were made for items on the agenda.

Minute No SLB-2020-03.015: Item 3 – Minutes of Formal Meeting held on 9 January 2020

3.1 Following an amendment in section 5.3 of the previous minutes to reflect that the share of the overspend for the year for Shropshire CCG should be £47m, the minutes of the meeting held on 9 January 2020 were agreed as a true and accurate record and were signed by the Chair.

Minute No SLB-2020-03.016: Item 4 – Matters Arising from Previous Meeting

4.1 The following updates were given about the actions from the previous meeting:

Minute No SLB-2020-01.007 – Ultrasound Guidance – Dr Povey advised that the CCG were in the process of renewing the iRefer subscription. Information requested from Dr Farrell at the previous meeting would be circulated once received

ACTION: Heather Clark to circulate information received from Dr Farrell re x-ray queries.

4.2 SOOS Letter – Dr Bird advised that he had previously written a letter to SOOS (Shropshire Orthopaedic Outreach Service) to raise the issue about inequitable service cover in the South Locality. The response was read out to the group. One of the main problems SOOS were experiencing in the South Locality was access to suitable venues. Dr Cook advised that there was a suite of rooms available at Ludlow Community Hospital that could be used. Dr Bird added that he had received many suggestions for venues in the South and these had been given to SOOS.

Minute No SLB-2020-03.017: Item 5 – CCG Chair's Update

5.1 CCG Constitution Changes - Dr Povey advised that a meeting had been planned for 24 March for both CCG Memberships to discuss the constitutions of the CCGs. Following this meeting there would be an electronic vote for Members to approve the constitution. Work to align the two constitutions was now moving ahead, and the main difference would be around voting and localities. Feedback had been received that Members would like Localities to continue, but the main difference would be that the Locality Chairs would not be members of the CCG Boards. The CCG Board would consist of three practice representatives from Shropshire and three from Telford and Wrekin; one of the six representatives would be the Chair of the CCG. There would also be a Secondary Care Doctor, Lay Members, Accountable Office and Executive Directors on the Board. The plan was for the new joint Board to start on 1 August 2020.

5.2 Management of Change - Staff at both CCGs were still going through a difficult stage with the Management of Change process, with the Mutually Agreed Resignation Scheme (MARS) out this week giving staff two weeks to apply. Following this the new structures would be announced for consultation. There would then be a process of job slotting in or ring-fencing for staff to go through.

5.3 Coronavirus / Covid-19 - A coronavirus FAQ (Frequently Asked Questions) document had been uploaded to GP Net. The CCG was looking into plans for home working, previously a token system was used to log in remotely but these had now expired. Telford and Wrekin CCG were piloting VDI (Virtual Desktop Infrastructure) which would allow any member of staff to work remotely; work on this was being accelerated. There was also some resilience money left over and there were ongoing discussions about investing this in iPads and webcams for practices. The CCGs were also looking at different solutions for video consultations, such as Skype. A letter had been sent to practices from NHS England to advise that practices would be receiving deliveries next week of facemasks, gloves and aprons; bigger practices would get a second delivery at some point in the near future. The letter also encouraged practices to ensure their business continuity plans were updated to cover things such as remote working.

Minute No SLB-2020-03.018: Item 6 – Locality Chair's Update

6.1 Dr Bird advised that a PLT (Protected Learning Time) planning meeting took place and the current proposal was to continue with 3 sessions, having 2 out of practice group sessions in June/July and October and one in-house during the week beginning 27 April 2020. Unfortunately Shrop Doc were unable to provide cover for the first session and Members were asked if they had any ideas for innovative ways to cover this. The CCG were looking into whether 111 could take calls and book in any urgent appointments at the end of the day. Another solution could be for PCNs (Primary Care Networks) to work together to provide cover.

6.2 Members had concerns with111 providing cover for the PLT session and the possibility of unnecessary work being created. There was also agreement that in-house sessions were more valuable than larger group sessions. Dr Povey advised that in Shrewsbury the PCN were going to put together a proposal to provide cover, and in the North they preferred to cancel the first date and have one in-house and one group session instead. A suggestion was made of the possibility of the Shrewsbury PCN providing cover. Tom Brettell stated that he would talk to the Locality Manager in Shrewsbury and would also contact Shrop Doc again to see if they had any flexibility or other dates they could provide cover for.

ACTION: Tom Brettell to make enquiries re PLT cover – to contact Shrop Doc and Jenny Stevenson.

Minute No SLB-2020-03.019: Item 7 – Palpitations Pathways

7.1 Dr Bird explained that the pathways had been developed following a workshop held in the Shrewsbury and Atcham Locality and was taken forward and developed by the CCG. The pathways had now been approved and were available on the CCG website. It was queried whether the pathways were on EMIS.

ACTION: Tom Brettell to find out if the palpitation pathways were on EMIS.

Minute No SLB-2020-03.020: Item 8 – Any Other Business

8.1 Dr Chamberlain mentioned a mental health workshop being supplied through the council. She completed this last year and found it to be very good and now has a good working relationship with schools in the area. A form had been developed to use between schools and practices so that there was no longer any consent issues. The complete course was a couple of sessions but worthwhile and did generate some good outcomes.

ACTION: Tom Brettell to circulate information about council mental health workshop.

8.2 Rachel Shields asked about a letter practices had received about extended access. The letter seemed to state that face to face appointments would be needed on a Sunday. Tom Brettell advised that there was flexibility on this and it was up to practices how to deliver this. Dr Povey added that the official guidance does state face to face on a daily basis and it would be a matter of working out a proposal for this; there would be an expectation of some face to face appointments.

