NHS Shropshire CCG
NHS Telford and Wrekin CCG

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

to be held on Wednesday 11 November 2020 at 9.45am

via Teleconference using Microsoft Teams

AGENDA

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

Item Number	Agenda Item	Presenter	Purpose	Paper	Time
GB-20-11.116	Apologies	Julian Povey	I	verbal	9.45
GB-20-11.117	Members' Declaration of Interests	Julian Povey	I	enclosure	9.45
GB-20-11.118	Introductory Comments from the Chair	Julian Povey	I	verbal	9.55
GB-20-11.119	Accountable Officer's Report • Emergency decision taken to secure sign off for the CCGs' Financial Plan submission	David Evans	I	verbal verbal	10.05
GB-20-11.120	Minutes of Previous Meeting held on: • Shropshire CCG Governing Body – 9 September 2020	Julian Povey	A	enclosure	10.15
GB-20-11.120	Minutes of Previous Meeting held on: • Telford and Wrekin CCG Governing Body – 9 September 2020	Julian Povey	A	enclosure	10.15
GB-20-11.121	Matters Arising of Previous Meeting held on: • Shropshire CCG Governing Body – 9 September 2020	Julian Povey	A	enclosure	10.20
GB-20-11.121	Matters Arising of Previous Meeting held on: • Telford and Wrekin CCG Governing Body – 9 September 2020	Julian Povey	A	enclosure	10.20
GB-20-11.122	Questions from Members of the Public Guidelines on submitting questions can be found at: https://www.shropshireccg.nhs.uk/get-involved/meetings-and-events/governing-body-meetings/ and https://www.telfordccg.nhs.uk/who-we-are/our-governance-board	Julian Povey	I	verbal	10.25
ASSURANCE					
GB-20-11.123	**Quality & Performance** NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report	Zena Young/ Julie Davies	S	*enclosure*	10.30

	Finance				
GB-20-11.124	NHS Shropshire CCG and NHS Telford and Wrekin CCG Finance and Contracting Report, including Quality, Innovation, Productivity & Prevention (QIPP) schemes	Claire Skidmore	S	*enclosure*	11.00
GB-20-11.125	COVID-19 Update	Sam Tilley	S	*verbal*	11.10
GB-20-11.126	Update on Shropshire, Telford & Wrekin System Restoration from COVID-19	Steve Trenchard	S	*verbal*	11.30
BREAK					11.40
GB-20-11.127	NHS Patient Safety Specialist	Zena Young	A	*enclosure*	11.50
GOVERNANCE					
GB-20-11.128	Joint NHS Shropshire CCG and NHS Telford and Wrekin CCG Board Assurance Framework (BAF)	Alison Smith	A	*enclosure (to follow)*	12.00
GB-20-11.129	Appointment of the Deputy Chair of the Governing Bodies of NHS Shropshire and NHS Telford and Wrekin CCGs	Alison Smith	A	*enclosure*	12.15
GB-20-11.130	NHS Shropshire CCG and NHS Telford and Wrekin CCGs Workforce Race Equality Standard (WRES) Annual Data Submission and Action Plan 2020	Alison Smith	A	*enclosure*	12.20
GB-20-11.131	Quality & Performance Committees in Common – 23 September 2020	Meredith Vivian	A	*enclosure*	12.30
OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY (Issues or key points to be raised by exception with the Chairs of the Committees outside of the Governing Body meetings)					
	Shropshire CCG & Telford and Wrekin CCG Joint Reports:				12.40
GB-20-11.132	Finance Committees in Common – 23 September 2020		I	*enclosure*	
GB-20-11.133	Primary Care Commissioning Committees in Common – 7 October		I	*enclosure*	
GB-20-11.134	Audit Committees in Common – 16 September 2020		I	*enclosure*	
	Shropshire CCG Reports Only:				
GB-20-11.135	North Shropshire Locality Forum – 24 September 2020		I	*enclosure*	
GB-20-11.136	Shrewsbury and Atcham Locality Forum – 17 September 2020		I	*enclosure*	
GB-20-11.137	South Shropshire Locality Forum – 2 September 2020		I	*enclosure*	

GB-20-11.138	Telford and Wrekin CCG Reports Only: TWCCG CCG Practice Forum – 15 September 2020		I	*enclosure*	
GB-20-11.139	Any Other Business	Julian Povey	I	*verbal*	12.50
	Date and Time of Next Meeting - Wednesday 13 January 2021, time and venue to be confirmed				13.00
RESOLVE:	*To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960).*				

Dr Julian Povey
CCG Chair

Mr Dave Evans
Accountable Officer

Joint Members of NHS Shropshire CCG Governing Body and NHS Telford and Wrekin CCG Governance Board
Register of Interests - 4 November 2020

Surname	Forename	Position/Job Title	Committee Attendance	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			JCCC = Joint Strategic Commissioning Committee FCiC = Finance Committees in Common QCiC = Quality Committees in Common PCCCiC = Primary Care Commissioning Committees in Common ACiC = Audit Committees in Common RCiC = Remuneration Committees in Common	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From (ie review date form completed)	To	
Ahmed	Astakhar	Associate Joint Lay Member - Patient and Public Involvement (PPI) for Equality, Diversity and Inclusion - **Attendee**	JSCC, FCiC					None declared	1.8.20	ongoing	
Allen	Martin	Independent Joint Secondary Care Doctor Governing Body Member	QCiC, FCiC	X			Direct	Employed as a Consultant Physician by University Hospital of North Staffordshire NHS Trust,	1.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Member of CRG (Respiratory Specialist Commissioning)	1.8.20	ongoing	Level 1 - Note on Register
					X		Direct	Chair of the Expert Working Group on coding (respiratory) for the National Casemix Office	1.8.20	ongoing	Level 1 - Note on Register
					X		Direct	Member of the Royal College of Physicians Expert Advisory Group on Commissioning	1.8.20	ongoing	Level 1 - Note on Register
						X	Indirect	Wife is a part-time Health Visitor in Shrewsbury and employed by the Shropshire Community Health Trust	1.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Board Executive member of the British Thoracic Society	1.8.20	ongoing	Level 1 - Note on Register

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

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

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						X	Indirect	Wife is a partner in Realising Solutions LLP, a Consultancy that contracts with the NHS, but is not a contractor of the CCG	21.10.19	ongoing	Level 1 - Note on Register
						X	Indirect	Wife is an employee of Tribal Education Ltd, which contracts with the NHS, but is not a contractor of the CCG	21.10.19	ongoing	Level 1 - Note on Register
James	Stephen	GP/Chief Clinical Information Officer (CCIO)	PCCCiC, CCC					None declared	10.9.19	ongoing	
Matthee	Michael	GP/Primary Care Health Professional Governing Body Member	North Localty Board, FCiC	X			Direct	GP Partner at Market Drayton Medical Practice	12.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	GP Member of North Shropshire PCN	2.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Member of North Locality Forum	12.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						X	Indirect	Wife is Practice Manager at Market Drayton Medical Practice	12.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
MacArthur	Donna	Lay Member for Primary Care	PCCCiC					(To be confirmed)			

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McCabe	Julie	Independent Joint Registered Nurse Clinical Governing Body Member	JSCC, QCiC					None declared	1.8.20	ongoing	
Noakes	Liz	Director of Public Health for Telford and Wrekin - **Attendee**		X			Direct	Assistant Director, Telford and Wrekin Council	9.4.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Honorary Senior Lecturer, Chester University	9.4.19	ongoing	Level 1 - Note on Register
Parker	Claire	Director of Partnerships - **Attendee**	PCCCiC, Shropshire North, S&A, South Loc Forums, TW Membership Forum		X		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	23.03.20	ongoing	Level 1 - Note on Register
Pepper	John	GP/Primary Care Health Professional Governing Body Member	JSCC	X			Direct	Partner at Belvidere Medical Practice (part of Darwin Group)	27.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Belvidere Medical Practice is a member of Darwin Group of practices and Shrewsbury Primary Care Network	27.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	NHS England GP Appraiser	27.8.20	ongoing	Level 1 - Note on Register

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

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Pringle	Adam	GP/Primary Care Health Professional Governing Body Member	PCCCiC, Shropshire North, S&A, South Loc Forums, TW Membership Forum	X			Direct	GP Partner, Teldoc (Lawley Medical Practice)	2.9.20		Level 1 - Note on Register
				X			Direct	Member of Shropshire Doctors Co-Operative Ltd (Shropdoc) an out of hours primary care services			Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Owner of the premises of Lawley Medical Practice (joint owner with wife)			Level 2 - Restrict involvement in any relevant commissioning decisions
Robinson	Rachel	Director of Public Health for Shropshire - **Attendee**		X			Direct	Director of Public Health for Shropshire	22.7.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Shepherd	Deborah	Interim Medical Director - **Attendee**	PCCCiC					None declared	5.8.20	ongoing	
Shirley	Paul	Representative of Healthwatch Telford and Wrekin - **Attendee**	PCCCiC, JSCC					(To be confirmed)			
Skidmore	Claire	Executive Director of Finance	FCiC, ACiC, PCCCiC		X		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	1.1.20	ongoing	Level 1 - Note on Register
Smith	Alison	Director of Corporate Affairs - **Attendee**	ACiC		X		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	1.1.20	ongoing	Level 1 - Note on Register

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						X	Indirect	Related to a member of staff in my portfolio structure who is married to my cousin. The individual is not directly line managed by me.	2.1.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Smith	Fiona	GP/Primary Care Health Professional Governing Body Member	JSCC	X			Direct	Advanced Nurse Practitioner at Shawbirch Medical Practice	1.8.20	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Tilley	Samantha	Director of Planning - **Attendee**			X		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	1.1.20	ongoing	Level 1 - Note on Register
						X	Indirect	Brother in Law holds a position in Urgent Care Directorate at SATH	23.8.19	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Timmis	Keith	Lay Member - Governance for Shropshire CCG	FCiC, ACiC, QCiC, RCiC			X	Indirect	Wife is a Archivist for Shropshire Council	25.4.19	ongoing	Level 1 - Note on Register
Trenchard	Steve	Interim Executive Director of Transformation	JSCC, PCCC		X		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	16.3.20	ongoing	Level 1 - Note on Register
Vivian	Meredith	Joint Lay Member - Patient & Public Involvement	QCiC, RCiC, AC, PCCC			X	Indirect	Wife is a part-time staff nurse at Shrewsbury & Telford Hospital NHS Trust (SATH)	9.1.20	ongoing	Level 1 - Note on Register
						X	Direct	Trustee of the Strettons Mayfair Trust (voluntary sector organisation that provides a range of health	9.1.20	ongoing	Level 1 - Note on Register

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Young	Zena	Executive Director of Quality	JSCC, F&P, PCCCiC		X		Direct	Shared post across Shropshire and Telford & Wrekin CCGs	14.4.20	ongoing	Level 1 - Note on Register
MEMBERS WHOSE BOARD ROLE HAS CEASED OR WHO HAVE LEFT THE CCGs WITHIN THE LAST 6 MONTHS											
Bird	Matthew	Locality Chair - South Locality	South Locality Board. CCC	X			Direct	GP Partner at Albrighton Medical Practice	9.1.19		Board role ceased on 31.7.20 continues as Locality Chair - South Locality
				X			Direct	NHS England GP Appraiser	9.1.19		
				X			Direct	Member of South East Shropshire PCN	13.11.19		
Fortes-Mayer	Gail	Director of Contracting & Planning	CCC, F&P					None declared	18.1.19		Left the CCG on 30.10.20 - Board role ceased on 31.7.20
George	Priya	General Practice Governing Body Member	CCC	X			Direct	GP Member of North Shropshire PCN	13.11.19		
				X			Direct	NHS England GP Appraiser	13.3.19		
						X	Indirect	Husband - Consultant (Radiologist) at University Hospitals North Midlands	13.3.19		
Leaman	Alan	Secondary Care Clinical Member	QC, CCC					None declared	21.1.19		Left the CCG on 31.7.20

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Lewis	Katy	Locality Chair - North Locality	North Localty Board	X			Direct	GP Principal at Westbury Medical Centre	24.1.19		Board role ceased on 31.7.20 continues as Locality Chair - North Locality. New role also as Clinical Lead wef 1.8.20
Morris	Kevin	General Practice Governing Body Member	CCC, F&P, PCCC	X			Direct	Managing Partner at Cambrian Surgery	9.9.19		Left the CCG on 31.7.20
				X			Direct	Cambrian Surgery is a member of North Primary Care Network (PCN)	26.6.19		
						X	Indirect	Wife was Chief Nurse for Shropshire CCG and Telford & Wrekin CCG	26.6.19		
						X	Indirect	Wife is Acting Chief Nurse at Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust	20.04.20		
Porter	Sarah	Lay Member - Transformation	RC, AC, PCCC, CCC, QC, F&P					None declared	15.8.19		Left the CCG on 31.7.20
Stanford	Colin	Lay Member	PCCC		X		Direct	Clinical Champion for Osteoarthritis - part time position at Keele University	13.5.20		Board role ceased on 31.7.20 continues as Independent GP Member on Primary Care Commissioning Committee
						X	Direct	Trustee - Bell Educational Trust (Concord College)	13.5.20		
						X	Direct	Director - Concord College International Ltd	13.5.20		
				X			Direct	Director - Apostle Coffee Ltd	13.5.20		
						X	Indirect	Wife is Nurse Manager for Jubilee Care Ltd - Churchill House (Ludlow) and The Sandford (Church Stretton) Nursing Homes	13.5.20		

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				X			Direct	Returning GP employed by the South Central Ambulance NHS Foundation Trust undertaking COVID-19 assessment work	17.4.20		

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Turner	Gary	Joint Lay Member - Primary Care	PCCC, RCiC, ACiC, JSCC			X	Indirect	Wife is employed by the CCG as PA to Chair, AO, Medical Director and Interim Executive Director of Transformation	1.8.20		Left the CCG on 18.9.20
						X	Direct	Chair of The Priory School Trust (Education)	1.8.20		
Wilde	Nicky	Director of Primary Care	PCCC, CCC			X	Indirect	Husband's family members are nursing staff (general and midwife) at Shrewsbury & Telford Hospital NHS Trust (SATH)	25.4.19		Board Role ceased on 31.7.20 continues as Interim PCN Programme Director

MINUTES

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

Wednesday 9 September 2020 at 9.00am

**The Telford Suite, The Mercure Telford Centre Hotel,
Forgegate, Telford, Shropshire, TF3 4NA**

Present from Shropshire CCG:

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

Present from Telford and Wrekin CCG:

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

Attendees for both meetings:

Mr Ash Ahmed	Joint Associate Lay Member for Patient and Public Involvement, Equality, Diversity and Inclusion
Dr Julie Davies	Joint Director of Performance for Shropshire and Telford & Wrekin CCGs
Miss Alison Smith	Joint Director of Corporate Affairs for Shropshire and Telford & Wrekin CCGs
Mrs Sam Tilley	Joint Director of Planning for Shropshire and Telford & Wrekin CCGs
Ms Claire Parker	Joint Director of Partnerships for Shropshire and Telford & Wrekin CCGs
Dr Deborah Shepherd	Joint Interim Medical Director
Dr Stephen James	Joint Chief Clinical Information Officer for Shropshire and Telford and Wrekin CCGs
Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire
Mr Paul Shirley	Chief Officer, Healthwatch Telford and Wrekin
Mrs Andrea Harper	Head of Communications and Engagement
Mrs Sandra Stackhouse	Corporate Services Officer – Minute Taker

1.1 Dr Povey welcomed members to the first NHS Shropshire CCG and NHS Telford and Wrekin CCG Governing Bodies meetings in common. A 2 minutes silence followed to mark Emergency Services Day (999 Day) in honour of those NHS and emergency personnel who had lost their lives as a result of their service to the nation.

Minute No. GB-2020-09.093 - Apologies

2.1 Apologies were noted from:

Mrs Julie McCabe	Joint Registered Nurse Governing Body Member
Mrs Rachel Robinson	Director of Public Health for Shropshire
Mrs Liz Noakes	Director of Public Health for Telford and Wrekin

Dr Julie Davies would be absent for the first part of the meeting as she would be attending the Gold Command meeting.

Minute No. GB-2020-09.094 - Declarations of Interests

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

3.2 Dr Povey declared two changes to his declarations of interest, which were as a Director of the Darwin Federation and his practice being a member practice of the Darwin Federation. Dr Povey explained that these interests had been removed as they had not taken place.

3.3 There were no further conflicts of interest declared.

3.4 Dr Pepper asked if the mitigation levels of the general practitioners in partnership should be standardised as the classifications on the register appeared to vary between Levels 1 and 2.

ACTION: Miss Smith to arrange for the review of the levels of mitigation for the general practitioners in partnership on the Register of Interests.

Minute No. GB-2020-09.095 - Introductory Comments from the Chair

4.1 Dr Povey reflected that a lot had happened since the last Governing Body meetings held in March. It was explained that the Governing Body meetings had been held virtually since the response to the COVID-19 outbreak. This meeting had been arranged following government guidance that allowed meetings to take place in COVID-19 secure venues for businesses for up to 30 people. A thank you was extended to the venue's staff, the technicians, the Head of Communications, and the Corporate Services Officer for enabling the arrangements for this meeting to take place.

4.2 This was the first time that both NHS Shropshire CCG and NHS Telford and Wrekin CCG Governing Body Members had met as meetings in common with the new jointly appointed Governing Body Members. This meant that technically both CCGs were meeting separately but at the same time in the same venue. The only difference for today's meetings would be in relation to the minutes of the CCGs' last meetings, the matters arising from those; and the Board Assurance Frameworks (BAFs), which would be combined for the next meeting.

4.3 A big thank you was extended to all the NHS staff and health and social care workers for the work they had carried out over recent months. As members were aware, the number of COVID-19 cases was beginning to rise and going into winter this was likely to have to continue. Given the new restrictions announced today, the format of future meetings was uncertain but it was hoped that the current rules for business meetings such as this would remain.

Minute No. GB-2020-09.096 – Accountable Officer's Report

5.1 Mr Evans provided an update on the improvement alliance for Shrewsbury and Telford Hospitals NHS Trust (SaTH) with University Hospitals Birmingham NHS Foundation Trust (UHB), which had commenced. The CCG had not had sight of the management agreement owing to this being commercial in confidence. However, Mr Evans had made Dr David Rosser, Chief Executive of UHB aware that both the CCGs and the local health system were supportive of the approach and offered any help that they could to progress the work moving forward.

5.2 The new Director of Nursing at SaTH, who had been the Deputy Director of Nursing at UHB had commenced in post. UHB's Associate Medical Director and their Transformation Director had also been appointed to provide help to the SaTH management team. The overall improvement team as part of the NHS England/Innovation (NHSE/I) service offer to SaTH had commenced and the Governing Bodies would be updated when further information was received on the work that was taking place.

5.3 The NHSE/I committee had met the day before to consider the CCGs' application to create one single strategic commissioner. It was understood the committee would make a recommendation to the NHSE/I Board to consider, on a date to be confirmed, which Members would be notified of as soon as it was received.

5.4 A system review meeting with all system partners and NHSE/I's regional team had been held the previous week. The meeting had noted both good areas but also other areas that required further work. In relation to this there was a Phase 3 planning meeting with NHSE/I on Friday and Mr Trenchard, Mrs Tilley and Dr Davies were currently working hard on the preparation for that meeting.

5.5 Mr Evans reported that the CCGs needed to urgently agree and sign-off the N365 Reseller Contract, which was due by 15 September and therefore could not be deferred until the next Governing Body meeting. It was explained that there was a small financial impact for Shrewsbury and Telford Hospital NHS Trust (SaTH) but all primary care practices would be connected to the N365 network rather than remaining on the N3 connection, which was being discontinued by NHSE/I and NHS Digital nationally. If the change was not implemented, the financial consequences for the CCG were much greater. It was proposed and agreed that Dr Povey and Mr Evans would take the Chair's and Accountable Officer's Action outside of this meeting to sign that contract off.

5.6 Mr Evans referred to the System to NHSE/I Board meeting held in July as a result of some of the concerns that had been raised, particularly in relation to SaTH. Following that meeting, a letter had been received from Amanda Pritchard, Chief Operating Officer, NHSE/I in which four key areas were highlighted: leadership; the Ockenden review of Maternity Services; Hospital Transformation Programme (HTP); and the Emergency Departments (EDs) including Estates. There was an expectation that SaTH would produce a Quality Improvement Plan.

5.7 Contained in the NHSE/I letter was the requirement for a system improvement plan to be developed which Sir Neil McKay had been asked to lead, which would focus on how the system could work with and help SaTH to achieve improvements in the four key areas. The system improvement plan was now being developed with the intention that there would be a completed draft for submission to NHSE/I by the end of the month. The plan would include a focus on how the system could help to address the Care Quality Commission's (CQC) concerns around quality and demand management which would include 'Think NHS 111'. For the area around workforce, safeguarding support was being providing from the CCGs. The mental health trust was also providing initial support and had appointed a secondee to the Trust for 6 months to help with some of the aspects of the Mental Health Act and DOLS (Deprivation of Liberty Safeguards). The System Improvement Plan would be presented to the next meeting.

5.8 Mr Vivian referred to the system review meeting, which sounded encouraging and asked if there was further information that could be provided.

5.9 Mr Evans reported that the CCG had been favourably seen in areas such as in: the restoration of services and separating elective care and emergencies; the restoration of Learning Disabilities (LDs) and Autism services; and the overall work on the development of the Integrated Care System (ICS).

5.10 Areas considered less than good were around the Phase 3 recovery projections and the CCGs' current positions did not look as good as some other areas. An early indication was that the local system may be ranked 42nd out of 42 systems in the country. Conversations had been held with system partners on what steps could be taken before the meeting on Friday to get the system into a better position. The CCGs needed to answer the question that was asked in the Phase 3 letter which was how the CCGs would achieve a set of targets by the end of October. Mr Evans stressed that the CCGs needed to be very clear that they just answered the exact question that was asked.

ACTIONS: Dr Povey and Mr Evans to take the Chair's and Accountable Officer's Action on the decision to appoint an N365 reseller and sign off of the contract outside of the meeting.

Mr Evans to arrange for the System Improvement Plan to be presented to the next Governing Body meeting.

For: NHS Shropshire CCG

Minute No. GB-2020-09.097 – Minutes of the Previous Meeting – 8 July 2020

6.1 The minutes of the previous NHS Shropshire CCG Governing Body meeting held on 8 July 2020 were presented and approved as a true and accurate record of the meeting subject to the following two amendments:

Page 13, paragraph 11.12, line 4, delete: 'relating to a backlog from last year'.
Page 14, line 1, delete: 'to' and insert: 'from' its programme budgets.

RESOLVE: MEMBERS FORMALLY RECEIVED AND APPROVED the minutes presented as an accurate record of the meeting of Shropshire Clinical Commissioning Group (CCG) held on 8 July 2020.

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

For: NHS Telford and Wrekin CCG:

Minute No. GB-2020-09.097 – Minutes of the Previous Meeting – 14 July 2020

6.1 The minutes of the previous NHS Telford and Wrekin CCG Governing Body meeting held on 14 July 2020 were presented and approved as a true and accurate record of the meeting.

RESOLVE: MEMBERS FORMALLY RECEIVED AND APPROVED the minutes presented as an accurate record of the meeting of Telford and Wrekin Clinical Commissioning Group (CCG) held on 14 July 2020.

For: NHS Shropshire CCG:

Minute No. GB-2020-09.098 – Matters Arising from the Minutes of the Previous Meeting

7.1 Dr Povey noted that the public questions from the last meeting and the answers provided had been attached to the minutes for information.

7.2 Following the change with the new aligned constitutions, the Executive Team had reviewed the matters arising and some of the actions for the Board had been deemed more appropriate to be completed by the subcommittees. Most actions from the previous meeting had been completed or included on the agenda. The following updates on the matters arising were noted below.

7.3 Mr Timmis sought clarification on the timetable for the governance process for the Out of Hours review. Mr Evans advised that this was still being worked on and was expected to be completed soon.

a) GB-2020-07.074 – Matters Arising [b/f GB-2020-01.010 – Shropshire CCG Strategic Priorities] – It was noted that the action for a progress report on the Alliance Agreement with the providers for the new model of care for the integrated provision of Musculoskeletal (MSK) services had been referred to the new Joint Strategic Commissioning Committee.

Dr Matthee sought clarification on those actions that were being referred to other committees and asked how the Governing Bodies would be assured that those actions had been completed.

Miss Smith clarified that after each committee meeting, the chair of each committee would submit a report to the Governing Bodies summarising the discussions and decisions and highlighting areas where assurance could not be given, which would enable the Governing Bodies oversight between those meetings and the Governing Bodies' meetings from the Committee Chairs' reports.

b) GB-2020-07.074 – Matters Arising [b/f GB-2020-03.034 – Update on Transforming Midwifery Care] – Mr Evans confirmed that a letter had been sent to NHSE/I conveying the CCG's frustration that it had not received further information on the proposals submitted for consideration by the national panel. A response had since been received from the Regional Team who was taking this up nationally.

Mr Vivian thanked Mr Evans for the information about the letter that had been sent to the regional team but had been disillusioned to hear that it had been escalated to the national team. Mr Vivian's concern was that NHSE/I may not be currently in a position to make a decision and then the CCG would again experience a possible long wait of 6-12 months to hear back. Mr Vivian therefore asked if

sufficient information had been included in the letter to express the need for an urgent decision and that pressure continued to increase around this issue. Mr Evans confirmed that the letter had been very clear around the continued impact of the delay in the CCG's ability to go out to public consultation.

c) **GB-2020-07.074 – Matters Arising [b/f GB-2020-05.055 – Quality and Performance Report]** – Ms Cawley reported that there had been a delay with regards to the meeting with Ms Bailey at SaTH which had been confused with the Healthwatch CHC meeting. However, Mrs Young and Ms Cawley had a meeting diarised to discuss the concerns raised by Shropshire Healthwatch on behalf of patients, after which Mrs Young would follow up with SaTH.

d) **GB-2020-07.075 – Public Questions –** Miss Smith confirmed that a review had been undertaken of the operation of other CCGs in how they dealt with some or very similar questions from the public that were received in quick succession. Other CCGs tended to operate a system whereby they did not accept questions from the public around the same issue within a 6 month period on the basis that they published the responses to previous questions within that timeframe. The CCG was therefore looking to adopt the same process which would be published on the CCGs' websites in the next two weeks in readiness for the November meeting.

e) **GB-2020-07.078 – Quality and Performance Report –** Mrs Young advised that the notification on best practice for clinical reviews had just been published which referred in the main to Referral to Treatment (RTT), which was not the kind of information that the CCGs required. SaTH in particular were looking at their harm review process, which included the experience in the Emergency Departments (EDs) of delays; and harms due to incorrect, missed or delayed treatments, which was a piece of work for SaTH. It was considered that there was further work that the CCG needed to consider which was around beyond waiting lists not least because of COVID-19 but cases around delays to services of a non-physical care nature.

Dr Pepper queried the process around the areas that were being transferred to the JSCC and asked if this was because there were commissioning decisions relating to those items that were pertinent for those actions to be transferred to the JSCC or were they being transferred for a separate conversation at the JSCC.

Dr Povey explained that previous Governing Body meetings had agreed and signed off the constitutions. There were on-going discussions that had looked at the different ways the CCGs work, and although both CCGs were doing the same work and providing the same assurance, they were doing it at different levels in their respective committees. The process had therefore been aligned so that the Governing Body would focus on the key areas of strategy and assurance. The other work around the detailed questions about the workstreams was going to be discussed by the other committees, which would follow a similar process to that followed for the Finance Committee, which had included a greater level of detail and then had reported back via a report from the Committee describing the areas of work that the committee had given assurance for.

Miss Smith also pointed out that the JSCC did have within its remit, commissioning and the functions of commissioning and that pathway development was a significant part of the commissioning process. In this regard, the particular actions on the list had prompted the movement of those items to the JSCC. Miss Smith suggested that the Governing Body should discuss which areas it wished to retain some oversight and assurance of, particularly areas of concern and risk over and above what the JSCC would be covering in terms of discharging the commissioning decision-making.

Ms Parker suggested that as a new remit for the Governing Body it was about separating out the operational and the detailed discussion around the pathways to be discussed at the committees and the assurance and oversight would still come to the Governing Body. For example, the Written Statement of Action, which was not completed yet because of the timings and changes to the meeting, would be presented to the Strategic SEND Partnership Board but would still come back to the Governing Body for oversight and assurance.

Mr Evans noted for the minutes that the reason for the SEND report was because of the inspection into SEND, which had included some actions that the CCG needed to do arising out of that. The overall report around SEND would include the waiting list numbers as well as the new pathways but that was not to say that they should not be reported in the normal way through to the Governing Body in terms of performance and quality.

In response to the action to include the waiting list numbers and timescales for the ASD and ADHD pathways in the SEND report, Ms Parker reported that as of May 2020, there were just over 100 children and young people waiting over 12 months and the total on the list was 174.

Dr Pepper asked about the ASD and ADHD waiting list numbers and times. Dr Povey clarified that the waiting list figures and any significant issues should be presented to the Governing Body through both the Performance Report and the Quality Report. The discussion on commissioning of the pathway and how that was resolved would be referred to the JSCC and the infrastructure below that.

Dr Pringle suggested that for completeness the list of actions that were being referred to other committees should remain on the Governing Bodies' action logs until it was confirmed within the Committee Chairs' reports that those actions had been resolved.

Following discussion, it was agreed that those actions that had been referred to the other committees would be retained on the Governing Bodies' action log until the Committee Chair's summary report had been received that confirmed the action had been completed.

Ms Cawley asked if the CCG could consider membership of Healthwatch Shropshire (HWS) and Healthwatch Telford and Wrekin on the joint committees. Ms Cawley said that she was really keen to continue to be involved in the Quality Committee because HWS had really benefitted from its involvement in that committee and had identified opportunities for HWS to carry out public engagement to support the CCG going forward.

At this point Dr Povey welcomed Dr Julie Davies and Mr Paul Shirley who had since joined the meeting.

f) **GB-2020-07.078 – Quality and Performance Report –** Dr Davies reported that the data from West Midlands Ambulance Service (WMAS) on the ambulance crew on scene timings had been requested from April 2020. A date had not yet been given as to when the data would be available but Dr Davies expected to report on that at the next Governing Bodies meetings in common.

g) Dr Davies confirmed that the ambulatory care comparator data quoted for Quarter 4 on page 10, section 6, of the last report had been double-checked and it had been found that this data related to 2019/20 and not 2020/21 owing to the data being 12 months in arrears because it was nationally standardised.

ACTIONS: Miss Smith to arrange for the CCGs' websites to include a message explaining that inappropriate questions and similar questions received which cover the same areas as those which have been answered within a 6 month period would not be accepted.

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

Those actions that have been referred to the JSCC from the Governing Bodies of both CCGs to remain on the Governing Body action log until the next meeting when the JSCC Chair's Report confirms those actions have been completed.

The CCG to invite the Healthwatch Shropshire and the Healthwatch Telford and Wrekin representatives to attend the Quality Committee meetings.

For: NHS Telford and Wrekin CCG

Minute No. GB-2020-09.098 – Matters Arising from the Minutes of the Previous Meeting

7.1 Mr Evans referred to the actions from the last Telford and Wrekin CCG Governing Body meeting held on 14 July 2020 and the following updates were given:

20.20.2 (10.03.20) Primary Care Commissioning Committee Chair's Report – Ms Parker reported that a date had been arranged for the meeting with the Telford Patient First Group to provide an update around the Primary Care Networks (PCNs).

43.20.20.7 (14.07.20) Governance – Mr Evans reported that the regularities of the new committees had been dealt with as part of the development of the constitutions of the two CCGs moving forward.

Minute No. GB-2020-09.099 – Public Questions

8.1 Dr Povey advised Members that no questions had been received from the public for this meeting.

ASSURANCE

Minute No. GB-2020-09.100 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report

9.1 Performance - Dr Davies presented the joint Quality and Performance Report, which was taken as read. The paper reported on the current challenged areas across the NHS Outcomes Framework (OF) and the appendices provided further information to consider such as quality issues, Continuing Healthcare (CHC) indicators and the NHS Constitution. Pages 1-3 of the report set out the performance against the following key areas of focus:

A&E performance – The key message was around the on-going focus on A&E performance, which continued to be a challenge but improvements had been seen. The challenge now was to continue with the 80%+ performance as we go into winter and see potential increases in demand. There was a continued differential in return of activity between the two sites, with The Royal Shrewsbury Hospital (RSH) back to pre-COVID levels; and The Princess Royal Hospital (PRH) remained at two-thirds to three-quarters to what it was previously.

Referral to Treatment (RTT) – RTT was very much in progress in terms of the restoration and recovery plans. A lot of work was being carried out over the next week for the next planning submission on 21 September, which would show for the first time the current position against the elective outpatient plans. There was a long way to go to achieving the recovery of the 18 weeks' performance and the Governing Bodies would be kept informed as those plans were further developed.

Diagnostic services – There was slightly more confidence in the diagnostic services. SaTH have been successful in getting MRI scans to three months which would considerably help the recovery of services. It was also understood that there had been another successful bid for an MRI CT Pod. It was hoped that the forward trajectories would be presented to the next meeting to see progress against that delivery.

Cancer – Shropshire and Telford and Wrekin was in a relatively good position compared with other parts of the region and country and had maintained good cancer performance during COVID-19. There had been a reduction seen in the over-62 day waits backlog of over 35% which continued to decrease. There was a challenge with some of the 104 day waits but this had been predominantly as a result of patient choice. Patients were wanting to go back to hospital for their either diagnostics or appointments. Dr Davies took the opportunity to reaffirm that hospitals were safe for patients to attend and to encourage patients to attend any appointments that they may have.

Dementia – There had been issues accessing dementia services because of the response to COVID-19 and access into primary care. There was every confidence that this service would recover over time, particularly in the Telford and Wrekin area. There were some good delivery plans that had been placed on hold which would now be reconvened.

IAPT (Improving Access to Psychological Therapies) – This service had been severely impacted again in Quarter 1 because of the response to the COVID-19 pandemic. Some recovery had been seen in Quarter 2 and the focus going forward would be on how to promote access capacity to support that service over the coming months.

9.2 Quality – Mrs Young talked to Section 2 of the report, 'Quality Concerns/Key Points – Providers' and noted that the information provided was as at Month 3 unless otherwise indicated. Mrs Young gave the following updates to that which was included in the report:

Serious Incidents (SIs) – SIs had been a concern for both CCGs over quite a long period of time, and it had been a challenge to achieve sustained improvements on the part of SaTH in particular. The CCG felt that it needed to have a better arrangement with SaTH around oversight and advising them on their SI process. The CCG followed the NHSE/I framework around managing SIs and it had its part to play to facilitate improvements. SaTH also had its part to play to ensure that the Root Cause Analysis (RCA) was fit for purpose and also to ensure that the RCAs were completely in a timely manner.

It was pleasing that the number of open and overdue RCAs had decreased significantly recently which was due in part to the Interim Chief Nurse addressing that as a corporate responsibility and also changes to SaTH's Patient Safety Team. The CCG had co-produced an improved process, which was due to be signed off by SaTH and the CCG was hopeful that the improvements made would remain in place.

Ms Parker reported that in addition to the ASD waiting list numbers already quoted there was a wider piece of work being carried out around the diagnostic pathways and the pre and post diagnoses. The funding had been released for the diagnostic pathway and so should start having an impact on the waiting

lists now, which had been a concern. Ms Parker had suggested to Mrs Young that reports on some of those elements should be presented to the Quality Committee as a SEND quality issue.

A further piece of work was looking at the system improvements. What was seen at the point of reporting SIs was that often patients had progressed through the system and had been held in other care areas prior to or post accessing Shropshire Community Health Trust (SCHT) services. There was therefore a piece of work to be undertaken between the different providers and the Directors of Nursing to take that forward.

9.3 Mr Timmis noted that in the NHS Oversight Framework there was a comparison with peer CCGs and asked if there was a process in the CCGs that looked at the reasons why the CCGs performed more poorly and whether they should then consult with their peer CCGs to find out what the CCGs could learn. Mr Evans confirmed that there was a peer group of CCGs with similar demographics, which regularly reviewed the data and discussed those CCGs that achieved better performance. Mr Timmis enquired as to how that information was fed back to the JSCC, Finance Committee and the Audit Committee.

9.4 Dr Davies highlighted that the Quality and Performance Report had been prepared in a new format and would welcome any feedback to either Mrs Young or herself. This was very much a work in progress and the aim was to stratify between areas that were performing well and those that were not performing so well. Work was being undertaken on the comparative information, which would be presented to the Quality and Performance Committee. It was anticipated there would be an improvement but equally Dr Davies did not wish the CCGs to lose sight of the areas that were performing well. The CCGs needed to be honest about the capacity and priorities because improvements could not be made on all areas. Plans needed to be made for future improvements but based on the resources available both in terms of workforce and financial.

9.5 Mrs Young added that there was an intention to provide a trend line to the reporting exceptions and escalations, which would enable the Governing Bodies to review performance over a period of time rather than just a point in time.

9.6 Dr Matthee shared the following observations:

- GPs were unable to directly refer children for ADHD services, which now needed to be made through the schools, who did tend to refer back with the request for general practice to make the referral.
- It was pleasing news about the MRI scans but concerns still remained about the appointments system and therefore it was hoped that there would be an improved system rather than reverting back to the old system, which had not worked very well.
- If RWT was taking over the Neurology service, did that mean that the CCG would be decommissioning SaTH's neurologist consultants. If this was not the case what was the future for our own neurologists.
- It had been previously raised about the district nurses and tissue viability and general practice was still waiting for formulary that had been promised.
- Regarding the reporting of SIs, GPs had written various letters to the hospitals and responses were still awaited especially concerning arrangements around the EDs and significant events. Dr Matthee asked how general practice was going to able to report concerns because the practice was unable to use the new Ulysses system.

9.7 Dr Davies explained that there would be an integrated service which would be hosted by RWT. The existing consultants and staff were actively involved in those discussions and were supportive of the plan because it would offer a sustainable service for the local population and for Mid Wales.

9.8 Mrs Young was aware that primary care had switched to using Ulysses and that would be the route by which practices were asked to report concerns. There was also the NHS to NHS Concerns (N2N) reporting process, which was referred to in the report.

9.9 Dr Shepherd explained that there had been simplifications in the way that concerns were reported on the system, particularly around contract breaches and secondary care. Mrs Jane Blay, who was the primary care quality support worker had offered training on Ulysses and Dr Shepherd would further discuss with Dr Matthee outside of the meeting.

9.10 Ms Cawley advised Members that HWS and Healthwatch Telford and Wrekin were currently launching a discharge survey to find out people's experience with discharge since March and had worked with a multi-agency team on developing the questions for that survey. A press release would be published this week and Ms Cawley requested support from the CCG to help promote that survey.

9.11 HWS and Healthwatch Telford and Wrekin were also working together on an Out of Hours palliative care survey, which it was hoped would gain feedback on the palliative care helpline. Work continued on HWS'

'Hot Topic' which was seeking feedback from the public on phone, video and online appointments. Ms Cawley hoped to share the findings as soon as this piece of work was complete.

9.12 Dr Pringle made the following comments:

- The performance data contained in the report showed that Shropshire, Telford and Wrekin was at the top of the comparators in terms of falls in the elderly, end of life admissions, emergency admissions for urgent care services, which suggested that the right patients were being admitted to hospital for the right length of stay, which was good but might limit the scope for improvement in other work.
- For the EDs, it was noted that there had been a 10% decrease in attendance for RSH and a 30% decrease in PRH, which correlated to a 30% decrease in admissions at PRH. So essentially for every 10% decrease in A&E attendance resulted in a 10% decrease in admissions. If the decrease in admissions was as a result of less sick people it would have been expected that there would be a smaller decrease in admissions. It was suggested that every child with a temperature that presented to PRH was admitted to Paediatrics because it was quick and partly because this was the way the CQC had driven things. In order to reduce admissions, particularly with the cross infection, which is the follow up of that in winter, the CCGs would probably need to look at access to primary care, the evidence of which suggested that 3 urgent appointments in primary care prevented approximately 1 A&E admission.
- The CCGs were actually above average on waiting list size on the comparator performance for the 52 week waits and so did focus on the poor performance and performed better than most. This would suggest that there was a lack of capacity nationally and rather than anything we are doing locally.
- Regarding the dressings that Dr Matthee raised, work was being undertaken on the wound dressing service and the prescribing data on silver dressings had shown that the expenditure for the Telford and Wrekin and Shropshire was decreasing which suggested the wound dressing formulary was being implemented and was having an effect.

9.13 Dr Povey thanked Mr Pringle for his comments and asked if Mrs Young could look into the point raised about children presenting with a high temperature being admitted to PRH.

9.14 Dr Povey voiced concern about the increase in the 52 week waits and also the longer waits and the comments made in the report. If the service had not returned to 100 per cent when referrals returned to capacity, it would be a challenge to clear the backlog of referrals. Following discussion, it was agreed that the Quality and Performance report would include more detail of the impacts of the waiting list numbers for further discussion at the next meeting.

9.15 Mrs Bryceland referred to the concerns that remained on the 4 hour A&E turnaround times and although the numbers had decreased it was difficult for SaTH to reach their target. There would be increased challenges when the Urgent Treatment Centre (UTC) was re-sited back into SaTH and Mrs Bryceland asked what assistance to SaTH was being provided in the community to solve the increase in demand that was expected. For instance, Mrs Bryceland queried whether the 'Think NHS 111 First' process and other solutions were being promoted sufficiently as there were few requests coming through to general practice now and asked what the plan was for driving this forward.

9.16 Mr Evans reported that Shropshire and Telford and Wrekin was the second area in the Midlands to go live with 'Think NHS 111 First', the official launch of which was on 28 September, and would be fully implemented by December. For that process to work effectively, the system as a whole needed to ensure that the directory of services was accurate to enable the call handlers in NHS111 to be able to refer patients to the appropriate services. Therefore there was significant work being undertaken to make sure that the right alternative services were in place otherwise patients would present at A&E or NHS 111 would have no option but to refer them to A&E.

9.17 Regarding the concerns around the 4 hour A&E turnaround times, Dr Davies explained that this was being addressed through the Urgent and Emergency Care (UEC) Delivery Group. It had been raised at Shropshire CCG Governing Body's July meeting where it was discussed that the challenge was that during the initial response to COVID the volume of activity had decreased and there had been concern that the level of improvement in performance had not be as expected based on that reduction in demand from March to May. However, significant improvements had been seen through June and July as a result of the work with ECIST within SaTH around their systems and processes. As activity returned at the end of August, performance had started to revert back again. The priority within the UEC Delivery Group and Board was around how to manage that demand and 'Think NHS 111 First' was the first element of that and the development of community services.

9.18 Focus needed to be maintained on the system and processes and there were significant challenges around staffing. Modelling based on workforce limitations indicated that 80%-85% performance was probably the best SaTH could achieve over the full 24 hour 7 day a week performance but the issue was

that this was currently at 80%-82%. As the actions around the work improved it was expected there would be an incremental improvement in achieving the over 85% performance.

9.19 Referring to page 3 of the report about mental health patients, Dr Pepper asked if the IAPT service was challenged by staffing pressures or was the limiting factor with people accessing the service rather than the provider.

9.20 Dr Davies confirmed that there had been some staffing issues and after recruitment these had been resolved and now the issues were around accessing the service.

9.21 Dr Pepper further asked about the ASD waiting list as noted on page 7 of the report that the sustainable future model for the pathways had been agreed and financial approval from NHSE/I was awaited. Dr Pepper asked if there were more details on the finances that were awaiting approval by NHSE/I.

9.22 Mrs Skidmore explained that the CCGs had been in a position for a few months now where the absence of an annual budget and an agreed plan with NHSE/I had meant that they had not been able to formally agree investment into new services. The approval that was mentioned in the report was a response from NHSE/I that was awaited in terms of in the absence of all those things did the CCGs have their support to continue with that investment. This had taken a long time to obtain as the regional team had lacked guidance from the national team. However, there had been subsequent conversations that had allowed the CCGs sufficient coverage to continue with the programme. Mrs Skidmore explained that the amount was for a small amount but as the finance was being aligned with the new regime, the CCGs were gaining more clarity on how they manage their finances moving forward.

9.23 Dr Pepper referred to page 19 and the comparator with the other 11 CCGs re. issues and workforce and sought clarity on the numbers given for numbers per 1000 for Shropshire CCG and Telford and Wrekin CCG. Dr Povey explained that the two CCGs were classified into different peer groups that were matched against population size and demographics and therefore it was not a true comparison.

9.24 Mr Evans raised the point that notwithstanding the challenge around speedy decision-making from the regulators nonetheless it did require an investment where the CCGs were already in deficit. Moving forward, where the CCGs needed to make investment decisions, the CCGs were going to have to seriously consider areas for disinvestment.

RESOLVE: The Governing Bodies NOTED the actions being taken to address identified issues.

ACTIONS: Mrs Young to pick up separately with Dr Matthee about the tissue viability concerns.

Dr Shepherd to meet with Dr Matthee to discuss further the reporting of concerns on the new Ulysses system and how to access training for the medical practice.

Mrs Young to discuss further with Dr Pringle re. the suggestion that children with high temperatures were being admitted following attendance at PRH A&E.

Dr Davies and Mrs Young to arrange for the inclusion of the impact of the waiting list numbers in the next and future Quality and Performance reports.

The CCG to assist Healthwatch Shropshire and Healthwatch Telford and Wrekin to promote the discharge survey on people's experience with discharge since March and the work on the Out of Hours palliative care survey and phone, video and online appointments.