Minute No SLB-2020-03.021: Item 9 – Medicines Management Update

9.1 Shola Olowosale attended the meeting and gave a presentation about Self-Care which included the following information:

- Costing information as a CCG compared to other CCGs in England showed that Shropshire CCG was performing well; compared to 10 similar CCGs Shropshire CCG was in the middle.
- Figures showed that dispensing practices in Shropshire were spending more than non-dispensing practices. It was thought this was due to not having access locally to buy over the counter medication in rural areas and a lack of public transport.
- NHS England set a savings target for Shropshire CCG of £270k, Shropshire CCG set a target to achieve £100k. The actual savings achieved were only £3200 between April 2019 and December 2019.
- Information about high cost conditions – Members thought there needed to be clear guidance and protocols in place to help practices. The Medicines Management Team were working through each condition and working on schemes with secondary care and other services. Members reported being asked by secondary care to prescribe vitamin D more often now.
- Information on campaigns in Shropshire and patient awareness/expectations – Shola asked practices to let her know if they no longer had the self-care banners in their practices. Members agreed that a national campaign on self-care was needed to change prescribing culture such as TV campaigns (like smoking/seat belts) and change from the government backed by legislation.

Minute No SLB-2020-03.022: Item 10 – NDPP (National Diabetes Prevention Programme) New Providers

10.1 Stuart Brown from Living Well Taking Control (LWTC) attended the meeting to introduce the service as the new provider for the NDPP from 1 April 2020. Mr Brown explained that LWTC was a partnership between a Midlands-based social enterprise and a south west charity. The service had been delivered by LWTC in 24 localities across England, including rural and urban areas. The service was currently in a transition phase with the current provider still taking referrals until the end of the month. The eligibility criteria for the new service and referral pathways would remain the same, and the referral template would be uploaded to clinical systems and switched over week commencing 23 March 2020. LWTC would be willing to engage with practices and help with contacting patients on the practices behalf, permitting that consent and data sharing agreements were in place beforehand.

10.2 LWTC were committed to ensuring patient outcomes were sent back to practices, but didn't want to overload GPs with information so would welcome feedback on how regular this feedback was needed. The service was very open to closer working relationships with primary care and felt that it would be ideal to deliver within practices if there was spare accommodation. If this was not available the service would still be delivered in local community venues. LWTC were also willing to start groups with lower numbers than usual due to the rurality of the area and could start groups with a minimum of 8 participants.

10.3 All materials for the programme conform to easy read and accessible standards. Non-English speakers could also get extra support and access to translation services. Sessions would be available for workers at more accommodating times in the evenings or at weekends where there is demand. LWTC also work with a digital partner who could provide NDPP remotely, for those with mobility issues or work shift issues. The number of people who could access the online service would be capped up to 20% of the contract target, which was currently 1500 participants. The evidence base for the online service was less robust than face to face, but was available for those who preferred it.

Minute No SLB-2020-03.023: Item 11 – Shropshire Care Closer to Home Update

11.1 Dr Finola Lynch attended the meeting to give an update about Shropshire Care Closer to Home. The presentation included the following information:

- Case Management – There had been a case management pilot in 8 practices, with 8 control practices to compare impact. Each practice had been allocated a case manager who identifies and writes to patients to explain what case management is and ask if they want to be involved – if they consent the case manager contacts them further to arrange a visit either in the practice or at home. So far 242 patients have gone through the process.
- Impact of the Service – comparing the control and pilot practices shows a 4% reduction in A&E attendances and non-elective admissions which equates to approximately £350k gain to the system. Currently only 42% of eligible patients have consented to case management.
- What Next? – Plan to increase case management to a further 8 practices by April 2020, and a county-wide roll out from October 2020.
- Feedback from practices in Clun and Bishops Castle – worked well with a team approach and good care for patients, and didn't generate extra work for practices.
- Feedback from Bridgnorth – Feedback from patients had been good but the practice found there was a little bit more work for GPs e.g. emails from the team or requests for meetings to discuss patients. It had been good to be involved and worked well

11.2 Concerns were raised about workforce issues as community matrons were no longer visible. Dr Lynch advised that there were 5 community matrons in Shropshire who rotate once a week through the frailty team. Members queried whether there was a read code for the teams involvement on EMIS, it was confirmed that the team do add notes to EMIS and there was a consent code in EMIS.

11.3 Dr Povey stated that it appeared that all practices in the pilot seemed to be following the model differently and that GPs should not be getting involved as this was the model agreed. If different pilots were needed these would need to be costed. The programme was designed to not create additional workload for GPs. The differences in the pilots would need to be analysed.

Minute No SLB-2020-03.024: Item 12 – Primary Care Update

12.1 The Primary Care update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No SLB-2020-03.025: Item 13 – Commissioning Update

13.1 The Commissioning update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No SLB-2020-03.026: Item 14 – Date of Next Meeting

14.1 The next formal meeting will take place on: **Wednesday 6 May 2020** at **Bridgnorth Medical Practice** at **3.30pm.**

14.2 Dates of future meetings:

Wednesday 6 May 2020	Bridgnorth Medical Practice
Thursday 2 July 2020	Mayfair Community Centre, Church Stretton
Wednesday 2 September 2020	Bridgnorth Medical Practice
Thursday 5 November 2020	Mayfair Community Centre, Church Stretton
Wednesday 6 January 2021	Bridgnorth Medical Practice

Thursday 4 February 2021	Mayfair Community Centre, Church Stretton
Wednesday 3 March 2021	Bridgnorth Medical Practice

Signed: …….. **Date:** ……

Dr Matthew Bird, Locality Chair