Minute No. GB-2020-09.101 – SaTH SOAG (System Oversight and Assurance Group) Update Report

10.1 Mrs Young presented the SaTH SOAG report and assumed the paper as read. It was noted that the report had not previously presented to either of the quality committees due to the timing of the change in governance arrangements.

10.2 The SOAG, chaired by NHSE/I, meets monthly and for that meeting the system provides a slide deck, a copy of which had been circulated for information with the papers. Much of the slide deck was populated by SaTH and the CCGs, as the commissioners, also included some information. SaTH was subject to a comprehensive CQC (Care Quality Commission) inspection during 2019 and the report was published earlier this year. Since then SaTH had received a revisit of certain elements around end of life care and the core services of medical care specifically that had shown that improvements had not been made and further requirement notices had been issued to SaTH.

10.3 Mrs Young raised that the CCG was assured in some areas and less so in others. There was now confidence that SaTH reporting to CQC would be reduced as a result of progress in some key areas ie. Maternity.

10.4 There was mixed progress on the standards of care evidenced by their documentation award level. The CQC found that SaTH's policies were not following up-to-date national best practice standards and a CCG-led quality assurance programme continued.

10.5 There was positive assurance on progress with achieving training in paediatric competencies for adult ED nurses and SaTH had achieved their target ahead of time.

10.6 There had been insufficient progress on recording and achieving 'Time to Triage' in the EDs with both child and adult attendances. This was a situation that the CCG had advised SaTH that it was significantly concerned about and was not assured on and they were asked to take additional action. As a result, there was an increased executive focus on triage for children in particular and the CCG had yet to see SaTH Trust take a hold of the situation and for it to be sustained. Regular fortnightly meetings were held with SaTH around the EDs in particular but those improvements had not yet been seen.

10.7 Dr Pringle expressed concerns about the triage times and asked if there was any benchmarking of where SaTH was in the triage system.

10.8 Mrs Young reported that the triage times had been discussed with SaTH at intervals and most recently last week. The time for the triage of patients as set out in the NICE guidance was 15 minutes and that was the SaTH policy which was what they were aiming to achieve. The important thing was to understand how SaTH were prioritising patients if there were delays in that time and whether there was any harm occurring as a result of those delays. The CCG was in discussions with SaTH about their triage times at the fortnightly joint assurance meetings. Dr Povey pointed out that it was also one of the CQC requirements in one of their actions against SaTH, which was to have triage within 15 minutes for adults and children.

10.9 Mrs Young confirmed that SaTH's policy was set against national guidance and the CQC would judge SaTH against achievement of their internal policy standards and the national guidance. One of the improvements for children was to have double availability of staff who can undertake the assessments on each shift, which meant two nurses on shift at each site, which SaTH were not able to fully achieve. The issue was about behaviour and some of this was about documentation and standards and it was within SaTH's gift to correct this. The CCG was frustrated that there had not been sustained improvement. There had been an improvement but it was not at the level that was required.

10.10 Dr Pepper referred to the on-going concerns with end of life care and the ReSPECT (Recommended Summary Plan for Emergency Treatment and Care) documentation. Dr Pepper wondered whether this was reflective of patients having the ReSPECT forms with them when transferring from primary care into secondary care or was the concern about the completion of those documents within the secondary care setting.

10.11 Mrs Young clarified that there was a system working group that looked at the launching of the ReSPECT forms. The explanation for insufficient completion of the forms at SaTH was around the way in which the forms were launched internally and additional training was required. The focus group that was looking at ReSPECT for the system were revisiting the whole suite of actions around ReSPECT.

10.12 Dr Shepherd believed that some of the issues were around training, particularly with a significant number of locum staff and so although there was the working group and people with a lot of knowledge about ReSPECT, it was actually about disseminating that information and training to the whole organisation and for transient agency and locum staff who have not accessed that training.

10.13 Mrs Young added that the ReSPECT end of life process and the MCA and DOLS corresponded because it was about informed decisions and assessing capacity of an individual to contribute to those decisions or whether or not it was in the best interest decision. The documentation of that was not as it needs to be to be fully compliant with the legal requirements of the form. Whilst the forms have been partially completed they were not to the standard requirements in every case and so it was a training and educational issue.

10.14 Dr Pepper referred to Dr Shepherd's earlier point about the reliance on agency and bank nurses, which was approximately 50% of the workforce and therefore must be a challenge for the ED consultants.

10.15 Mrs Young confirmed that there was some mitigation for that temporary workforce in that some were engaged on longer contracts and so whilst the workforce was split into substantive and temporary staff, there was a cohort of staff that were there constantly.

10.16 Dr Povey highlighted that another issue that had been picked up in the CQC report was that because of the high number of agency staff there was not a good nurse to patient ratio and so Mr Evans and Dr Povey had welcomed UHB forming the improvement alliance with SaTH. The issues were not about individual staff but putting the right systems and processes in place but unfortunately there were repeated issues where the forms and assessments had not been fully completed.

10.17 Mrs Young confirmed that what the CQC had commented on in the two reports that were published on 14 August was a degree of complacency where forms and assessments had not been completed sufficiently and had not been challenged. They had just been accepted by the next care delivery teams and so there is opportunity to improve this now.

10.18 Dr James referred to the triage and the initial assessment of adults and sought clarification on what the initial assessment involved. Dr James also noted concern that the rates had increased in August beyond what would be considered acceptable levels.

10.19 Mrs Young confirmed that the time to triage included an initial assessment and then a judgement about which category the individual would be streamed to. It was understood that there had been some confusion at an earlier stage that SaTH had not been carrying out the initial assessment within the timeframe but actually carried out the two elements together. In some respects the data shown for the walk-in patients had shown an improvement.

10.20 Dr Matthee firstly reported that there was still concern in general practice about the ReSPECT forms and the opinion of GP colleagues was that some hospital consultants were unaware of how to complete the ReSPECT form. Secondly, some of the discharge summaries were of very poor quality and unfortunately there was no-one to report this back to. However, Dr Matthee welcomed the Healthwatch survey on discharge.

10.21 A further issue that remained was that the communication between secondary care and primary care when patients had been discharged from hospital had been very poor. This did not only apply to those patients who had been admitted for a short stay but patients that had been very ill for several weeks and yet there seemed to be no communication between the families and secondary care doctors. Dr Matthee stressed that although the system required improvements, the on-going issue was not with all secondary consultants, it was attributed to particular consultants and what they will and will not do.

10.22 Mr Vivian referred to the relationship with UBH in the new overall delivery of the system and asked if UHB was part of the system, would UHB be accountable for the quality and safety of services at SaTH.

10.23 Mr Evans answered that broadly UHB would not be accountable but there were committees in common now between UHB and SaTH and one of those would be a quality committee. Whilst UHB was not directly accountable because SaTH was the statutory organisation, the alliance was to help SaTH improve. However, Mr Evans believed that there was an expectation on both sides and throughout the system as a whole that the work that UHB would do with SaTH would improve quality over time.

10.24 Dr Povey referred to the CCG being told on a number of occasions that it was the arbiter of system quality and provider quality and asked how the CCGs were going to judge the success of the UHB and SaTH alliance.

10.25 Mr Evans understood there was no different set of metrics in terms of overall quality improvement than the ones that would normally be considered as part of the quality framework with the organisation. The expectation of all system partners was that there would be some significant improvement seen quite quickly. This was predominantly a major part of the reason that UHB and SaTH had formed the improvement alliance. Mr Evans expected that the CQC would carry out a further inspection within the coming weeks. As the commissioners for the services, the CCGs needed to monitor the situation but it was hoped that improvements would be seen quite quickly.

RESOLVE: The Governing Bodies NOTED the actions taken and the progress made to address the identified issues.

FINANCE

Minute No. GB-2020-09.102 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Finance and Contracting Report including Quality, Innovation, Productivity & Prevention (QIPP) schemes

11.1 Mrs Skidmore presented the combined report that provided information for both CCGs for the reporting period up to end of Month 4 (July), which was taken as read. Mrs Skidmore focussed on three particular areas from the report as follows:

11.2 Month 4 finance position: As previously reported, the CCGs were not operating to the plans previously set as individual CCGs, which were not signed off. The CCGs were reporting against a budget that had been allocated centrally to them. Excluding the expenditure on COVID-related activities that the CCGs were currently able to reclaim through central sources, the CCGs were reporting a combined overspend to date of £4.6m, which was £2.2m for Shropshire CCG and £2.4m for Telford and Wrekin CCG. The reasons for the drivers for that position against the budget that the CCGs had been allocated was set out in the report and had not changed materially since previous reports. The CCGs were therefore still looking at a spend in excess of a plan for areas such as: individual commissioning; prescribing; and certain areas of primary care where the CCGs had been anticipating additional allocations but because of the funding regime these allocations had not been made. There was also a continued slippage against the CCGs' running costs targets as a result of the delay to some of the management of change process.

11.3 Months 5 and 6 finance: Since the report was written, work had commenced on the Month 5 position. Mrs Skidmore was pleased to report that confirmation had been received of the CCGs' allocation which breaks even the CCGs' position at Month 4. It was previously reported that the CCGs were reimbursed for COVID-related expenditure but for other areas there had been an overspend. In terms of the CCGs' Month 5 and 6 position onwards, budgets had been loaded into the ledger up until Month 6, and for the Month 5 reporting regime, the CCGs were not being asked to provide any forecasts of future expenditure.

11.4 Work continued on developing what the forecasts would look like, which have been shared informally with the Finance Committee Members, but there were some uncertainties around the CCGs' allocations for the rest of the year, which to date had not been confirmed.

11.5 QIPP It had been previously reported that the QIPP Programme Board had been stood down at the start of the year owing to the QIPP programmes having been paused following the response to COVID-19. A decision had been made that the CCGs would resurrect some of their governance for QIPP so that where they could, they could maintain their oversight and give their assurances around the activities that they could do to manage their spend in the situation that they were in.

11.6 The joint QIPP Programme Board meeting had been held and a report would be taken to the Finance Committee meetings in common at the end of the month. There was very much a focus on those areas where it was known that the CCG could influence directly to make a difference on the expenditure curve. Separate meetings had taken place with Mrs Young for medicines management and her team; and with Ms Parker with the CHC and the individual commissioning team. The QIPP Programme Board meetings and meetings in the intervening periods were to ensure the CCGs could pick up the pace on some of those programmes of work. There had also been some really good discussions about recognising that the Governing Body conversations needed to be a little bit fluid because of the wider system work that would make the more material difference in terms of the CCGs' spend in its totality. The CCGs were therefore starting to have more discussions internally and were formalising their governance around that approach as well. The report that would be presented to the Finance Committees in Common would reflect those conversations and then would report on the information received.

11.7 In connection with Mr Timmis' earlier comment, it was reported that a conversation was held the day before with Dr Davies about making sure that the CCGs recognised the value of benchmarking in influencing and informing some of the ideas that the CCGs were developing, which would be developed over a period of time through the QIPP Programme Board also. Where there were comparisons with peer groups, ie. with Rightcare data, the CCGs wanted to ensure that that was absolutely recognised and embedded into the processes that they were using.

11.8 Mr Timmis reflected on the last meeting held two months' ago, when Members were informed that clarification of the budgets to the end of the financial year was imminent. Mr Timmis repeated what he had said at that meeting in that he understood the reasons why but when Shropshire CCG had been criticised for not setting an effective budget it was unsatisfactory of the NHS not to give clarity on this. The fact that the CCGs had broken even to Month 4 was good news but Mr Timmis agreed with the point made about the underlying position and the fact that as it stands the information that was presented to Finance Committee members did show that the CCGs were likely to have a significant overspend by the end of the financial year. Mr Timmis applauded all the QIPP work that was in hand but it was difficult when the CCGs did not know the full context in which they were operating and this was really frustrating.

11.9 Dr Pepper referred to the financing of the ASD service and had been surprised to learn that the CCG was having to seek NHSE approval for a relatively small part of the CCG's expenditure for a neuro development pathway when Shropshire and Telford and Wrekin's performance had already featured in a SEND report. Mr Evans had earlier commented that for every service the CCG now invested in it would need to decide what it was going to disinvest in. Dr Pepper asked was the CCG now charged to seek approval from NHSE/I for those services that it was disinvesting in; or when it asked to invest in a service, did this mean that it was going to balance the finance by not spending it elsewhere.

11.10 Mr Evans clarified that the reason the CCGs were asked to seek approval for any investment decisions this year was because the CCGs were exceeding their allocated budgets and therefore that had an impact on NHSE/I finances. It was thought that this was no different to any other CCG or provider in the present financial world of block allocations that all added up to the national NHS budget. Therefore, any further investment over and above the allocation required agreement. Clearly as the CCGs had made changes to the system services as a result of the response to COVID-19 there had been an expectation that the CCGs would consult with the regulators on those service changes.

11.11 Mr Evans reported that the CCGs did consult with NHSE/I to ensure they were supportive of for example the movement of the Urgent Treatment Centres (UTCs) as part of the work during COVID. It was thought likely moving forward that where there was an intention to disinvest in a service, it would be wise to consult with the regulators to ensure for completeness, in relation to engagement with the local population, that the CCGs had carried out a good quality impact assessment on the likelihood of what that disinvestment would mean and had weighed up the benefits and risks of that disinvestment. It was, therefore, considered that it was not necessarily about losing the autonomy, it was a sense check that the proper process to make that decision had been followed.

11.12 Mrs Bryceland sought confirmation that there was one Medicines Management Team across the CCG and that Prescribing QIPP was looked at across the system and not just for primary care.

11.13 Mrs Skidmore confirmed that there is one Medicines Management Team with one single lead. The CCGs are standardising processes in the team and this will help to make sure that the numbers are calculated in a consistent way. It was considered that the drivers of the prescribing spend numbers that were being seen were not necessarily local inefficiencies but rather the estimated impact of national pricing changes such as NCSO and CATM drugs (as seen in previous years). The QIPP programme aims to deliver efficiencies on a local level and the CCG Medicines Management Team supports work across the whole system not just primary care.

11.14 Mrs Bryceland asked if this was a national challenge and not for just Shropshire and Telford and Wrekin.

11.15 Mrs Skidmore explained that increases in prescribing spend was a national challenge though it may manifest in different areas in different ways. Some of it would be impacted by the population and its demographics. The Prescribing Team have some really good networks regionally so they are able to keep abreast of the costs and the benchmarking to ensure that they can be as efficient as they could be.

11.16 Mrs Young added for clarity that there was a certain element, which was Brexit dependent and the customs supply of certain drugs, which was a national issue. This was taken into account in the CCGs' forecasts and so in the QIPP and the spend on medicines management.

11.17 Ms Parker further added that there had been a significant change in Category M pricing which was often used to fund community pharmacy contracts. There was also the issue about the use of anti-coagulants with the newer anti-coagulants being used to prevent patients requiring additional phlebotomy services and Warfarin clinics, etc that has had an impact on the prescribing budget as well.

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

Minute No. GB-2020-09.102 – COVID-19 Update

12.1 Mrs Tilley presented a verbal update on the current position of the response to the COVID-19 pandemic. Shropshire, Telford and Wrekin was currently in a steady state but was beginning to see small increases in prevalence rates and the position was being tracked very carefully. It remained important to reinforce the message about managing the spread of the virus, which was for people to continue to wear a face mask, to regularly wash hands, to follow the social distancing guidelines and to undergo a test if symptoms are experienced. The CCGs continue to promote this message through communications with its staff groups and with the public around this.

12.2 There are a range of testing options still available, however, there have been some issues both nationally and locally with some of the options but assurance has been given that these were being addressed and were temporary issues. The communications team across the system was keeping the public up to date around this.

12.3 The incident management structure continues to maintain a multi-agency approach to respond to COVID-19. The main themes focussed upon were around maintaining the testing capacity going forward and continuing to offer Infection Protection Control (IPC) input across the system; and also maintaining its focus on the Personal Protection Equipment (PPE) supply chain, the position of which was currently stable.

12.4 Members would be aware of the Government's announcement the day before of the return of some restrictions, which demonstrated how precarious the situation remained. However, the Governing Bodies were assured that the incident team continued to have a robust approach to local management of the pandemic within the national guidance parameters.

12.5 Ms Fiona Smith queried what messages were being communicated to the public because general practice was seeing a lot of anxious patients who were listening to the general news about the outbreaks and the increase in the number of positive cases. The question was asked how could the public in Shropshire, Telford and Wrekin could be assured that the county was currently in a steady state.

12.6 Mrs Tilley advised that there was a communications cell which included representation from across the agencies who met regularly to assess the current situation, any specific communications that might need to be published in in terms of changing guidance but also to continue to promote those relevant messages around how people can stay safe and the actions that they may need to take. In particular, Public Health Shropshire circulated up to several updates a day communicating with the public around the messaging of the situation. Mrs Tilley explained that it was difficult to strike a balance in not wishing to alarm the public but also that the county had been fortunate in that its prevalence rates had not escalated in the way that some areas had experienced.

12.7 Ms Cawley reported that both Healthwatches were really keen to have more sight on the communications that were published. Apart from the press releases it was thought that the Healthwatches did not receive all the communications and as it was the role of the Healthwatches to provide patient and public information, they could help to share any messaging. Mrs Tilley agreed that she would facilitate the links with the comms team to help the messaging to be spread more widely.

12.8 Mr Timmis referred to the prevalence rates and the report that the 'R' rate across England was now 1.2, Mr Timmis asked if the CCGs were anticipating an impact on local NHS services over the next few weeks.

12.9 Mrs Tilley explained that the modelling that was being developed was based on reaching a certain percentage level of the surge in capacity experienced during the peak in April. As the system had been progressing through the restore process the CCGs have been ensuring that services were able to step down appropriately to allow that COVID-19 response to increase should this be required. The position was being tracked through the Health Protection Board and through Public Health representatives on how the situation was evolving locally. Presently, the levels were showing some very small increases but would be continued to be monitored so that adjustments to services could be made accordingly.

12.10 Mr Vivian referred to Mrs Tilley's statement that the county had been fortunate in experiencing lower prevalence rates than some areas. Mr Vivian considered that part of that luck was as a result of regular planning, co-ordination and a joined up approach across public sector organisations and hoped that Mrs Tilley would take some credit for that.

12.11 Mr Vivian referred to communications and suggested that it would be helpful to review the effectiveness of the communication work through the experience of people with whom the system was communicating. This may be a resource-intensive activity but would gain some confidence that what was actually being communicated was being heard. Mr Vivian said he would be interested to know if there were any steps that could be put in place to understand how good the CCGs were and how well they were performing in communication terms.

12.12 Mrs Tilley thanked Mr Vivian for his comments and would take back to Gold and Silver Command the suggestion to review the effectiveness of the communications work.

ACTIONS: Mrs Tilley to ensure Healthwatch Shropshire and Healthwatch Telford and Wrekin receive all the relevant information that is being communicated regarding guidance released on COVID-19 to the public.

Mrs Tilley to take back to Gold and Silver Command the suggestion to review the effectiveness of the communication processes and outputs.

Minute No. GB-2020-09.104 – Update on Shropshire Telford and Wrekin System Restoration from COVID-19

13.1 Referring to the paper circulated, which was taken as read, Mr Trenchard gave a verbal update in relation to the requests included in the NHSE/I Phase 3 letter.

13.2 Mr Trenchard reported that across all system services at the outbreak of COVID-19, the first submission to NHSE/I had recorded 103 services. At the last submission on 5 September, there were 106 services

that have been identified for restoration, ie services that have been stood down and had gone through a sift and sort of whether they were ready for recovery or restore. Currently 47 services had been fully restored, which equated to 44%; 36 have been partially restored; and 23 are still to be restored.

13.3 When viewed across the particular providers, SaTH have 23 services that are fully restored with 7 still to be restored. The Midlands Partnership Foundation Trust (MPFT) have 3 services that are fully restored with 7 still to be restored. SCHT have 5 services fully restored with 1 to be restored. Primary care have 16 services fully restored with 1 to be restored.

13.4 Alongside the Silver and Gold Command framework for decision-making and response, a System Restore Group had been established, which had held its last meeting. The three programme boards which existed before the COVID response and focussed on mental health, learning disabilities and autism in young people, acute specialist and community based covers the primary care element. The decision-making for the oversight of the restore process has been transferred to those programme boards, the advantage of which begins to align some of the complexity of the system response going into winter for the implementation of the services that are required.

13.5 The local health system was in financial challenge and one of the key asks in the Phase 3 letter was to return back to where the system was in terms of performance. Shropshire and Telford and Wrekin was not performing well before the response to COVID and so there was a significant transformation challenge across some key pathways and parts of the services. Therefore, there needed to be a real focus on this work in order to describe those services in the CCGs' long-term plan.

13.6 In relation to the clinical prioritisation that was carried out at multiple levels, one of the first changes during the onset of the COVID outbreak was to move the Trauma service from SaTH to RJAH. That service had now been repatriated to SaTH on 24 August but had been a difficult process. There had been a number of meetings held with clinical staff and colleagues from both organisations to think about the lessons learned and what was to be done differently in that space in the future. One of the key asks was that attendees at the meetings put the system work first before the interests of individual organisations.

13.7 In relation to the development of the system plan, the first plan had been submitted on 2 September. It was considered that perhaps the ask had been conflated in relation to where the system was heading rather than what the current performance was and also aligning with some of the narrative particularly around the winter planning. A whole system winter planning workshop had since been held, chaired by Mrs Tilley, which had reviewed a number of schemes that had a good evidence base and to help demand management particularly at the front door of SaTH and PRH. That work was now being prioritised to look at the impact on SaTH in relation to bed days so that the right decisions can be made going forward. The community boards and the other programme boards would be implementing some of those services.

13.8 There is a challenge regarding the financing of the winter schemes. A meeting would be held the following week, chaired by Dr Jane Povey, STP Clinical Lead, to look at those services that have been prioritised through the winter planning process to ensure that they reflect the best evidence based programmes that can be put into place.

13.9 Work was being undertaken on one of the key areas of the narratives submission, which focussed on the health inequalities the system faced. For example, people's annual health checks, and people's learning disabilities but there were more significant health inequalities in relation to Shropshire's rurality and possibly new health inequalities that may need to be considered.

13.10 The next step in relation to the plan is to finalise it ready for submission on 21 September. There were daily meetings taking place and this week there was a significant meeting to identify the key impact of COVID and Restoration and Recovery from providers so that they are feeding that information back to the CCGs to then turn into a description of what will follow over the next six months.

13.11 Ms Cawley reported that in addition to attending the restoration and recovery meetings, the Healthwatch representatives had also been invited to the cluster meetings but had not received any invitations to attend any of the programme boards meetings. Mr Trenchard apologised for this oversight and said he would ensure that the Healthwatch representatives were invited to attend the programme board meetings.

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

ACTION: Mr Trenchard to ensure that the Healthwatch Shropshire and Healthwatch Telford and Wrekin representatives are invited to attend the programme board meetings.

GOVERNANCE

Minute No. GB-2020-09.104 – Joint Governing Body Report: Strategic Risk Update – Shropshire CCG Board Assurance Framework (BAF) and Telford and Wrekin CCG Board Assurance Framework (BAF)

14.1 Miss Smith presented the joint report and the individual Board Assurance Frameworks for both CCGs, which were different, and had been updated following the last Audit Committee meetings, and were taken as read.

14.2 Members were reminded that the Board Assurance Framework was a way of systematically capturing the risks associated with non-delivery of each CCG's strategic objectives. The Governing Bodies, therefore, when they were considering the BAFs, should be thinking about: challenging the risk ratings and target risk scores that were being presented; assessing the robustness of the controls and action plans that were identified; and ensuring that progress was made to reduce the gap between the current risk that was stated and the target risk aspired to.

14.3 Miss Smith highlighted Sections 2 and 3 of the report, and that no new risks for either CCG had been added and none that have been removed but there were some amendments to individual risks which were highlighted in the report.

14.4 It was noted that both Governing Bodies had previously expressed a wish to develop a joint BAF as quickly as possible. Miss Smith was planning this but work was dependent on the organisational development discussions that had commenced with the two Governing Bodies about identifying joint strategic objectives. The two BAFs were different in terms of the principles and the objectives currently sighted and it was difficult to combine at the present time without shared objectives. Work will be undertaken to develop a joint BAF that can be presented to the Governing Bodies' meetings in November.

14.5 Reference was made to an action from the last Shropshire CCG Governing Body meeting, which was for the Executive Team to consider the original risk score being added. This had been discussed and agreed that it would be more beneficial to include the last reported risk so that any movement in the risk was clear in the presentation of the information. Miss Smith would ensure that this was added to any new joint BAF in the future. Members were invited to share their comments on or suggestions for the development of the joint BAF with Miss Smith.

14.6 Dr Pringle noted that the Shropshire CCG BAF included the risk 77/16 Sustainability of Provider Workforce and could not see an equivalent workforce risk in the Telford and Wrekin CCG BAF. Dr Pringle highlighted that while primary care was mentioned under the key controls it did leave a significant risk in the mitigating actions. Dr Pringle also pointed out that in a generation there had been a reduction of 3 GPs per hospital consultant to less than 1 GP now. It had been reported that there would be a shortage of 7000 GPs nationally, and considering the massive shift in workload from secondary care to primary care included in the Future Fit work, there needed to be the finance and the staff in place to carry out that work. Dr Pringle considered the risk for the current model was high and the risk for the future vision was even higher and suggested the risk score should be increased on the BAF and made more visible.

14.7 A short discussion ensued on whether or not because the PCCC had delegated authority the risk should be recorded separately on the PCCC risk register. Ms Parker would discuss with the Chair of the PCCC the development of a joint PCCC risk assurance framework report for presentation to the Governing Bodies.

14.8 Miss Smith suggested that a discussion was required about how the Governing Bodies have line of sight of the primary care risks given that there was delegation of decision making for primary care in the PCCC. Agreement needed to be reached on how the risks were presented in the BAF because the general risks around workforce that were included did not highlight the primary care workforce risks in particular. It was agreed that the Director of Partnerships would work through how these risks would be reported and visible enough at a Governing Body level.

14.9 Referring to page 3 of the Shropshire CCG BAF, Item 10, Risk no 78/16 on the 0-25 service, Dr Pepper highlighted the risk change from red to amber, and queried whether the risks included on the BAFs were aligned to reflect their current risk. Dr Davies agreed this was a good point and agreed that the BAF needed a refresh and a review of the detail to update it.

RESOLVE: The Governing Bodies:

- ***ACCEPTED and NOTED the content of the report and supporting Appendix A for assurance purposes.***

- ***REVIEWED the updated strategic risk position and CONFIRMED that the current level of risk was acceptable in line with the actions outlined.***
- ***NOTED the planned development of a joint Board Assurance Framework for both CCGs.***

ACTIONS: Members are invited to share any suggestions with Miss Smith for the review of the presentation of information on the new shared NHS Shropshire CCG and NHS Telford and Wrekin CCG Board Assurance Framework.

The Director of Partnerships to consider the inclusion of primary care workforce risks on the BAF and/or on the PCCC risk register.

Ms Parker with the Chair of the PCCC to consider a joint PCCC risk assurance framework report for presentation to the Governing Bodies.

Dr Davies to look at Item 10 for possible refresh of the risk score.

Minute No. GB-2020-09.106 – Proposed changes to the Constitutions and Governance Handbooks of NHS Shropshire CCG and NHS Telford and Wrekin CCG

15.1 Miss Smith explained that both CCGs had very recently changed the content of their constitutions and governance handbooks to allow the CCGs to appoint the joint Governing Body Members present at this meeting today and to align the decision-making processes between the two CCGs prior to the application to create a new single strategic commissioner in April 2021.

15.2 The process for undertaking the application to create a new single strategic commissioner had been lengthy and in the interim period non-material changes had taken place that needed to be reflected both in the constitutions and the handbooks, which were documented in the report. The main changes involved were:

- The new role of Associate Lay Member for Patient and Public Involvement in Equality, Diversity and Inclusion.
- Attendance by the Medical Director and the description of the Medical Director role in the constitution.
- Attendance of Public Health representatives from both local authorities, which was not clear in the Terms of Reference for the Individual Funding Committee.

15.3 Changes to the constitutions would normally require ratification by both the memberships however the constitutions did allow the Accountable Officer to make non-material proposed changes that can be approved by the Governing Bodies of both CCGs. The Governing Bodies were allowed under the constitution to make any changes to the governance handbook without any further ratification by the membership. Miss Smith had therefore advised the Accountable Officer that the changes to the constitutions were considered not material and ought to be signed off by both Governing Bodies without ratification by the membership.

15.4 A further recommendation that was not included in the report was for the role of the Chief Clinical Information Officer (CCIO), to be added as an attendee at the Governing Body Part 1 and Confidential Part 2 meetings of both CCGs going forward until the establishment of the new organisation. Miss Smith therefore proposed and it was agreed that the CCIO role would be included in the list of additional attendees at the Governing Body meetings in the constitutions as listed in Appendix 1, section 5.6.3.

RESOLVE: The Governing Bodies:

- ***NOTED the changes proposed to both the Constitution and the Governance Handbook as outlined in the report and appendices.***
- ***APPROVED the proposed amendments to the Constitution under clause 1.4.2 of the Constitution that the changes are not material and do not require approval by the membership of the CCG;***
- ***APPROVED the proposed amendments to the Governance Handbook.***
- ***APPROVED the recommendation that the role of Chief Clinical Information Officer should be included in the list of attendees to attend both Part 1 and the Confidential Part 2 Governing Body meetings until the establishment of the new single strategic commissioner.***

ACTION: Miss Smith to include the CCIO role in the list of changes to the additional attendees at the Governing Body meetings in the constitutions as detailed in Appendix 1, section 5.6.3.

At this point, due to a conflict of interest, Dr Adam Pringle stepped out of the meeting room at 12.10pm.

Minute No. GB-2020-09.107 – Appointments to the Governing Bodies of NHS Shropshire and NHS Telford and Wrekin

16.1 Miss Smith noted the recent joint appointments to both Governing Bodies as listed in the paper, which were:

- An appointment by election of the GP/Healthcare Professional Governing Body Members of Dr Julian Povey as Joint CCG Chair.
- Appointment by election of the Shropshire CCG membership of GP/Healthcare Professional Governing Body Members: Dr Michael Matthee; Dr John Pepper; Dr Julian Povey.
- Appointment by election of the Telford and Wrekin CCG membership of GP/Healthcare Professional Governing Body Members: Mrs Rachael Bryceland; Dr Adam Pringle; Ms Fiona Smith.
- Appointment by an external recruitment process of: Ms Julie McCabe - Registered Nurse Governing Body Member; Dr Martin Allen – Secondary Care Doctor Governing Body Member; Mr Gary Turner- Lay Member Primary Care Governing Body Member; and Mr Meredith Vivian – Lay Member Patient and Public Involvement Governing Body Member.
- Appointment by an external recruitment process of Mr Astakhar Ahmed as the Associate Lay Member Public and Patient Involvement – Equality, Diversity and Inclusion.

16.2 The Constitutions of both CCGs stated a requirement to confirm the appointment of the joint role of Vice Clinical Chair of the CCGs who would deputise for the Chair of the CCGs in their absence to undertake the clinical leadership elements of the Chair role. The Vice Clinical Chair must be appointed from one of the GP/Healthcare Professionals that have been elected by either membership onto both CCG Governing Bodies. That group of individuals had discussed this and proposed Dr Adam Pringle as the Vice Clinical Chair, the appointment of which was agreed by the Governing Bodies.

RESOLVE: The Governing Body:

- ***NOTED the recent joint appointments to the Governing Bodies of NHS Shropshire CCG and NHS Telford and Wrekin CCG as set out in full in section 2.1 of the paper.***
- ***NOTED the appointment of Mr Astakhar Ahmed as the Joint Associate Lay Member Public and Patient Involvement (PPI) – Equality, Diversity and Diversity for both CCGs.***
- ***NOTED the requirement for the Governing Body of both CCGs to appoint a Joint Deputy Chair of both CCGs at the next Governing Body meetings in Common held in public in November.***
- ***APPROVED the proposed appointment by the Governing Bodies of Dr Adam Pringle as the Joint Vice Clinical Chair.***

ACTION: An item to appoint a Joint Deputy Chair to both CCGs to be added to the agenda of the next Governing Body meetings in Common held in public in November.

For: NHS Shropshire CCG:

Minute Nos. GB-2020-09.108 to GB-2020-09.113

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

GB-2020-09.108 Shropshire CCG Finance & Performance Committee – 29 July 2020
GB-2020-09.109 Shropshire CCG Quality Committee – 29 July 2020
GB-2020-09.110 Shropshire CCG Clinical Commissioning Committee – 20 May 2020
GB-2020-09.111 Shropshire Locality Forum – North – 25 June, 23 July 2020
GB-2020-09.112 Shropshire Locality Forum – South – 2 July 2020
GB-2020-09.113 Shropshire Locality Forum – Shrewsbury and Atcham – 30 July 2020

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

For: NHS Telford and Wrekin CCG:

Minute Nos. GB-2020-09.108 to GB-2020-09.110

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

GB-2020-09.108 Telford and Wrekin CCG Planning, Performance and Quality Committee – 28 July 2020
GB-2020-09.109 Telford and Wrekin CCG Audit Committee – 21 July 2020
GB-2020-09.110 Telford and Wrekin CCG Practice Forum – 21 July 2020

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

Minute No. GB-2020-09.114 – Any Other Business (for Shropshire) GB-2020-09.115 (for T&W)

18.1 Mr Vivian noted that Ms Cawley had asked about Healthwatch membership on committees and understood that there was already Healthwatch representation at the Quality and Performance Committee.

18.2 Miss Smith said that she could not recall from memory but had invited Ms Cawley and Mr Shirley to discuss with them Healthwatch involvement in the CCGs and also their view of patient engagement on a wider basis. Miss Smith would ensure the Healthwatch representatives were invited to attend the right committees at the right time.

18.2 There were no further items raised.

DATE OF NEXT MEETING

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

- Wednesday 11 November 2020 – time and venue to be confirmed.

Dr Povey thanked Members for their attendance and officially closed the meeting at 12.20pm.

SIGNED …….. DATE ……

Shropshire Clinical Commissioning Group (SCCG) and Telford and Wrekin CCG (TWCCG)

ACTIONS FROM THE GOVERNING BODY MEETINGS IN COMMON – 9 SEPTEMBER 2020

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2020-09.094 – Members' Declarations of Interests	Miss Smith to arrange for the review of the levels of mitigation for the general practitioners in partnership included on the Register of Interests.	Miss Alison Smith		Complete
GB-2020-09.096 – Accountable Officer's Report - N365 Reseller Contract	Dr Povey and Mr Evans to take the Chair's and Accountable Officer's Action on the decision to appoint an N365 reseller and sign off of the contract outside of the meeting.	Dr Julian Povey / Mr David Evans		Complete
System Improvement Plan	Mr Evans to arrange for the System Improvement Plan to be presented to the Governing Body. Item to be included on the next agenda.	Mr David Evans Mrs Sandra Stackhouse	Next meeting	 Complete
For Shropshire CCG: GB-2020-09.097 – Minutes of the Previous Meeting – 8 July 2020	Mrs Stackhouse to make the agreed amendments to the draft minutes as noted in paragraph 6.1.	Mrs Sandra Stackhouse		Complete
For Shropshire CCG: GB-2020-09.098 – Matters Arising [b/f GB-2020-01-010 – Shropshire CCG Strategic Priorities]	*b/f:* Mr Trenchard to bring back a progress report on the MSK Alliance Agreement to the next formal Part 1 meeting. **Note: Action to be retained on the action log until confirmation has been received from the JSCC's Chair's report that this action has been completed.**	Mr Steve Trenchard	*To be included on the JSCC agenda	Awaiting confirmation that this action has been completed
GB-2020-07.075 – Public Questions	Miss Smith to arrange for the publication of a message on the two CCGs' websites regarding the CCGs will not accept inappropriate questions and similar questions received which cover the same areas as those which have been answered within a 6 month period.	Miss Alison Smith	30 September	Complete

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
For Shropshire CCG: GB-2020-07.078 – Performance and Quality Report including integrated, secondary and primary care	Dr Davies to share the data on the ambulance crew on-scene timings with Members when received. *[09.09.20 Update provided by Dr Davies: Information has been requested to include data from April, which was expected to be received for presentation at the next meeting.]*	Dr Julie Davies	Next meeting	*WMAS have still not provided the data requested – this has been escalated to the regional commissioning lead*
	b/f: Ms Parker to include the waiting list numbers and timescales for the ASD and ADHD pathways in the SEND report. **Note: Action to be retained on the action log until confirmation has been received from the JSCC's Chair's report that this action has been completed.**	Ms Claire Parker		Complete
	b/f: Mr Trenchard to provide an update on the new ASD and ADHD pathways to the next meeting. **Note: Action to be retained on the action log until confirmation has been received from the JSCC's Chair's report that this action has been completed.**	Mr Steve Trenchard	*To be included on the JSCC agenda	Awaiting confirmation that this action has been completed
	Those actions that have been referred to the JSCC from the Governing Bodies of both CCGs to remain on the action log until the next meeting when the JSCC Chair's Report confirms those actions have been completed.	Mrs Sandra Stackhouse		Complete
	The CCG to invite the Healthwatch Shropshire and Healthwatch Telford and Wrekin representatives to attend the Quality Committee meetings.	Executive Team	As soon as possible	
For Shropshire CCG: GB-2020-07.084 – Update on SEND Inspection Report	*b/f:* Ms Parker to present to the next Governing Body meeting an assurance report on SEND together with the final draft of the written statement of action.	Ms Claire Parker	Next meeting	Complete – included on next agenda for 11.11.20

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
	b/f: The Executive Team to agree a process for providing the Governing Body with assurance around SEND.	Executive Team	Next meeting	
GB-2020-09.100 – Performance and Quality Report including integrated, secondary and primary care	Mrs Young to pick up separately with Dr Matthee about the tissue viability concerns raised.	Mrs Zena Young		Mrs Young has contacted Dr Matthee for further information and is awaiting a response. Dr Matthee has confirmed that his query related to progress regarding the wound care formulary and has received a response on progress with this.
	Dr Shepherd to meet with Dr Matthee to discuss further the reporting of concerns on the new Ulysses system and how to access training for general practice.	Dr Deborah Shepherd / Dr Mike Matthee		CCG quality team have contacted Dr Matthee. Action completed.
	Mrs Young to discuss further with Dr Pringle about the suggestion that children presenting with high temperatures at the PRH ED were being admitted.	Mrs Zena Young / Dr Adam Pringle		This action was followed up with Dr Pringle who clarified his concern that Children attending ED are triaged and then admitted to paeds with minor illness, instead of being seen and discharged with advice - as they

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
				would have been had they seen a GP. The quality team are liaising with the Contracting Team on discussions with SaTH to understand if this is a current concern.
	Dr Davies and Mrs Young to arrange for the inclusion of the waiting list numbers in the next and future Quality and Performance reports.	Dr Julie Davies / Mrs Zena Young		Within the Q&P report in November Complete
	The CCG to assist Healthwatch Shropshire and Healthwatch Telford and Wrekin to promote the discharge survey on patient experience with discharge since March and the work on the Out of Hours palliative care survey; and phone, video and online appointments.	Executive Team	As soon as possible	
GB-2020-09.103 – COVID-19 Update	Mrs Tilley to ensure Healthwatch Shropshire and Healthwatch Telford and Wrekin receive all the relevant information that is being communicated to the public regarding guidance released on COVID-19.	Mrs Sam Tilley	As soon as possible – verbal update will be given at the next meeting	
	Mrs Tilley to take back to Gold and Silver Command the request to review the effectiveness of the communications processes and outputs.	Mrs Sam Tilley	As soon as possible – verbal update will be given at the next meeting	

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2020-09.104 – Update on Shropshire, Telford and Wrekin System Restoration from COVID-19	Mr Trenchard to arrange for the Healthwatch Shropshire and Healthwatch Telford and Wrekin representatives to be invited to attend the programme board meetings.	Mr Steve Trenchard	As soon as possible	
GB-2020-09.105 – Board Assurance Frameworks (BAFs) for NHS Shropshire CCG and NHS Telford and Wrekin CCG	Members are invited to share with Miss Smith their suggestions for the review of the presentation of information on a new shared NHS Shropshire CCG and NHS Telford and Wrekin CCG BAF. The Director of Partnerships to consider the inclusion of the primary care workforce risks on the BAF and/or on the PCCC risk register. Ms Parker with the Chair of the PCCC to consider the primary care risks in the joint PCCC risk assurance framework for presentation to the Governing Bodies. Dr Davies to look at Item 10 for possible refresh of the risk score.	All Members / Miss Alison Smith Ms Claire Parker Ms Claire Parker Dr Julie Davies	 Before the next PCCC & Governing Body meetings 	Complete Complete Complete
GB-2020-09.10 – Proposed changes to the Constitutions and Handbooks of NHS Shropshire CCG and NHS Telford and Wrekin CCG	Miss Smith to include the CCIO role in the list of changes to the additional attendees at the Governing Body meetings in the constitutions as detailed in Appendix 1, section 5.6.3.	Miss Alison Smith		Complete

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 11 November 2020**

Item Number:	Agenda Item:
GB-20-11.123	Governing Body Board Quality and Performance Report

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

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

History of the Report (where has the paper been presented:		
Committee	**Date**	**Purpose**

		(A,R,S,D,I)
October Quality and Performance Committee	28th October 2020	S

Executive Summary (key points in the report):

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

- A&E
- Referal To Treatment (RTT)
- Cancer
- Dementia

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

During the ongoing pandemic situation, the scope and detail of this report are limited due to suspension of many of the data flows Performance against certain indicators is expected to deteriorate in this period (for example, RTT waiting lists). Recovery planning is underway but the process is likely to take some time, and any resumed services will have reduced capacity due to the need for social distancing.

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

Performance around A&E remains a concern moving into the winter with an unknown expectation around Covid 19 on top of winter pressures. The resurgence of Covid cases and the impact this may have on

other services is clearly a major concern for the coming weeks and months.

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

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

Key Quality Points:

- Shrewsbury and Telford Hospitals NHS trust (SaTH) remain the most challenged provider and cause for concern within the health system.
- CQC have confirmed to SaTH that sustained improvements has resulted in the two S31 conditions relating to Maternity services being lifted and reporting requirements reduced.
- Some data accuracy issues and inconsistent assurance for SaTH Maternity are noted as ongoing concerns
- A number of concurrent Covid-19 outbreaks have been reported, predominantly at the PRH site.

The Learning Disability & Autism agenda, including Annual Health Checks and Autistic Spectrum Disorder (ASD) pathway remain a key area of focus for improvement.

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

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

1. Key Performance Challenges

At month 5 of 2020/21, unless otherwise indicated

Area	Indicator	Target *or National rate*	Latest Position		Change from last period		Headline issues/actions
			SCCG	TWCCG	SCCG	TWCCG	
A&E	**4-hour A&E** (SaTH, M05)	95%	**71.2%**		⇩		Ambulance conveyances to A&E reduced due to Covid-19. Category 3-4 Ambulance requests now go via 111 clinical assessment service. SaTH has mostly maintained level one escalation levels during the pandemic; this resulted in improved performance against targets. The difference in the levels of activity between RSH and PRH sites continues with the former showing much stronger levels of recovery back to pre-Covid-19 levels. This applies for both A&E attendances and ambulance conveyances. A system wide discharge operational group is in place to ease flow out of SaTH and to support during the pandemic. SaTH continues to work with ECIST (Emergency Care Intensive Support Team) to improve operational processes and standards. The system-wide UEC (Urgent and Emergency Care) delivery group has been re-focussed to work particularly on initiatives to reduce demand on A&E. In particular it will be working closely with WMAS to reduce conveyances. The national project to utilise booking for non-urgent ED attendances (NHS111 First) is underway with implementation planned for later this year. The aim of this is to divert around 20% of 'unheralded' A&E attendances into pre-booked time slots in a variety of locations including Primary care, MIU, hot clinics, etc. A dashboard has been developed for the UEC Delivery group to focus on the areas requiring improvement and to enable the group to monitor the impact of improvement plans as they are delivered. At both sites it is the younger age groups where the majority of the reduction in activity during Covid-19 occurred and it is this section of the population which is still showing the lower levels of activity. This is thought to be contributing to a change in the case mix of patients admitted from A&E.

Area	Indicator	Target	SCCG	TWCCG	Change		Headline issues/actions
RTT	**Referral to Treatment** within 18 weeks	92%	**48.2%**	**51.1%**	↓	↓	The reduction of elective work during the Covid 19 period is reflected in worsening performance against RTT indicators. There are increasing numbers of longer waits, including 52 week waiters. This is occurring at all providers both in and out of county. Work has begun to develop a shared waiting list so that higher priority patients across the system in all specialties may be identified. This is aimed at ensuring those with greatest need are identified clearly and to ensure best use is made of the available capacity. Clinical validation of the waiting lists is taking place. Agreements are in place with the Nuffield to utilise capacity there under the terms of the national contract with Independent Sector providers, weekly meetings are taking place chaired by the CCG to ensure this capacity is being fully utilised The impact of capacity limitations arising from the need to operate social distancing rules is likely to mean increasing numbers waiting and an increase in long waits. All the waiting list profiles show a clear 'shift to the right' indicating longer waits. Cancer patients and other urgent cases continue to receive necessary treatment. The system is working hard to find mitigations to offset the shortfall in elective capacity as a result of the pandemic and resulting infection control segregation at SaTH. The working groups set up under the Restore and Recovery Programme have been tasked with developing mitigations and identifying rebalancing capacity where possible.
	Referral to Treatment waits > 52 weeks	0	**281**	**151**	↑	↑	
	Diagnostic waits of more than 6 weeks	1%	**65.4%**	**66.6%**	↓	↓	Performance has been severely impacted by Covid 19 and will continue to be compromised as a result of the need to introduce social distancing procedures. Some limited additional modular capacity for imaging has been made available and is having a positive impact on the waiting lists. If this capacity can be maintained then a reduction in the backlog will be seen in the New Year. Performance for endoscopy remains compromised due to the need for increased social distancing, swabbing of patients prior to procedure and the additional complications associated with aerosol generating procedures.

Area	Indicator	Target	SCCG	TWCCG	Change	Headline issues/actions

Cancer Waits	**31 days** to cancer treatment (surgery)	94%	**100%**	**93.8%**	↑	↓	Cancer performance has generally held up well during the Covid 19 crisis as priority has been given to cancer patients. The expectation is for levels of performance to continue to improve over the next few months. Referrals decreased substantially during the Covid 19 peak but now recovering to just slightly below normal levels. Significant capacity issues in diagnostics impact on performance but cancer and other urgent cases are being given priority. Performance on the 62 day standard is currently expected to recover by November. Use of the Nuffield continues to support cancer care under the remit of the nationally agreed contract and this is planned to continue through the rest of the year. Gynaecology and Breast Cancer Assurance Meetings continue, with Commissioner attendance. Best Practice Pathways continue to be discussed fortnightly with Commissioner attendance. The impact of Covid 19 has inevitably delayed a number of projects but these are now re-starting including Breast Project Holistic Need Assessments, Personalised Follow up and Treatment Summaries. Learning/ experience is being shared across West Midlands Lead Cancer Nurse /Managers.
	31 days to cancer treatment (radiotherapy)	94%	**93.3%**	**100%**	↓	↔	
	62 days from referral to cancer treatment	90%	**86.7%**	**74.3%**	↑	↑	
Dementia	**Dementia** Diagnosis Rate	66.7%	**65.2%**	**59.5%**	↑	↑	TWCCG remains below target. Planned events for dementia awareness in practices are on hold due to Coronavirus. Shropshire CCG performance has improved slightly, but is still failing to achieve target due to the coronavirus outbreak, the patients within this cohort, are the ones that have been shielding. Work to re-establish activities in practices around dementia awareness has begun but may be disrupted by the second wave of the pandemic. The potential success of these will be dependent on willingness of patients to present and of finding different ways of delivering the service where this is a problem.

Area	Indicator	Target	SCCG	TWCCG	Change		Headline issues/actions
Mental Health	IAPT Access (YTD)	25% at Year End	2.17%	1.26%	↑	↑	During Q1 there was a significant reduction in activity as a result of Covid 19 impacting on numbers of patients presenting. M4 has seen a partial recovery in numbers but they are still well short of pre-Covid 19 levels. Staffing resources are in place to provide the service, so recovery will be influenced by initiatives to encourage patients to present. Work is being undertaken with MPFT to identify options for increasing presentation and forecasting work being explored jointly to assess the likely demand trajectories. Given the low level of achievement against the target in Q1 and the likely recovery pathways, it will be difficult for the CCGs to achieve the year-end target of 25% access.

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

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

2. Quality Concerns/ Key Points - Providers

Provider	Areas of Concern, current position and actions
2.1 Shrewsbury & Telford Hospitals NHS Trust	
Quality of care: Concerns remain in relation to the quality of care within in Trust particularly in relation to the completion of patient risk assessments; culture and leadership. NHSEI and ECIST continue to work with the Trust on a new package of support, with a new Improvement Director in post. Formal sign of for the alliance agreement with UHB is in progress, but the work to align policies and processes has commenced with the first committee in common having taken place on 21st September. There is a targeted focus on falls management and prevention; care of the deteriorating patient and essentials of nursing care across the care groups. A high degree of attention from the CCG remains in place. **Cancer services**: Assurance in relation to the management of 2Wk Waits and 104 day breaches has taken place through discussions at Clinical Quality Review Meeting, the Cancer team and visit to meet the Consultant Oncologist. Performance targets are all reviewed at the Trust's Cancer Performance and Assurance Meeting. Following the temporary guidance released in April 2020, the Trust continue to triage referrals with telephone appointment, face-to-face appointments or straight to test, the most appropriate approach is confirmed following review of the referrals by the Consultant. 11 patients received their first definitive treatment for cancer after 104 days in July 2020 (the latest reported data). 8/11 of these were Urology patients, one Colorectal, one skin and one Head &Neck. Diagnosis or treatment delays as a result of Covid was cited in 9/11. Patient's co-morbidities delaying the pathway and patient's own choice were the reasons for delays. The CCG quality team met with the consultant Oncologist in September to understand and observe the harm review process. The policy for breach reporting which was shared with the CCG for comments has been approved and signed off through the Trust internal governance processes. **Maternity Services**: Weekly reporting to CQC on two maternity-related S31 notices has continued since 14 September 2018. These are: CTG interpretation and escalation (Assurance regarding escalation for medical review in Triage; Management of reduced foetal movements); and appropriate documentation (escalation of the Maternity Obstetric Early Warning Score; documentation of management plans following handover of care at the twice daily handovers on Delivery Suite). All of the 20 overarching actions have been completed, and the Trust has received confirmation from CQC that they are satisfied that improvements have been made and sustained and that these two S31 conditions are to be lifted and the frequency of reporting on maternity services reduced accordingly. An increase in births overall was seen during August. Face to face bookings recommenced in July. Capacity issues and timing to undertake these has been a challenge. Breast feeding initiation rate (72%) is above the national average and smoking rate at birth has reduced which is positive, although we note that this is a patient self-reported measure as CO testing has been paused on national direction. A new maternity performance dashboard has been developed which aligns the correct targets and performance indicators and was shared at	

September CQRM; it is expected that the new dashboard will be implemented from January 2021. The CCG has raised concerns to SaTH that inconsistencies were again identified between the Exception Reporting and the Maternity Clinical Dashboard at the October CQRM. Data and information was reconciled in the meeting. SaTH acknowledged this has been a recurrent concern and committed to addressing this matter. CCG has also raised concern to SaTH that assurance of an action (LocSSIPS) associated with a maternity never event was previously verbally received to CQRM and follow-up agreed, leading to the closure of the associated RCA. The assurance has since been retracted and no further assurance provided.

Neurology: Meetings continue to progress to the new model which is to be provided by RWT. There are challenges in relation to the available space in SaTH to enable Royal Wolverhampton Trust (RWT) clinicians to deliver a service at SaTH. SaTH note their expectation is for a speedy resolve with estates. The meetings are attended by clinicians from both secondary care providers and primary care colleagues to ensure robust clear pathways are in place. It has been agreed that the service requires a single point of referral. The referrals will be triaged and patients offered treatment at appropriate locations, being mindful of patient choice, patient logistics and capacity. RWT have given assurance that they will be able to offer some form of remote clinics to patients in Shropshire if required due to forthcoming winter issues or 2nd wave Covid-19.

RTT: The Trust's RTT performance remains a concern. A sub-group has been formed to review recovery of the elective position. Every specialty reported as failing RTT in July and August. The Trust is completing harm pro-formas as required. Data and progress will be reported within the performance section of this report. Q&P Committee will receive an update at the November meeting on harms experienced as a result of delays to diagnostics and treatments.

Serious Incidents: The Trust are now aligning the Serious Incident (SI) policy to follow University Hospital Birmingham (UHB) processes. They are planning to use bespoke Root Cause Analysis (RCA) templates for level 1 SIs (Falls, Infection Prevention & Control (IPC) and Tissue Viability(TV)) and RCA training has been undertaken in the trust. A new meeting has also been established - NIQAM (Nursing Incident Quality Assurance Meeting) where these cases are heard and final approval granted, which are chaired by the Chief Nurse. Significant improvements have been made within the Trust in relation to reporting and monitoring processes over recent months and it is hoped the changes will further improve processes. The CCG will attend a future NIQAM.

There are currently 39 open SIs, 6 serious incidents were reported in September. 5 related to falls, and 1 surgical procedure. Three 12 hour ED breaches were reported in September and ten (data to be validated) to date in October.

Falls: It is acknowledged that the increase in number of falls being reported has increased in part due to changes in criteria of reporting falls as an SI. However the initial notifications are indicating recurring themes: incomplete risk assessments; inconsistent application of bay safe; and post falls management. The Trust-wide falls prevention improvement plan is under review and is key area for development for the new Chief Nurse. The implementation of this work continues to be overseen by the matrons and audited as part of their Nursing Quality Assurance Metrics audits. The CCG is reviewing this through its quality assurances processes.

Discharges: The Safer Discharge task and finish group set up by the CCG has led to a discharge audit. The outcome and recommendations of

this audit will be shared to the Urgent & Emergency Care Group (UEC) to ensure that there is system wide learning to improve the effectiveness and safety of discharge processes

IPC: A number of concurrent Covid-19 outbreaks have been reported, predominantly at the PRH site and these have been managed in accordance with the Incident Management (IMT) process, and reported as a SI. Actions are underway at the trust to improve their swab testing and results tracking which was a learning point from the outbreak. The CCG undertook an IPC assurance visit with NHSEI in October and areas of good clinical practice were noted, however the estates fabric (peeling paint, damage to walls) and breaches of integrity of some seat and mattress covers in certain areas was found and the Trust is replacing these. A further IPC assurance visit is planned for RSH.

Quality Assurance visits: CCG quality assurance visits, both announced and unannounced to SaTH have continued throughout the Covid 19 pandemic. The quality leads also continue to attend joint 'Exemplar' visits with SaTH colleagues (this is the trusts internal ward assurance programme). Ward 15 was the most recent attended visit on 5th October, the full report is awaited. Recurring issues identified during visits are: inconsistency in repeating risk assessments following patient inter ward transfers; Falls indicators and interventions being appropriately assessed; completion of Food charts, patient weights, fluid balance charts; Repositioning charts, top to toe assessment, pressure ulcer prevention; Patient communication, knowledge of care & treatment plan; staff support, staff morale. New quality Matrons have been recruited onto the Trust and have met with the CCG quality lead.

2.2 Robert Jones and Agnes Hunt Orthopaedic Hospital

RTT: Due to service changes related to Covid 19, the number of patients waiting Over 52 Weeks for treatment continues to increase. The Trust reported this is likely to continue to increase significantly until full services resume. The CCG discussed the harm review and risk stratifying process during the QA visit in September. The prioritising of activity is a clinically led process at consultant level. Clinicians carry out desktop harm review and the outcome is documented within the patient care record. Reports are submitted to the monthly Patient Harm Committee (PHC) and the monitoring of clinical harm reviews is undertaken at the weekly RTT pre-meetings, RTT panel meetings, unit meetings and reported monthly to the Patients Harm Group and in turn to the Patient Safety Committee. The definitions of harm are categorised as per the Trust Policy.

Serious Incidents: As the time of reporting the trust currently have 2 serious incidents open and under investigation. One SI related to an IPC outbreak was closed during September. The RCA related to a treatment delay SI, has now been sent to the CCG and is under review. The other RCA relating to a surgical incident in theatres is due the end of October. The Trust are not an outlier or cause for concern in relation to SIs. Their SI processes and RCA templates are currently under review.

Quality Assurance visit: Quality assurance visits took place to RJAH on 23.07.20 and 15.09.20. The purpose of the visit in July was to gain assurance that the appropriate actions, in response to learning from the Never Event 2019/19394 had been put in place. The return visit in September was to follow up on the actions discussed as not able to go into theatre at the time of the first visit due to the Covid-19 pandemic. Firm assurance was demonstrated through observing the WHO 5 steps to safer surgery in practice.

2.3 Midlands Partnership FT

Serious Incidents/ Never Events: There have been 4 STEIS reported SIs during September 2020.
1 x unexpected /potentially avoidable; 1 x HCAI (D&V); 1 x suspected suicide; 1 x slip/ trip/fall deaths. RCA reports are now being submitted for CCG review which relate to incidents which occurred since the start of the COVID 1919 pandemic. This factor and the impact that this may have had on the incident will be considered as part of the review process.

ASD Waiting List: financial approval from NHSEI has been agreed. Monitor of waiting times and rate of increase continues.

Work continues to take place across the wider health care and education system to achieve a multidisciplinary approach to neurological development support.

A contract review meeting was held on 25/9/2020 - progress and service plans discussed.

SaTH - High Intensity Service Users: A meeting has recently been held to discuss a number of issues that have been identified by the project team. These possibly to relate to misunderstandings of the purpose of the project. The role of staff within the team and recognition that collaborative working across providers is essential to enable the aims and objectives of the project to be realised and achieved. This will be discussed with MPFT at CQRM and the contract review meeting.

2.4 Shropshire Community Healthcare NHS Trust

Serious Incidents/Never Events: There has been 1 SI reported on STEIS for July and August 2020 which was in relation to a pressure ulcer. No Never Events have been reported for July and August 2020.

There are no quality concerns to report by exception.

2.5 GP Led Out of Hours Service (SCHT leads on OoH contract, subcontracting Shropdoc since 1st Oct '18.)

Serious Incidents/Never Events: None reported during August 2020.

There are no quality concerns to report by exception.

2.6 Primary Care

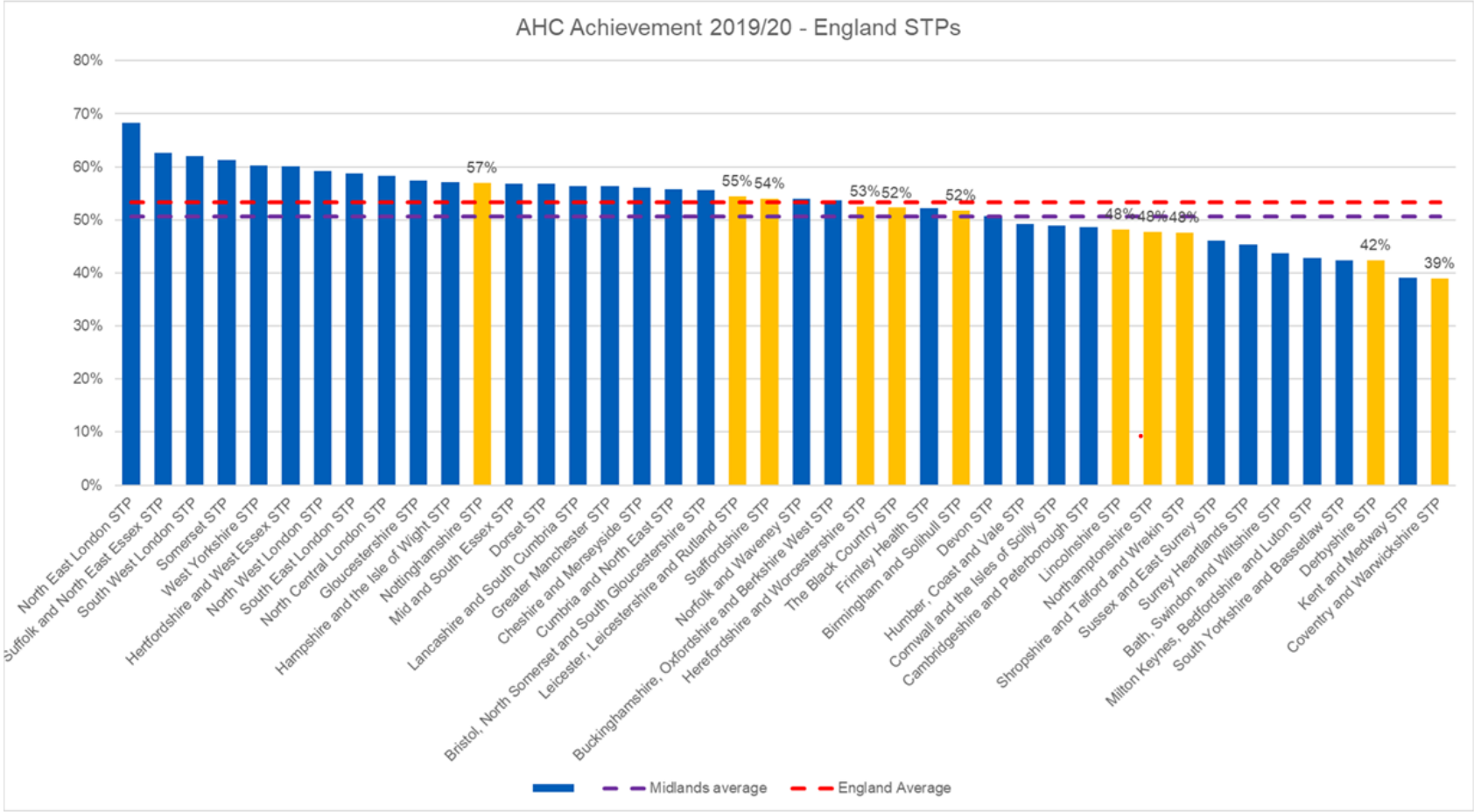
A comprehensive report is submitted to Primary Care Commissioning Committee separately. There has not been a further report since this paper was presented at Quality & Performance (Q&P) Commitee in September, therefore a more detailed update will be provided in November Q&P report.

The Quality Lead for Primary Care is working with locality and commissioning managers to identify Practices which require additional deep dive into results and support to improve in areas identified as impacting on patient experience such as access to appointments. A draft quality offer has been developed and will be shared with Committee once finalised with Primary Care colleagues.

Annual Health Checks: The CCG and partners are continuing work to improve the uptake and quality of Annual Health Checks (AHCs) for people with Learning Disabilities. There is significant variation in uptake of AHCs across the system. A multi-agency approach is being developed to ensure system buy-in to improve this area of work. A pilot scheme has been successfully developed to support the completion of AHC's virtually during Covid restrictions; this is being rolled out to other GPs. There is a focus on the 14-18 year age group, working jointly with other agencies such as education / LA / parent & carer groups to ensure AHCs are embedded within services, i.e. ECH.

The National team are indicating that they expect 67% achievement during 2020/21, with a target of 75% by the end of 2024. The CCG are committed to the aspiration of offering 100% of people with a learning disability an annual health check with clear reasons recorded and reviewed if an individual chooses not to attend or DNAs.

At the request of last month's committee the graph below indicates how Shropshire, Telford & Wrekin compare with other regions in terms of AHC uptake. It can be seen that STW are in the bottom quartile. Uptake per practice is known and those with lowest uptake being targeted with extra support and training, and those with high uptake are being asked to support and share good practice across their PCN.



Note: Midlands figure includes local Dudley data which is not reported via national system

2.7 West Midlands Ambulance Service (WMAS)

There are no quality concerns to report by exception.

2.8 Care Homes
Information sharing meetings between CCG, Local Authority, CQC and Healthwatch are held via video conferencing facilities. The CCG care home quality lead continues to work with the LA quality monitoring officers for care homes is monitoring care homes across Shropshire, Telford and Wrekin and will undertake a joint CCG/LA visit to any care home where high risk concerns are known. **Homes requiring increased monitoring/ cause for concern:** There are currently no care homes under level 4 scrutiny. The CCG's continue to provide the care sector with IPC advice and support in collaboration with Public Health England, CQC and Local Authorities.
2.9 Independent Providers
Smaller Providers requiring increased monitoring/ cause for concern: There are no concerns to report by exception in relation to the smaller providers.

3 Quality Concerns/ Key Points - System

3.1 Infection Prevention & Control (IPC)
The CCG IPC service continues to support the local health & social care response to the Covid-19 pandemic with a number of specific work streams including facilitating the IPC work stream, and supporting the Personal Protective Equipment, and Care Sector Task & Finish Groups along with the provision of advice & support to primary care and the care sector including care homes with suspected/confirmed cases and outbreaks of Covid-19. This work has been extended to include IPC training support to the care sector including care homes and domiciliary care agencies. The CCGs have agreed to host a 12 month IPC nurse position, jointly funded by Shropshire and Telford & Wrekin Local Authorities, to support the ongoing IPC proactive and reactive work streams within adult and children's social care and specialist schools. The 2020/21 infection targets for CCGs and NHS Trusts have yet to be published. It is anticipated that the zero tolerance MRSA bacteraemia will continue in 2020/21 and reduction targets of other 'Alert Organisms' will be set to include *Clostridium difficile* infection and Gram-negative bacteraemias (GNBSI), including Escherichia coli, Klebsiella and Pseudomonas. The CCG IPC service continues to monitor rates of these infections across the STP together with infection outbreaks/incidents and subsequent monitoring/ implementation of actions. Local counts of 'Alert Organisms' are lower in Quarter 1 2020/21 than the same period last year. This is line with national reporting to Public Health England and is thought to be as a direct result of the Covid-19 pandemic.

The CCG Head of IPC continues to support NHSE/I Project/Programme Board in the development an IPC safety support programme. The first wave has started with three Trusts. Learning from the first wave will be taken forward into the second wave, which is anticipated to cover up to fifteen Trusts, prior to closure of the programme by 31 March 2022.

In September, the CCG Quality/IPC Nurse held a virtual 'Winter Planning Forum' for care homes, to support staff when managing and caring for residents with influenza and norovirus infections. The session also included recognising deterioration early warning tools, clinical frailty scale assessment and SBAR communication tool.

3.2 Safeguarding

3.2.1 Safeguarding Adults

The quarterly safeguarding Adults report will be provided to Board this month

3.2.2 Safeguarding Children

The quarterly safeguarding Children report will be provided to Board this month

3.2.3 Looked After Children

The quarterly Looked After Children report will be provided to Board this month

4 Compliments and complaints

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

Compliments: 6 compliments of which 4 related to the POD service and 2 to the support provided by the CCGs' Complex Care Team.

Complaints: 13 complaints with no clear theme emerging given the wide and diverse range of issues raised.

MP Letters: 7 MP Letters, predominantly related to access issues across a range of services and providers.

PALS: 52 queries were also received via the PALS route predominantly related to access issues across a range of services and providers.

5 Concerns

N2N Concerns: A total of 15 issues were raised during August, of which 7 referenced concerns about discharges from SaTH.

These will be duly captured in the Discharge Audit currently being progressed.

6 Patient Experience

Friends and Family Test (FFT): The intention is that this will be re-launched in December 2020 with reports available in February 2021. Providers are being encouraged to seek alternative ways of gathering feedback to reduce any risk of infection particularly those associated with traditional paper based collection methods. In the meantime, it remains as important as ever that patients are able to raise concerns about the services they are using and Providers are being encouraged to seek this in the most innovative and proactive way possible with greater reliance on telephone and virtual methods.

The Q1 2020/21 Insight report was shared at the October Quality and Performance Committee in Common to provide an overview of all patient experience related feedback received by the CCGs during the period. It is clear from analysing the feedback that this has been significantly and understandably impacted by the COVID-19 pandemic and the re-focussing of services and their subsequent restoration with a significant proportion of the concerns raised by patients around access to services.

Appendix 1 Exception Reporting: Priority Areas (month 4 unless stated)

1. A&E Waits at Shrewsbury and Telford Hospitals (month 5, 2020/21)

Local Lead	Key Performance Indicator	Target *or National Rate*	Latest Position		Change from previous	Last achieved
			Official	Un-validated		
SC/EP	A&E attendances admitted/ treated/ discharged in 4 hours	**95%**	**71.2%**		↓	n/a

2. RTT and Diagnostic Waits

Local Lead	Key Performance Indicator	Target *or National Rate*	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
AP	Referral to Treatment within 18 weeks	**92%**	**48.2%**	**49.1%**	↓	Nov 2018	**51.1%**	**53.6%**	↓	Dec 2018
AP	Referral to Treatment > 52 weeks	**0**	**281**	**379**	↑	Feb 2020	**151**	**194**	↑	Mar 2020
AP	Diagnostic test waits > 6 weeks	**1%**	**58.4%**	**56.8%**	↓	Jun 2019	**58.6%**	**61.0%**	↓	Feb 2019

Backlog Positions: RTT and Diagnostic Waits (M05)

RTT End August Position				
Provider	under 18 weeks	Over 40 weeks	Gt 52 Weeks	Total Waiting
NUFFIELD HEALTH, SHREWSBURY HOSPITAL	1	49	5	458
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	12370	2006	328	24117
SHROPSHIRE COMMUNITY HEALTH NHS TRUST	1629	29	1	2454
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOS	4262	847	198	9927
Total Provider Position	18262	2931	532	36956
Commissioner				
NHS SHROPSHIRE CCG	12963	2104	379	26411
NHS TELFORD AND WREKIN CCG	7680	1060	194	14338
STW Total	**20643**	**3164**	**573**	**40749**

Diagnostic Waits at End of August				
Provider	**Under 6 weeks**	**Over 6 weeks**	**13+ Weeks waits**	**Total Waiting**
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	4639	6866	4232	11505
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FC	343	524	354	867
Provider Total	**4982**	**7390**	**4586**	**12372**
Commissioner				
NHS SHROPSHIRE CCG	3151	4137	2545	7288
NHS TELFORD AND WREKIN CCG	2704	4233	2539	6937
STW Total	**5855**	**8370**	**5084**	**14225**

3. Cancer Waits

Local Lead	Key Performance Indicator	Target *or National Rate*	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
HR	2-week wait for breast appointment	**93%**	**92.0%**	**93.8%**	↓	Jun 2020	**100%**	**92.6%**	↔	Jul 2020
HR	31-day wait for cancer treatment (surgery)	**94%**	**100%**	**93.3%**	↑	May 2020	**93.8%**	94.1%	↓	May 2020
HR	31-day wait for treatment (radiotherapy)	**94%**	**93.3%**	97.4%	↓	Jun 2020	**100%**	96.9%	↔	Jul 2020
HR	62-day wait from GP referral to cancer treatment	**85%**	**70.3%**	86.7%	↑	Jul 2020	**74.3%**	82.4%	↑	Dec 2018
HR	62-day wait for treatment after referral from cancer screening	**90%**	**100%**	**0%**	↑	Sep 2019	n/a	100%	n/a	Dec 2019
HR	104 day Waits (SaTH provider position)	**0**	**5**		↓					

4. Dementia Diagnosis Rate

Local Lead	Key Performance Indicator	Target *or National Rate*	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
FS	Dementia Diagnosed, as a proportion of estimated prevalence in over-65s	**66.7%**	**65.2%**		↑	Apr 2020	**59.5%**		↑	Mar 2020

5. IAPT Access Rate

Local Lead	Key Performance Indicator	Target *or National Rate*	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
CD	Access to IAPT services, as a proportion of estimated prevalence (year to date)	**25%** by year end	**2.17%**		↑	n/a	**1.26%**		↑	n/a

Appendix 2 The NHS Oversight Framework

Sub-section	Local Lead	KPI	Target	England value	Rank against 10 peer CCGs		Latest value (date)	
					SCCG	TWCCG	SCCG	TWCCG
Preventing Ill Health and Reducing Inequalities								
Child Obesity	VP/FE	Children aged 10-11 classified as overweight or obese	n/a	34.2%	5/11	11/11	31.25% (2015-18)	37% (2015-18)
Frailty	EP	Injuries from falls in people aged 65+	n/a	2065	1/11	1/11	860 per 100K (Q2, '19/20)	532 per 100K (Q2, '19/20)
	EP	Combined score, inequality in unplanned hospitalisation for chronic ACS conditions or urgent care sensitive conditions	n/a	2211	1/11	1/11	955 (Q2, '19/20)	985 (Q2, '19/20)
Anti-microbial resistance	LW	Appropriate prescribing of antibiotics in primary care	<1.16	0.94	5/11	1/11	0.95 (yr to Nov '19)	0.86 (yr to Nov '19)
	LW	Appropriate prescribing of broad spectrum antibiotics	<10%	8.4%	3/11	5/11	7.6% (yr to Nov '19)	6.8% (yr to Nov '19)
Maternity	VP/FE	Choices in maternity services	n/a	60%	1/11	11/11	67.6% (2018)	55% (2018)
	VP/FE	Maternal Smoking at Time of Delivery (SaToD)	<15% (TW)	11% (Q4)	3/11	9/11 (Q2)	11% (Q4, '19/20)	16% (Q4, '19/20)
Quality of Care and Outcomes								
Urgent Care	SC/EP	Proportion of patients having at least 3 emergency admissions in final 3 months of life	n/a	7.4%	2/11	1/11	4.9% (2017)	6.2% (2017)
Care Ratings	ZY	Use of high quality providers: hospitals	n/a	n/a	7/11	10/11	58 (Q1, '19/20)	58 (Q1, '19/20)
	ZY	Use of high quality providers: primary care	n/a	n/a	5/11	9/11	68 (Q1, '19/20)	65 (Q1, '19/20)
Diabetes	CR/SE	Diabetes patients receive all recommended treatment targets	n/a	39.1%	8/11	11/11	38% (2018/19)	34% (2018/19)
	DF	People newly diagnosed attend structured education	n/a	12.1%	8/11	8/11	7.6% (2017/18)	6.3% (2017/18)
Primary Medical Care	CR/SE	Carers with LTC feel supported to manage their condition	n/a	0.57	3/11	9/11	62.8% (2019)	0.52 (2019)
	CR/SE	Patient Experience of GP services	n/a	83%	1/11	9/11	88% (2019)	77% (2019)
Cancer	HR	Cancers diagnosed at an early stage	n/a	52%	10/11	4/11	49% (2017)	52% (2017)
	HR	GP RTT for cancer within 62 days	>85%	78%	9/11	10/11 (Q2, 19/20)	69% (Q1, 20/21)	63% (Q1, 20/21)
	HR	One-year survival for all cancers	n/a	73%	8/11	9/11	73% (2017)	70% (2017)
	HR	Cancer patient experience	n/a	n/a	7/11	4/11	8.8 (2018)	8.8 (2018)
Maternity	VP/FE	Neonatal mortality and stillbirth per thousand births	n/a	n/a	8/11	11/11	4.3 (2017)	7.7 (2017)
	VP/FE	Women's experience of maternity services	n/a	83%	9/11	4/11	81% (2018)	83% (2018)
Mental Health (MH)	FS/CD	IAPT recovery rate	>50%	52%	7/11	1/11 (Q2, 19/20)	46% (M04, 20/21)	59.4% (M04, 20/21)
	FS/CD	IAPT: access to psychological therapies	5.5% per quarter	4.7%	7/11	4/11 (Q1, 19/20)	2.17% (M04, 20/21)	1.26% (M04, 20/21)
	FS/CD	EIP: recommended care package within 2 weeks of referral	>50%	77%	8/11	4/11	75% (yr to	80% (yr to

		for first episode of psychosis					Sep ’19)	Sep ’19)
	FS/CD	Out of Area placements for acute MH inpatient care	n/a	129	9/11	0/11	131 (M08, 19/20)	317 (M08, 19/20)
	FS/CD	Patients on GP Severe Mental Illness register receiving Annual Health Check	n/a	30%	5/11	4/11	34% (Q2, 19/20)	34% (Q2, 19/20)
	FS/CD	Delivery of MH investment standard	n/a	n/a	1/11	1/11	Compliant	Compliant
	FS/CD	DQMI: quality of MH data submitted	n/a	n/a	9/11	6/11	90% (M07, 19/20)	93% (M07, 19/20)
MH	VP	CYP and eating disorder investment as % of MH spend	n/a	n/a	n/a	n/a	unknown	unknown
Learning Disability (LD)	FS	Reliance on specialist inpatient care for people with LD and/or autism	n/a	n/a	7/11	7/11	56 per million (Q2, 19/20)	56 per million (Q2, 19/20)
	FS	Proportion of people with LD receiving Annual Health Check	n/a	51%	9/11	6/11	53% (19/20)	44% (19/20)
	FS	Proportion of registered population on GP LD register	n/a	0.5%	9/11	0.5%	0.52% (18/19)	0.47% (18/19)
	FS	Mortality review completed within 6 months of notification	n/a	n/a	n/a	n/a	unknown	unknown
Dementia	FS	Estimated diagnosis rate for people with dementia	>66.67%	68%	1/11 (M11)	8/11 (M11)	65% (M04, 20/21)	60% (M04, 20/21)
	FS	Care planning and post-diagnostic support	n/a	78%	3/11	10/11	79% (18/19)	76% (18/19)
Sepsis	ZY	Annual statement provides evidence that sepsis awareness raising amongst healthcare professionals is CCG priority	n/a	n/a	8/11	4/11	Red (2018)	Green (2018)
Elective access *Data for July 2020 unless stated*	AP/BE	Patients wait up to 18 weeks from referral to treatment (RTT)	>92%		4/11 (M09, 19/20)	3/11 (M09, 19/20)	48%	51%
	AP/BE	Overall size of waiting list	Local	n/a	5/11 (M09, 19/20)	2/11 (M09, 19/20)	23320	13412
	AP/BE	Patients waiting over 52 weeks RTT	0	1398	2/11 (M09, 19/20)	1/11 (M09, 19/20)	281	151
	AP/BE	Patients waiting over 6 weeks for diagnostic test	<1%		4/11 (M09, 19/20)	8/11 (M09, 19/20)	58%	59%
	AP/BE	Evidence-based interventions	n/a	n/a	5/11	6/11	Amber (Q2, 19/20)	Amber (Q2, 19/20)

New Service Models								
Personalisation	CP	Personal Health Budgets	n/a	102	11/11	7/11	10 (Q2, 19/20)	55 (Q2, 19/20)
Urgent Care	EP/SC	Emergency admissions for urgent care sensitive conditions per 1000 registered patients	n/a	2497	1/1	1/11	1716 (Q2, 18/19)	1496 (Q2, 18/19)
	EP/SC	A&E patients admitted, transferred or discharged < 4hours	>95%	87%	11/11 (M12, 19/20)	11/11 (M12, 19/20)	71% (SaTH, M05, 20/21)	
	EP/SC	Average Delayed Transfers of Care days per 100000 pop'n.	n/a	11	2/11	2/11	7 (M09, 19/20)	4 (M09, 19/20)
	EP/SC	Population use of hospital beds following emergency admission	n/a	982	3/11	5/11	815 (Q2, 19/20)	922 (Q2, 19/20)
Primary Care	CR/SE	Patient experience of getting appropriate GP appointment	n/a	n/a	n/a	n/a	unknown	unknown
Seven Day Service	ZY	Achievement of clinical standards in delivery of 7-day services	n/a	n/a	5/11	2/11	2 (2017/18)	2 (2017/18)
Continuing Healthcare	YC	CHC full assessments take place within hospital setting	<15%	6.2%	1/11	1/11	0 (Q2, 19/20)	0 (Q2, 19/20)
Paper-free at point of care	AP	Use of NHS e-referral service (ERS) to enable choice at first routine elective referral	100%	99%	1/11	1/11	100% (M04, 19/20)	100% (M04, 19/20)
Finance and Use of Resources								
Financial stability	CS	In-year financial performance	n/a	n/a	8/11	8/11	Red (Q2, 19/20)	Red (Q2, 19/20)
Improvement	CS	Expenditure in areas with identified scope for improvement	n/a	n/a	n/a	n/a	n/a	n/a
Medicines	LW	Reducing low-priority prescribing	n/a	n/a	5/11	1/11	Amber (Q2, 1920)	Green (Q2, 19/20)
Leadership and workforce								
Primary Care	CP	Number of GPs and nurses per 1000 weighted pop'n	n/a	1.06	9/11	5/11	1.21 per 1000 (M12, 18/19)	0.99 per 1000 (M12, 18/19)
Governance	AS	Probity and corporate governance	n/a	n/a	1/11	n/a	Fully compliant (Q2, 19/20	Fully compliant (Q2, 19/20)
Workforce engagement	AS	Staff engagement index	n/a	3.82	7/11	8/11	3.73 of 5 (2018)	3.68 of 5 (2018)
	AS	Progress against workforce equality standard	n/a	0.14	3/11	5/11	0.10 (2018)	0.11 (2018)
Local system	DE	Effectiveness of working relationships	n/a	n/a	11/11	9/11	57% (18/19)	69% (18/19)
Leadership	DE	Quality of CCG Leadership	n/a	n/a	11/11	8/11	Red (Q2, 19/20)	Amber (Q2, 19/20)
Engagement	AS	Compliance with statutory guidance on patient and public participation in commissioning health and care	n/a	n/a	2/11	1/11	Green Star (2018)	Green Star (2018)

Appendix 3 Provider Quality Dashboards

3.1 Shrewsbury & Telford Hospitals

Secondary Care Team Quality Dashboard: SaTH														
Quality Performance Indicators														Quality Lead: Helen Bayley
Shrewsbury and Telford Hospitals	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of STEIS reportable Serious Incidents		4	4	5	3	4	6							26
Never Events	0	1	1	0	1	0	0							3
Falls reported as SI/ NE	0	0	1 NE	3	3	0	4							11
12 Hour Trolley Breaches	0	1	2	3	0	0	3							9
Pressure Ulcers Grade 2		7	11	8	12	TBC								38
Pressure Ulcers Grade 3	0	0	1	0	0	1								1
Pressure Ulcers Grade 4	0	0	0	0	0	0								0
Catheter-associated UTI	0	NA	NA	NA	1	TBC								1
MRSA Bacteraemia	0	0	0	0	0	0								0
C. Difficile	43	1	3	4	2	1								11
Klebsiella Bacteraemia	0	1	2	0	2	1								6
Pseudomonas Aeruginosa Bacteraemia	0	0	0	1	0	1								2
Escherichia coli (E. coli) Bacteraemia	0	4	3	4	1	2								14
VTE Assessments*	95%	93.7%	93.9%	NA	NA									93%
Cancer Breaches 104+ Days	0	10	21	12	10	5								58
Friends & Family Test Result**	95%	-	-	-	97.6%									
Complaints	-	19	30	28	51									

EMSA Breaches*** (ITU/CCU discharge delay >12hours)	0	5	28	-	-									
Staff Appraisal rates		-	-	-	-									

3.2 Robert Jones & Agnes Hunt

Secondary Care Team Quality Dashboard: RJAH														
Quality Performance Indicators														**Quality Lead: Helen Bayley**
The RJAH Orthopaedic Hospital	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of STEIS reportable serious incidents reported	0	0	1	0	0	0	0							1
Never Events	0	0	0	0	0	0	0							0
Pressure Ulcers Grade 3	0	0	0	0	0	0	0							0
Pressure Ulcers Grade 4	0	0	0	0	0	0	0							0
Patient falls (with moderate or severe harm)	10	3 (0)	3 (0)	7 (0)	6 (0)									19 (0)
Friends & Family Result	95%	99.2%	97.85%	97.4%										97%
Complaints	8	2	7	5										14
EMSA Breaches	0	0	0	0										0
Delayed Discharge Rate	2.5%	7.5%	2.16%	2.31%										0
MRSA Bacteraemia	0	0	0	0	0	0								0
C. Difficile	3	0	0	0	0	0								0
Klebsiella Bacteraemia	0	0	0	0	0	0								0
Pseudomonas Aeruginosa Bacteraemia	0	0	0	0	0	0								0
Escherichia coli (E. coli) Bacteraemia	0	0	0	0	1	2								3
VTE Assessments	95%	100%	100%	100%										100%
Waits over 6 weeks for diagnostics	99%	77.6%	20%	26.36%.										26%

RTT waits over 52 weeks	0	12	35	68										68
Sickness Absence Rate	3.06%	4.06%	3.98%	2.82%										2.82%

3.3 Midlands Foundation Partnership Trust

Integrated Care Team Quality Dashboard: Midlands Partnership														
Quality Performance Indicators													Quality Lead: Angela Turner	
MPFT	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of STEIS-reportable serious incidents reported			4	5	7	4	4							4
Pressure Ulcers Grade 2	0	0	0	0	0	0	0							0
Pressure Ulcers Grade 3	0	0	0	0	0	0	0							0
Pressure Ulcers Grade 4		0	0	0	0	0	0							0
Never Events	0	0	0	0	0	0	0							0
MRSA Bacteraemia	0	0	0	0	0	0								0
C. Difficile	0	0	0	0	0	0								0
Complaints received directly to SSSFT			1		2									3
Complaints / PALS / N2N (received directly to CCG)		0/2/0	0/0/1											0/2/1
EMSA Breaches	0	0	0	0	0									0
Regulation 28 Reports	0	0	0	0	0									0
Trust wide Staff Appraisal rates/ Mental Health Shropshire Directorate	90%		67/65	52%	55.61%									
Sickness Absence Trust wide / Mental Health Shropshire Directorate	4.5%		5.23/ 4.48	5.51%	4.99%									

3.4 Shropshire Community Health Trust

Integrated Care Team Quality Dashboard: SCHT															
Quality Performance Indicators															**Quality Lead: Jane Sullivan**
Shropshire Community Health Trust		Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of STEIS reportable serious incidents reported		53	4	6	2	0	1	2							
Never Events		0	0	0	0	0	0	0							
Pressure Ulcers Grade 2		144	20	25	17	20									
Pressure Ulcers Grade 3 / unconfirmed grade	0	37	5	0	0	0									
Pressure Ulcers Grade 4	0	5	0	0	0	0									
MRSA Bacteraemia	0	0	0	0	0	0	0								0
VTE Assessments	95%	90%	N/A	98.7	97.3	97.4									
C. Difficile	3	2	0	1	0	0	0								1
Staff Appraisal rates	95%	86%	82.3	79.7	80.4	77.4									
Complaints (received directly to SCHT)		85	4	8	4	7									
EMSA Breaches	0	0													
Regulation 28 Reports	0	0													

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common – 11 November 2020**

Item Number:	Agenda Item:
GB-20-11.124	2020/21 Month 6 Financial Position

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

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Finance Committee	28th October 2020	S, I

Executive Summary (key points in the report):

- M1-6 budgets have been set by NHSEI and are based on 2019/20 Month 11 expenditure. We have now also been issued with system financial envelopes for M7-12 and therefore have started to produce a full year forecast position.

- We have now received both COVID and non COVID allocations for Month 1 -5 to cover all overspends up to Month 5 and allow the CCG to show a break even position. We anticipate that this will also be the case in Month 6.

- At Month 6 the CCGs reported a combined year to date overspend of £3.6m, £2.3m of which related directly to COVID expenditure in Month 6 and is currently unfunded. We expect a retrospective allocation for this £2.3m during Month 7.

- The Month 6 NON COVID related position is therefore a combined £1.3m overspend. (SCCG £0.4m and £0.9m T&WCCG). Details of the category variances are within the report. Again we anticipate that this overspend will be funded retrospectively.

- The report highlights the main areas of overspend but also focuses on comparisons to both our original 20/21 financial plan and expenditure run rates as these are a better indicator of expenditure trends given that the budgets were not set by the CCG.

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

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

Tables included in this report:

Graphs included in this report:

Schedules appended to this report:

Appendix	Content
Appendix A	Summary of M6 COVID expenditure return
Appendix B	2020/21 Forecast by CCG

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

Finance Committee Briefing October 2020

2020/21 Month 6 Financial Position

Introduction

1. M1-6 budgets have been set by NHSEI and are based on 2019/20 Month 11 expenditure. We have now also been issued with system financial envelopes for M7-12 and financial framework guidance and therefore have started to produce a full year forecast position.

2. We have now received both COVID and non COVID allocations retrospectively for Month 1-5 to cover all overspends and allow the CCG to show a breakeven position. We anticipate that this will also be the case in Month 6.

3. At Month 6 the CCGs reported a combined year to date overspend of £3.6m, £2.3m of which related directly to COVID expenditure in Month 6 and is currently unfunded. We expect a retrospective allocation for this £2.3m during Month 7.

4. The Month 6 NON COVID related position is therefore now a combined £1.3m overspend. (SCCG £0.4m and £0.9m T&WCCG). Again we anticipate that this overspend will be funded retrospectively.

5. The report highlights the main areas of overspend but also focuses on comparisons to both our original 20/21 financial plan and expenditure run rates as these are a better indicator of expenditure trends given that the budgets were not set by the CCG.

Financial Performance Dashboard

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

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

8. The cash target is to have a cash balance at the end of the month which is below 1.25% of the monthly drawdown or £250,000, whichever is greater. This was met for both CCGs during Month 6.

Table 1: Financial Performance Dashboard

Target/Duty	Target	CCG	RAG
Cash	1.25% monthly drawdown	SCCG	G
		TWCCG	G
Better Payment Practice within 31 days (Number of invoices)	>=95%	SCCG	G - 99.2%
		TWCCG	G - 99.5%
Better Payment Practice within 7 days (Number of invoices)	>=95%	SCCG	A - 58.5%
		TWCCG	A - 61.9%

Summary Financial Position

9. Table 2 shows the summary year to date financial position for both CCGs combined. The ledger position is a £3.6m overspend, with £2.3m of that sum relating to COVID. We again expect the full £3.6m to be retrospectively topped up to breakeven and Month 6 will be the last time this happens as we move to the new financial framework. Without the retrospective top up, the overspend at M6 (excluding COVID costs) would be £6.9m.

Table 2: Combined Financial Position M6 2020/21

	TOTAL					
	YTD BUDGET AT M6	YTD ACTUAL AT M6	VARIANCE	Remove Non-COVID Funding	Add Expected M6 Retro COVID Funding	ADJUSTED VARIANCE
Total Resource Limit	**412,236**	**412,236**		**(5,630)**	**2,350**	
Acute services	191,882	191,766	(115)	54	(28)	(141)
Community Health Services	35,528	35,458	(70)	52	11	(133)
Individual Commissioning	33,865	34,587	722	(341)	1,035	28
Mental Health Services	37,409	38,842	1,433	(628)	81	1,980
Primary care services	54,856	54,504	(352)	(1,395)	183	860
Other	18,621	20,231	1,610	(1,243)	1,089	1,763
Running costs	5,400	5,504	104	(788)	(21)	913
Primary Care Co-Commissioning	34,677	35,005	327	(1,341)	0	1,668
Total Expenditure	**412,237**	**415,895**	**3,658**	**(5,630)**	**2,350**	**6,938**
Deficit/(Surplus)	**0**	**3,658**	**3,658**	**0**	**(0)**	**6,938**

10. A financial forecast has now been produced for the CCG, details of this and how it sits within the overall system position can be found in the forecast outturn section of the report.

Year to Date Position

11. The Month 6 combined YTD position in the ledger is an overspend of £3.6m.

12. In Month 6 the CCGs received a retrospective allocation increase of £2.3m to match YTD COVID expenditure reported at Month 5.

13. In addition to this the CCGs have been given a £0.1m non recurrent non-COVID allocation to add to the £5.5m received at Month 4 to cover all non COVID cost pressures for Months 1-5 (£5.6m) and therefore report a break even position for the period. We anticipate this process will continue for Month 6 but then all top up payments will cease in M7-12 as systems will then need to operate within the notified financial envelopes.

14. We are anticipating a retrospective COVID allocation increase for M5 of £2.3m which would take the YTD non COVID overspend to £1.3m.

15. In Month 6 there is £12.7m of total COVID expenditure included in the position. £2.3m of this remains unfunded. Details are shown in Appendix A but the main areas of COVID expenditure are:
    - £4.6m Individual Commissioning/Mental Health
    - £2.2m Primary Care expenditure
    - £5.7m Local Authority expenditure
    - £0.1m COVID recovery beds
    - £0.1m Running Costs

16. At Month 6 the non COVID YTD overspend is therefore £1.3m and as Table 2 indicates if we hadn't received retrospective top ups to break even in M1-6 then the YTD overspend would currently be £6.9m (excluding COVID costs). The category variances within this are described below:

    - (£0.3m) small underspend in acute and community services (£0.2m underspend following retro top up)
    - £2.0m total year to date overspend (£1m following retro top up) on Individual Commissioning/Mental Health due to CHC growth and price increases being significantly higher than funded by NHSE/I in budgets and higher than our original plan (our original plan suggested 7% growth and 2% price increase). There are also YTD cost pressures in Mental Health NCAs.
    - £0.9m total year to date overspend (£0.2m underspend following retro top up) in primary care mainly due to increased prescribing due to growth above levels funded in budgets, some of which relates to increased demand during the pandemic and also the impact of Cat M and NCSO pricing. Refined assumptions in prescribing have reduced the overspend associated with prescribing demand in previous months.
    - £1.8m cost pressure on Other (£0.5m after retro top up) relating to BCF for T&W (intermediate care beds), property services for Shropshire and part to full year effect of 2019/20 contract value increases associated with NHS 111 and Patient Transport Services.

- £0.9m on running costs (£0.1m after retro top up) relating to the reduced running cost allocation and the delay in the management of change process.
- £1.7m primary care co commissioning overspend (£0.3m after retro top up) due to the reduced allocation in comparison to that originally notified, plus the underlying overspend against allocation in Shropshire CCG.

17. It is anticipated that the overall net £1.3m YTD overspend will again be funded retrospectively and that this will be the last retrospective top up received as the new M7-12 financial framework comes into play from M7.

Forecast Outturn Position

18. At Month 6 we were not required to submit a forecast outturn position into the ledger. However, following the release of the system financial envelopes and the M7-12 financial framework guidance, a system wide forecast outturn position was requested by NHSEI for submission on 20th October 2020 with detailed organisational level plans to follow on 22nd October 2020. The plans for the CCGs were signed off at an extraordinary session of the Governing Body on 20th October and submitted on time.

19. The system envelope received is shown in Table 3 and is split into:
    - CCG allocations
    - Growth allocation- usage to be agreed across system partner positions
    - System top up funding – usage to be agreed across system partner positions but suggested trust split issued with guidance
    - COVID funding- usage to be agreed across system partner organisations and replaces M1-6 retrospective top up process
    - Provider income assumptions from sources other than CCGs

Table 3: System Financial Envelope M7-12

		Total M7-12 £000s
CCG Allocations	[i]	378,157
CCG NR Adjustments to Model Breakeven	[i]	20,285
Revised Allocations		398,442
Total Growth Funding	[i]	4,954
System Top-Up Funding / Non-Recurrent Allocation Adjustment	[i]	27,432
Covid Funding	[i]	18,361
Total System Envelope Funding		**449,189**
In addition to the envelope funding above, systems are also assumed to receive the below funding:		
Provider block income from CCGs outside of the system		5,274
Provider block income from Specialised Commissioning hubs		35,536
Provider block income from Direct Commissioning Regional Offices		8,257
Assumed provider income from outside of system - other (non-block income)		56,319
Total provider income from outside of the system		**105,386**
CCG block expenditure to providers outside of the system	[i]	(55,919)
Total Assumed Funding Available for System Consumption		**498,656**

20. Separate SDF (Service Development Funding) is also available for specific schemes in the second part of the year.

21. In addition to the CCG element of the system financial envelope we have also made an assumption around anticipated Hospital Discharge Programme funding and funding in relation to Independent Sector activity. Table 4 therefore shows the full anticipated income envelope for the CCG in Months 7-12. SDF allocations will also be received on top of this. (Both the income and the spend for these are not currently included in the forecast position).

Table 4: CCG Financial Envelope M7-12

Reconciliation to system allocations envelope M7-12:	
	£m
CCG revised allocations	398.4
CCG share of system COVID/Growth allocations	4.4
Assumed HDP COVID funding to match spend	6.1
Assumed IS funding to match spend	2.5
TOTAL	**411.4**

HDP- Hospital Discharge Programme
IS- Independent Sector

22. The clear expectation in the guidance was that systems will deliver a breakeven position for the year against the system envelope. Unfortunately, our modelling suggests that this will not be possible.

23. The current CCG forecast outturn position against this funding envelope suggests a combined forecast overspend of £15.4m. (£11.8m SCCG and £3.6m TWCCG- see Appendix B for CCG breakdown). The main areas of overspend for the CCG are:
    - Individual Commissioning/Mental Health due to both price and activity growth
    - Prescribing due to the impact on demand of the pandemic plus Cat M and NCSO price issues
    - Co Commissioning due to the historic recurrent overspend in Shropshire
    - Part to full year effect of 2019-20 contract issues eg NEPTS, NHS 111
    - Running costs overspend due to the delay in the Management of Change process
    - Winter schemes – spend is nearly three times as high as 2019/20 in non STP providers

24. The CCG forecast position of a £15.4m deficit is shown in Table 5.

Table 5: CCG Forecast Outturn Position 2020/21

	Annual Budget £m	Annual Forecast £m	Annual Variance £m
Allocations/Assumed Income	(826.0)	(826.0)	
Acute	386.4	385.8	(0.6)
Community	71.0	70.9	(0.1)
Individual Commissioning	67.3	73.9	6.6
Mental Health	73.4	76.8	3.4
Primary Care	178.4	183.4	5.0
Other	39.7	39.7	-
Running Costs	9.8	10.9	1.1
Total Expenditure	**826.0**	**841.4**	**15.4**
Variance	-	**15.4**	**15.4**

25. Items of note for M7-12 in the CCG position include:

    - QIPP savings are forecast to deliver £2.5m.
    - Additional costs are forecast for independent sector, mental health investment standard, Individual Commissioning, Prescribing, Primary Care Co Commissioning and winter schemes.
    - £2.1m income is allocated as our share of the COVID system pot (allocated based on shares of overall spend). Total predicted spend is currently £0.6m higher than this.
    - £2.5m independent sector national funding is assumed to match forecast expenditure

26. The main areas of concern in terms of overspend continue to be Individual Commissioning and Primary Care. Benchmarking information is currently being gathered from other CCGs and significant work is being carried out between financial and operational teams to ensure that the story around the drivers of spend and our actions to address overspend is clear. Further information will be provided to the Finance Committee next month.

27. The overall system position submitted to NHSEI on 20th October was a deficit of £24.0m, the organisational breakdown of this can be seen in Table 6.

Table 6: System Deficit by Organisation

Organisation	**Deficit £'000**
CCGs	15,354
SATH	8,638
RJAH	-
Shrop Comm	-
TOTAL SYSTEM	**23,992**

28. At the time of writing this report, the providers are reviewing their work plans to establish whether there can be any scaling back of the financial assumptions made. This would contribute to reducing the £23.99m deficit further.

29. For individual organisation positions the system has had to agree how the full growth allocation of £5m and the £4.8m balance of the system COVID funding (after funding organisation predicted COVID spend) is to be allocated.

30. The recommendation from the system finance group was that this total £9.8m is allocated across organisations in the following way:
    - Support for the Integrated Care Record (ICR) costs as agreed at Gold- £0.5m currently sitting as costs within the CCG position.
    - Support for agreed Winter Schemes as agreed at Gold- £3.3m across all organisations
    - Support for SCHT and RJAH deficit positions, as agreed by CEOs prior to the submission on 5th October 2020.
    - Allocate the balance of the fund to support SaTH development schemes

31. The group recommended that this position should be kept under review throughout the year and changes in circumstances should be reflected accordingly (eg receipt of any additional funding to any organisations to address non NHS income etc).

32. The allocation of the £9.8m by organisation is outlined in Table 7.

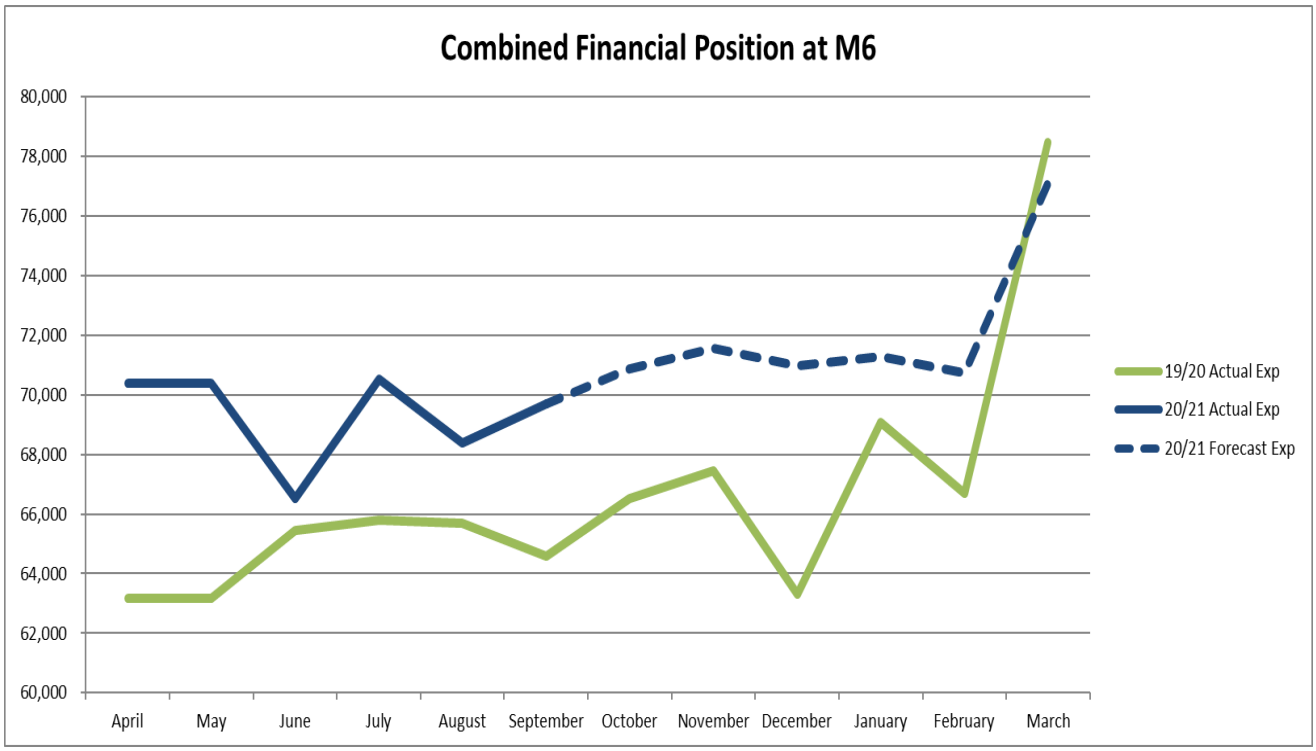
Table 7: Allocation of remaining system funding

System Fund Allocation	SaTH	RJAH	SCHT	CCG	Adj
System Growth Fund	0	0	0	0	4,954
Excess Covid Fund	0	0	0	0	4,855
Funds For Allocation	0	0	0	0	9,809
ICR Costs				520	(520)
Winter Plan agreed schemes	835	0	793	1,753	(3,381)
SCHT & RJAH Defict positions	0	2,060	1,626	0	(3,686)
Support to SaTH Development schemes	2,222	0	0	0	(2,222)
Recommended Allocation	**3,057**	**2,060**	**2,419**	**2,273**	**0**

Run Rate

33. The graph below shows the current run rate of spend this year and a comparison to 2019-20. Overall spend is set to grow by 6.4% compared to last year's recurrent spend, this includes NR spend including COVID, whereas recurrent spend is set to grow by 3.6%.

Figure 1: Combined Financial Position Graph



Comparison to Plan

34. Table 8 shows the current M12 forecast compared to the original financial plan submitted to NHSEI in March '20. Non recurrent expenditure has been stripped out so that the recurrent movements can be reviewed to see if spend is accruing as we

were expecting. Note that this direct comparison does not work in all areas given the new funding arrangements and the current changes to service patterns but the analysis does help to aid understanding of the position.

Table 8: M12 forecast compared to March plan

COMBINED	2020/21 Operating Plan			2020/21 FOT as at Month 5 system submission				
	Total Expenditure	Recurrent	Non-Recurrent	Total Expenditure	Recurrent	Non-Recurrent	Difference in recurrent spend between 20-21 plan and outturn	Comments
Expenditure	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	
Acute	403,584	403,584	0	385,784	385,335	449	(18,249)	The acute position is far less than the original plan due to blocks operating on basis of 2019-20 M9 spend uplifted for small growth percentage. The original plan inlcuded significant growth with acute providers agreed as part of STP discussions. The current spend also doesnt include the independent sector who are now paid centrally.
Community	76,653	76,653	0	70,921	70,921	0	(5,732)	The community position is less than the original plan due to blocks operating on basis of 2019-20 M9 spend uplifted for small growth percentage. In addition to this original planned community investment is now removed from the forecast.
Mental Health	77,043	77,043	0	76,752	76,440	312	(603)	Broadly the same -includes Mental Health Investment Standard planned investment.
Individual Commissioning	58,664	58,664	0	73,856	68,813	5,043	10,149	FNC backdated price increase £0.9m. £3m lost QIPP due to impact of COVID. Remaining pressure due to increases in both activity and price forecast. Assumption that 75% of new cases since March will transfer to CCG responsibility by the end of the year following the trajectory of backlog assessments carried out. Significant work is currently being undertaken to understand the drivers of the increase and the steps to be put in place to address it.
Primary Care	101,282	101,282	0	110,710	107,471	3,239	6,189	Increase due to increased prescribing spend due to Cat m and NCSO pressures factored in (£3.3m) and GPFV expenditure (£3.3m) which is normally funded by NR allocations and therefore wasn't part of the original plan submission. This will be badged as Non Recurrent spend in the next iteration of figures.
Co Commissioning	72,840	72,840	0	72,719	72,757	(38)	(83)	Spend now in line with original plan
Running Costs	9,178	9,178	0	10,917	9,178	1,739	0	Broadly the same, assuming that the 20/21 in year overspend is NR given management of change will still occur.
Other Programme	28,235	28,235	0	39,679	27,545	12,134	(690)	Broadly the same
Unidentified QIPP	(6,365)	(6,365)	0	0	0	0	6,365	Unidentified QIPP not delivered in forecast
Contingency	3,781	3,781	0	0	0	0	(3,781)	Contingency not created in forecast
Total Spend	**824,895**	**824,895**	**0**	**841,338**	**818,460**	**22,878**	**(6,435)**	

35. Overall recurrent spend is £6.4m less than original plan. However, if we exclude the acute and community benefit due to block arrangements, recurrent spend is £14m higher. This is predominantly due to:
    - a £10m increase in spend on Individual Commissioning
    - £6m increase in spend in primary care
    - £6.4m of undelivered unidentified QIPP
    - (£3.8m) benefit from the planned contingency used to offset the pressures described above
    - (£1.2m) reduction in spend across Mental Health and other
    - (£3.5m) reduction in community spend due to reduced block arrangements and the removal of the community investment associated with original QIPP plans.

Comparison to 2019-20

Table 9: M12 2019/20 bridge to M12 2020/21

		£Millions
19/20 Outturn		**799.393**
Non Recurrent 19/20	-	9.013
19/20 Underlying Position		**790.380**
Inflation		14.001
Cost growth		6.305
Demand Growth		10.031
Planned service changes		3.572
Covid costs		19.427
Non-recurrent activity reductions and contract cessation	-	8.461
Other income / contractual changes	-	2.755
MHIS service developments		2.535
Cost pressures		11.134
Efficiency programmes	-	4.830
20/21 FOT @ M6		**841.339**
Non Recurrent 20/21	-	22.878
Recurrent 20/21		**818.461**

36. Table 9 shows the bridge between 2019-20 spend and 2020-21 current forecast outturn. The total growth in recurrent spend is approximately 3.6%.

QIPP

37. The PMO team have captured the latest position and forecast for each of the projects within the joint QIPP Programme, paying particular attention to those schemes that are within the control of the CCGs. Forecast QIPP savings for the year are reported as £4.9m (£3.4m Shropshire CCG and £1.5m for Telford CCG.) A summary by budget area is shown below in Table 10.

38. The forecasts are based on the CCG's most likely scenario however schemes remain at risk, particularly due to the uncertainty around Covid-19 and the potential impact on staff resource. £2.5m of the £4.9m total is due to be delivered between Months 7 and 12.

39. System level programme boards are meeting regularly to progress with the priorities that have been agreed. Plans are now at the design phase and implementation plans are currently being developed which set out how these are to be delivered over the next few years.

Table 10: 2020/21 QIPP forecast at M6 £000's

Budget Area	Forecast Delivery M6		
	Shropshire CCG	Telford & Wrekin CCG	Total
Primary Care Services	1,966	738	2,704
Individual Commissioning	1,252	671	1,923
Corporate Services	60	34	94
Community Services	53	0	53
STP Programmes	24	60	84
Total	**3,356**	**1,503**	**4,859**

Risks and Mitigations (High Level)

40. We have also risk assessed the financial position reported for the following:

Income risk:

- £2.7m of Hospital Discharge programme funding assumed based on current trajectory of assessments
- £2.5m independent sector funding assumed to match expenditure

There is a risk that these may not be centrally funded as suggested in the guidance.

Expenditure risk:

- £0.7m of Individual Commissioning QIPP factored into M7-12 which may not be delivered due to staff capacity constraints
- £1.0m of risk around growth in activity and price in Individual Commissioning
- £1.5m assumption of flu recharges to NHSEI that have not yet been confirmed as accepted

Mitigation:

- Current overspend of £0.6m COVID costs in comparison to share of system allocation, all directorates reviewing all costs to attempt to reduce.

41. The CCG risk adjusted position of a £23.2m deficit is shown in Table 11.

Table 11: Risk adjusted CCG forecast 2020/21

	Annual Budget £m	Annual Forecast £m	Annual Variance £m		Risk £m	Mitigation £m	Risk Adjusted Position £m
Allocations/ Assumed income	**(826.0)**	**(826.0)**	**-**		**5.2**		**(820.8)**
Acute	386.4	385.8	(0.6)				385.8
Community	71.0	70.9	(0.1)				70.9
Individual Commissioning	67.3	73.9	6.6		1.7		75.6
Mental Health	73.4	76.8	3.4				76.8
Primary Care	178.4	183.4	5.0		1.5		184.9
Other	39.7	39.7	-			(0.6)	39.1
Running Costs	9.8	10.9	1.1				10.9
Total Expenditure	**826.0**	**841.3**	**15.4**		**3.2**		**844.0**
Variance	**-**	**15.4**	**15.4**		**8.4**	**(0.6)**	**23.2**

42. These are unprecedented times which means that, for some spend areas, accruing year to date and estimating future expenditure is difficult given that historic trends do not always give a true reflection of the current situation. This is particularly pronounced in areas such as prescribing and CHC. We are working hard to track our spend patterns, encouraging our budget managers to monitor spend carefully, and as our recovery and restoration activity scenarios develop we will refine our financial modelling accordingly. We will ensure, where appropriate, that we align our estimates with our system partners.

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

44. 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 have built up a trajectory of assessments to get through the backlog and financial forecasts associated with both expenditure and income are linked to this trajectory. Therefore any slippage to this programme of work could impact on the overspend position.

45. The forecast position includes an element of QIPP delivery which needs to be carefully monitored in particularly in a potential second COVID surge scenario.

46. 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.

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

Conclusion

48. At Month 6 the CCGs are collectively £3.6m over budget. If the anticipated retrospective allocation adjustments for both COVID and non COVID costs are applied this will become a break even position year to date.

49. The latest CCG forecast position is a £15.4m overspend within an overall £24.0m system deficit. The main areas of concern for the CCG continue to be primary care and Individual Commissioning.

50. The forecast position presented in this paper is in line with the system plan submission on 20th October and CCG plan submission on 22nd October.

NHS Telford and Wrekin, Shropshire CCGs

Summary of Covid Costs for April 20 - September 20

	Non ISFE category	TWCCG £	SCCG £	Total £
A	**Acute Services**			
	Local Maternity Services	-	-	**-**
	Recovery Beds	-	108,727	**108,727**
B	**Mental Health Services**	56,806	35,258	**92,064**
C	**Community Health Services**	10,800	-	**10,800**
D	**Primary Care Services**			
	Prescribing	-	-	**-**
	General Practice - Community base services	269,737	966,659	**1,236,396**
	General Practice - IT	21,923	12,315	**34,238**
	Hot Sites - Infrastructure	-	301,075	**301,075**
	Hot Sites - Staffing		328,505	**328,505**
	Care Home Support (CHAS)	29,520	86,000	**115,520**
	Phlebotomy	65,254	65,254	**130,508**
	Patient Transport		7,082	**7,082**
	Other	19,487	42,883	**62,370**
E	**Running Costs**	17,517	53,634	**71,151**
F	**Continuing Care Services (Hospital Discharge Programme)**			
	Other Programme services	2,698,516	3,035,094	**5,733,610**
	CCG directly commissioned	1,913,269	2,600,695	**4,513,964**
	Total	**5,102,830**	**7,643,180**	**12,746,010**

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

Appendix B 2020/21 Forecast Outturn by CCG

	Combined Position £m	Shropshire Position £m	Telford Position £m
Allocations/Assumed Income	**(826.0)**	**(540.5)**	**(285.4)**
Acute	385.8	250.1	135.7
Community	70.9	50.3	20.6
Individual Commissioning	73.9	56.6	17.3
Mental Health	76.8	48.1	28.7
Primary Care	183.4	118.7	64.7
Other	39.7	21.7	18.0
Running Costs	10.8	6.7	4.0
Total Expenditure	**841.4**	**552.3**	**289.0**
Variance	**15.4**	**11.8**	**3.6**

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs**
Governing Body Meetings in Common held on 11 November 2020

Item Number:	Agenda Item:
GB-20-11.127	NHS Patient Safety Specialist

Executive Lead (s):	Author(s):
Zena Young – Executive Director of Quality	Zena Young – Executive Director of Quality

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
None	N/A	N/A

Executive Summary (key points in the report):

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, was published by NHSE/I in July 2019. The strategy sits alongside the NHS Long Term Plan (LTP) and the LTP Implementation Framework.

The Strategy will build on two foundations: a patient safety culture and a patient safety system. Three strategic aims will support the development of both:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).

NHS guidance indicates:
Patient safety specialists will lead, and may directly support, patient safety improvement activity and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.

As the senior leader for patient safety in their organisation, the patient safety specialist will work with many people who already have specific patient safety responsibilities.

Whilst programmes introduced in the NHS patient safety strategy either continue to be developed with amended timescales to be confirmed or have been put on hold until further notice, The National Director of Patient Safety has written to commissioning and provider organisations requesting they each nominate a 'Patient Safety Specialist' by 30 November 2020. The Patient Safety Specialist will undertake training for the role, however the extent and scope of role for this position has yet to be shared.

It is recommended that this role is initially undertaken for the CCG by the Associate Director of Quality

Assurance and Transformation and approval from the board is sought for this.

It is recommended that an update to board is brought once more the details of the role and training are known.

The guidance for identifying Patient Safety Specialists is appended for information.

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

Recommendations/Actions Required:

That CCG Governing Body:

- Note the content of this report
- Endorse the recommendation to nominate the CCG Patient Safety Specialist
- Receive an update on progress during Q4 2020/2021.

Identifying patient safety specialists

August 2020

Purpose of the role

The NHS Patient Safety Strategy[1] set the ambition for the new role of patient safety specialist to be introduced in every NHS organisation in England; this includes providers and commissioners of NHS-funded care. We consulted on a draft specification for patient safety specialists earlier in 2020 and this final specification is informed by the views of those who responded.

Patient safety specialists will be the lead patient safety experts in healthcare organisations, working full time on patient safety. They will be 'captains of the team' and provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations. They will support the development of a patient safety culture and safety systems, and have sufficient seniority to engage directly with their executive team. They will work in networks to share good practice and learn from each other.

Patient safety specialists will lead, and may directly support, patient safety improvement activity and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes. They will promote patient safety thinking beyond why things go wrong in healthcare (Safety I), to examining why things

[1] https://improvement.nhs.uk/resources/patient-safety-strategy/

routinely go right and how that can be maximised (Safety II). They will support their organisations' 'patient safety partners' (patient and public representatives specifically involved in patient safety) as identified in the NHS Patient Safety Strategy.

We know significant patient safety expertise and experience already exist across the NHS; with people in many places effectively fulfilling the role of a patient safety specialist in all but name. Formally creating this role will provide status and the expectation that having a patient safety specialist who is fully trained in the national patient safety syllabus is standard across the NHS.

As the senior leader for patient safety in their organisation, the patient safety specialist will work with many people who already have specific patient safety responsibilities. The patient safety specialist role does not diminish the fundamental principle that patient safety is everyone's responsibility and they will be key in supporting work to make patient safety a core element of training for every member of staff in their organisation.

Implementation

Each **NHS trust, foundation trust and clinical commissioning group (CCG)** will identify one or more individuals as their patient safety specialist(s) and notify the national patient safety team who these individuals are by the end of November 2020. This will enable us to directly engage with them. Once identified, we will undertake further work with the patient safety specialists to agree specific responsibilities and develop the role further.

Other organisations should designate a patient safety specialist if they are able to, but we recognise that some organisations, particularly smaller providers outside the secondary care sector, may not yet be in a position to do so. For this reason, at this point only NHS trusts, foundation trusts and CCGs are required to identify their own specialist. Smaller organisations should however start to consider their future approach. They may wish to consider accessing appropriate input from a patient safety specialist working across multiple organisations or part time. In time, our ambition is for all healthcare organisations, irrespective of size, to be able to identify and work with their patient safety specialist to improve safety.

It should not be necessary to recruit new people to fill this role, unless an organisation wishes to, but it may be necessary to reorganise responsibilities between individuals. We expect patient safety specialists will be identified from people in existing patient safety-related roles, which may be clinical, although organisations can create new posts and increase their number of patient safety-related roles if they consider this appropriate.

The patient safety specialist(s) role should be full time, although this may not be possible immediately for some individuals as they may need time to hand over non-safety responsibilities to others. We expect patient safety specialists to be focusing solely on patient safety from April 2021.

Two or more people, possibly of different seniority, may fulfil this role by sharing the responsibility. This will enable people to combine being a patient safety specialist with, for example, clinical work. The most important thing is that a patient safety specialist is always available and working on safety within an organisation. Organisations are of course free to specify more than one full-time patient safety specialist. This may depend on their size, complexity or number of sites.

When identifying or recruiting their patient safety specialist(s), organisations should pay particular attention to the importance of equalities and should ensure that opportunities to become patient safety specialists are equitable. They should consider how best to ensure specialists contribute to a wider leadership cohort that is representative of their staff and the patients they serve.

Accountability and responsibilities

The existence of the patient safety specialist role does not alter overall accountability for the safety of healthcare services provided by an organisation. This still sits with the leadership of the relevant organisation.

Similarly, creation of this role does not alter responsibility or accountability for patient safety-related areas set out in statute or elsewhere, such as safeguarding, health and safety, controlled drug responsibilities, HR processes or fitness-to-practice activities.

The patient safety specialist should be able to influence and have direct access to their executive/leadership team, including access at no notice to escalate immediate risks or issues. One option is for the patient safety specialist to be directly line managed by a member of the executive team, but this is not a compulsory arrangement.

Patient safety specialists should have an overview of and ability to influence and interact with all patient safety processes within the organisation. This may include managing teams that lead on patient safety processes, such as patient safety incident reporting, risk management and investigation.

Further responsibilities for the patient safety specialists will be agreed in collaboration with the specialists once their role has been established.

Key relationships

The patient safety specialist(s) will work as part of a wider team to ensure that patient safety is appropriately prioritised and considered in the work of the organisation. They should build and maintain good working relationships with a broad range of internal and external stakeholders on issues relating to patient safety.

Key relationships include the following:

Internal relationships:

- executive team – although the patient safety specialist is not a board-level role, there is a requirement that they have direct and immediate access to a member of the executive team and are able to influence this team to enable effective change management
- their organisation's patients, families and carers
- medication safety officers (MSOs), medical device safety officers (MDSOs) and other leads with responsibility for aspects of patient safety in their organisation (existing MSOs or MDSOs may be suitable people to become patient safety specialists)
- chairs of relevant internal patient safety and/or clinical governance committees, often non-executives, and divisional/directorate managers and members of other safety departments, teams and initiatives, including medical examiners and Learning from Deaths leads
- their organisation's patient safety partners[2] as these roles develop
- their organisation's Caldicott Guardian, information governance lead, Freedom to Speak Up guardian, director of infection prevention and control, equalities lead, PALS and complaints teams, quality improvement teams, education teams and safeguarding leads.

External relationships:

- patient safety specialists in other organisations
- the national patient safety team
- NHS England and NHS Improvement regional teams
- local integrated care systems
- local Healthwatch organisations as statutory representatives of patients' views and concerns
- local patient and carer representatives

[2] 'Patient safety partners' are patient and public representatives specifically involved in patient safety.

- Healthcare Safety Investigation Branch
- patient safety collaboratives and Academic Health Science Networks
- Health Education England
- Care Quality Commission and relevant parts of profession regulators such as the Nursing and Midwifery Council.

Knowledge and experience

In the medium to long term we intend all patient safety specialists to be able to demonstrate the knowledge and experience listed below. It is unlikely that anyone nominated as their organisation's patient safety specialist will have this full set of knowledge and experience to begin with, and we expect organisations to identify individuals who meet some of these criteria and are willing to develop further. More work will be undertaken to determine the further training and education that patient safety specialists may need.

Patient safety specialists should:

- be educated to Master's or equivalent level, or equivalent experience of working at a senior level
- have worked in a patient safety-related role for at least two years, with an understanding of the principles that underpin approaches to improving patient safety in health systems
- have knowledge and experience of driving improvement for the safety of patients
- be willing and committed to developing expertise in all aspects of patient safety science, such as human factors, systems thinking, investigation, quality improvement, change management, prospective and reactive risk analysis and management, error theory and just culture
- have had previous responsibility for/involvement in clinical governance systems
- have significant knowledge of local organisation's patient safety policy and strategy
- have significant knowledge of national patient safety policy and strategy, and levers for change in the NHS system; and ability to interpret national advice, guidance and requirements and advise their organisation on how these should be implemented
- have knowledge of safeguarding and the legal duties expected of NHS organisations

- have proven ability to develop and communicate a long-term vision for patient safety and convert that into plans, objectives and deliverables for their organisation
- be able to develop and maintain strong relationships across an organisation
- have proven and significant leadership experience
- have knowledge and understanding of the Equalities Act 2010, including the importance of collecting and analysing data on protected characteristics, and wider understanding of the impact of discrimination and bias on the safety of patients.

Being a healthcare professional with a relevant clinical qualification and registration can be useful but is not essential for a patient safety specialist.

Skills and attributes

Patient safety specialists should have the following skills and attributes:

- ability to provide senior leadership and work with senior leaders
- ability to use informed persuasion to influence others
- credibility and enthusiasm for patient safety
- expert communication skills and ability to provide and effectively communicate highly complex, sensitive and contentious information to staff, patients and relatives/carers, particularly where a potentially antagonistic or highly emotive atmosphere may present significant barriers to acceptance
- ability to use established networks and create new ones to share good practice and facilitate engagement with regional colleagues and the national patient safety team
- ability to analyse complex information (including patient safety incident data, administrative data, mortality data) that may conflict and where expert opinion may differ
- ability to develop, maintain and monitor information systems to support improvement initiatives
- ability to manage time effectively and to prioritise
- strong self-awareness and coping strategies
- enthusiasm and interest in ensuring others are trained and developed in patient safety, as appropriate.

Values and behaviours

Patient safety specialists should demonstrate the following values and behaviours:

- commitment to quality work; promotes high standards in all they do
- courage to speak truthfully and challenge appropriately
- values diversity and difference; operates with integrity and openness
- works well with others by being positive, helpful and listening to them; involving, respecting and learning from others
- involves patients and the public in their work
- commitment to and proactive in addressing inequalities in healthcare in general and in patient safety in particular.

Learning and development

The NHS Patient Safety Strategy stresses the importance of in-depth training in patient safety for patient safety specialists. This will be based on the national patient safety syllabus we are developing with Health Education England. A gap analysis will be undertaken to understand the particular training needs of patient safety specialists. Ultimately they will be trained in all elements of patient safety science.

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR0089

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 11 November 2020**

Item Number:	Agenda Item:
GB-20-11.128	Joint Governing Body Report: Interim Joint NHS Shropshire CCG and NHS Telford and Wrekin CCG Board Assurance Framework (BAF)

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

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
BAF Report for both CCGs	9th September 2020	S

Executive Summary (key points in the report):

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

1.2 Both Governing Bodies have expressed a desire to develop a joint Board Assurance Framework during the Autumn of 2020 in preparation for the planned creation of a single CCG from April 2021 onwards. The creation of a joint BAF is dependent on agreement on joint objectives by both CCGs that strategic risks can then be identified from. Since appointing and electing joint Governing Body members an Organisational Development Plan for the Joint Governing Body members has started to be delivered which will include facilitated discussions on developing joint objectives but these discussions will continue into workshop 3 and therefore it is not possible to base a joint BAF on newly created shared objectives at this stage.

1.3 There remains a need to provide both Governing Bodies with an accurate overview of the strategic risks both CCGs are currently managing in the interim. Therefore the Executive Team have developed a joint Interim BAF for both CCGs that, although not based upon shared objectives, does capture the shared strategic risks, risk ratings and mitigating actions based upon current risk profile of both CCGs. The interim joint BAF is attached as appendix A.

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

- challenge the risk ratings and target risk scores
- assess the robustness of the controls and actions plans identified

- ensure that progress is made to reduce the gap between the current risk rating and the target score.

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

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

Recommendations/Actions Required:

NHS Shropshire CCG Governing body is recommended to:

- accept and note the content of this report and supporting appendix A for assurance purposes;
- review the updated strategic risk position and confirm that the current level of risk is acceptable in line with actions outlined.

NHS Telford and Wrekin CCG Governing body is recommended to:

- accept and note the content of this report and supporting appendix B for assurance purposes;
- review the updated strategic risk position and confirm that the current level of risk is acceptable in line with actions outlined.

NHS Shropshire CCG and NHS Telford and Wrekin CCG - Joint Interim Board Assurance Framework (BAF) 2020/21 - Oct 2020

Appendix A

1	2	3	4	5	6	7	8	9	10	11	12	13
Risk ID	Objective	Opened / added by	Risk and description	Opportunity	Existing key controls	Existing sources of assurance	Gaps in controls or assurances	Risk score (consequences x likelihood)	Action plan / cost / action lead /(target date) /sufficient mitigation	Target risk score for end of financial year	Executive Lead and Risk Owner	Amendments: name and date
1	SCCG - 3 TWCCG - 5	Claire Skidmore	Underlying Financial Position There is a risk that the CCGs fail to deliver their financial plans for 2020/21 and that the underlying position going forward significantly deteriorates	This offers the opportunity to fully assess commissioned services to ensure best clinical value as well as financial efficiencies. The COVID19 situation also presents opportunity to reset to a 'new normal' which may assist in driving out inefficiency in the cost base of the system	Detailed 20-21 financial YTD and forecast reporting in place QIPP Programme Board meeting monthly to monitor delivery of savings and action plans Constitution/Prime Financial policies etc in place and communicated across organisation Regular budget meetings with budget holders and both budget manager handbook and regular training programme in place	Regular reporting to Finance Committee and Governing Body Internal audit reporting to audit committee on assessment of financial processes/systems Longer term financial plan and strategy in place	1. Development/refresh of financial strategy/recovery plan aligned to system financial plan including programme board implementation plans for key priorities. 2. Absence of formal signed off 2020/21 plan with NHSEI due to financial arrangements in place due to COVID-19 3. CHC process issues remain - action plan refresh required	15 (possible x catastrophic)	1. CCG financial strategy to be updated for submission to NHSEI by end of November 2020 in line with system plan. System long term financial plan to be updated by 18th Dec 2020, to include implementation plans from programme boards to address priorities and inclusion of COVID-19 recovery trajetories. 2. CCG financial plan for M7-12 2020/21 submitted on 22nd Oct 2020, awaiting NHSEI feedback, budget setting for second part of year to be aligned to plan 3. CHC action plan being reviewed and refreshed. CFO and AO to review with CHC and finance team in November 2020 to ensure clarity around drivers of overspends and detailed actions to address.	10 (unlikely x catastrophic)	C Skidmore	Laura Clare 22.10.20
2	SCCG - 1 TWCCG - 1	Zena Young	Quality and Safety If the CCGs fail to commission safe, quality, services for their populations then there is a risk that patients will come to harm, that regulatory action will result in closure of services, and a risk of adverse publicity	System service improvement plan System wide Quality Surveillance, Patient Safety, Medicnes Safety Groups Agreed system quality metrics LMNS exploring opportunity to benchmark data across region/similar maternity systems	1. CCG attendance at all providers quality and contract monthly meetings RAP in key areas of concern inc; ED, Maternity, Ophthalmology, Diagnostics, neurology, cancer waits, RTT, mental health, LAC 2. Monthly SIRG's (serious incident review group) for each provider. 3. Monthly internal CCG SIRG 4. Quality visit schedules for all providers, primary care and care homes 5. IP&C health economy meetings and attendance at IPC committees and outbreak meetings 6. NHS England/Improvement Oversight and Assurance process in place with agreed support 7. Regular monitoring re workforce inc; mandatory training, supervision, sickness, adbscence and vacancy rates for all providers	1. Monthly Quality & Performance Committee 2. Board reporting and scrutiny 3. Robust Monitoring processes of SI's following the NHSE SI framework. Number of overdue SI reports is reducing for acute provider 4. Patient Safety Group - system group to review themes from SI's and share learning 5. Quality Surveillance Group is in the process of being established to provide system quality oversight. Providing opportunity to share, drive and monitor quality priorities. 6. Care Homes and Dom Care information sharing meetings with LA: 7. Quality monitoring of providers in place based on concerns escalation 8. Regular information sharing CQC/LA for all providers 9. Information sharing and benchmarking via LMNS and MatNeo Clinical Network.	1. Provider failing to meet required performance and quality standards 2. Necessary workforce is not in place/do not have capacity/capability, or achieved with temporary staffing solutions 3. Providers not being 'well-led' 4. Triangulated information indicates areas of concern within providers 5. Patients are not seen within national guidelines/evidence base which has consequences re: patient outcomes 6. Iinsufficient resources to ensure staff are able to work safely and effectively. Provider workforce vacancy and staff turnover for skilled workers 7. Backlog in key performance areas leading to poor outcomes, patient experience 8. Specific performance and quality concerns with Culture and Leadership 9. Unvalidated provider metrics/data quality - maternity services 10. Time lag of 2 years for nationally validated and published comparative maternity mortality data	4x5 = 20 (likely x catastrophic)	1. Programme of quality visits and attendance at key provider meetings 2. Greater inclusion of patient experience 3. Thematic reviews 4. Escalation of concerns to NHS England/Improvement 5. Improvement plan agreed and positive oversight 6. Implement a System Wide approach to quality improvements - Quality Surveillance Group; Patient Safety Group; Medicines Safety Group. 7. Undertake themed reviews for both individual providers and system quality concerns and issues 8. Maternity & Neonatal network to independently review maternity position - SBLCB v2 9. Evidence to support maternity CNST submission to be reviewed by CCG 10. Recruit to LMNS data analyst post	3x5 = 15 (possible x catastrophic)	Z Young	Zena Young 02.11.20

3	SCCG - 1 TWCCG - 1	J Davies	NHS Constitution Performance Targets There is a risk that the CCGs fail to meet the NHS Constitution performance targets consistently	To improve the delivery of key performance targets for the services our patients received which are designed to improve the quality of care and outcomes and patient experience	CCG attendance at :- Monthly Planned Care Working Groups Fortnightly UEC Delivery Group Fortnightly SaTH Cancer Performance meeting Monthly provider contract meetings	Monthly Quality & Performance Committee Monthly ICS Shadow Board	1) Lack of staff resource to develop improvement plans and oversee delivery 2) Lack of overarching improvement plan for A&E performance 3) Multiple sources of performance information 4) Impact of COVID pandemic preventing recovery work on elective care and RTT	5 x 4 = 20 (Almost Certain x Major)	1) MOC for staff due to complete in December, possible recruitment to new performance posts in January 2) Agree key elements of A&E improvement plan at UEC Delivery Group by end of November 3) Working across system to get single performance framework and single reporting through system PMO by the end of March 21 (Pandemic permitting) 4) Maximising use of all available system capacity for cancer and urgent elective care through to the end of March 21 and beyond as required. Minimal improvement in Referral to Treatment Times this year due to COVID so mitigation is not sufficent to improve overall risk score this financial year- listed mitigation should improve A&E performance and help maintain cancer performance.	5 x 4 = 20 (Almost Certain x Major)	J Davies	J Davies 04.11.20
4	SCCG - 1 & 4 TWCCG - 1 & 4	Sam Tilley	Covid 19 EPRR Response There is a risk that the CCGs fail to manage with partner organisations the local health system response to Covid 19 second wave pandemic	Opportunity to develop innovative and more effective approaches to patient care Opportunity to develop a system approaches to patient pathways and care	Gold Command Silver Command CV19 work stream Task & Finish Groups	Weekly System CV19 Gold and Silver SitReps System CV19 Risk Register Regional PHE intelligence briefings Weekly regional and National NHSE/I briefings Weekly Demand and Capacity reporting Weekly Outbreak reporting	Business Intelligence capacity and capability to adequately adress data needs lack of workforce capacity to assign adequate SRO and PM to support all programmes of work lack of capacty in system to address competing demands of delivery of CV19 response, winter pressures, restoration and recovery requirements and system improvement as a result of social distancing PPE, swabbing and wider IPC issues Lack of workforce to deliver the above Staff resillience	25 Almost certain x catestrophic	Full programme in place to address all elements of CV19 response. System incident response structure in place and operational. Continued system approach to managing the incident as it evolves. Ongoing demand and capacity work to track impact in real time and inform decision making. Continued evaluation of winter and surge planning. Ongoing disucssions across region regarding mutual aid as well as with the Independent sector. MoU in place to support re-deployment of staff	15 Almost Certain X moderate	S Tilley	S Tilley 30.10.20
5	SCCG - 1 TWCCG - 1	Sam Tilley	Restoration of health servcies during Covid 19 second wave There is a risk that the CCGs fail to take account of best practice and learning during Covid 19 response in the planning for future health needs	Opportunity to develop innovative and more effective approaches to patient care Opportunity to develop a system approaches to patient pathways and care	Gold Command Silver Command CV19 work stream Task & Finish Groups System Transformation Delivery Group System Planning & Performance Group	Weekly System CV19 Gold and Silver SitReps System CV19 Risk Register Regional PHE intelligence briefings Weekly regional and National NHSE/I briefings Weekly Demand and Capacity reporting Weekly Outbreak reporting Winter Plan Phase 3 Plan System Improvement Plan Range of learning exercises	Lack of staff resource to adequately manage the oversight and implementaiton of learning Lack of staff resilience to embrace change Lack of time to step outside of the immediate CV19 response requirements to implement change	20 Major x almost certain	Commitment via Gold and Silver Command to embrace new ways of working and where possible encourage the implementation of innovative ideas and solutions. Outputs of a number of learning exercises presented to Silver and Gold to support change Implementation of a number of plans (Winter, Phase 3 and System Improvement Plan) underway	12 Possible x Major	S Tilley	S Tilley 30.10.20
6	SCCG - 1 & 2 TWCCG - 1	A Smith	Patient and Public Involvement There is a risk that the CCGs fail to involve patients and the public in planning commissioning arrangements, in development and consideration of proposals to change existing services or to cease existing services.	To ensure that service redesign is informed by consistent and robust involvemenbt of patients and the public	Communications and Engagement Strategies Communications and Engagement teams working jointly across both CCGs providing expertise in planning and delivery Reports to Govenring bodies/Committees require section completing on Patient involvement Decisions at STP levcel on restore of services require equality and engagement plans to be completed Presence of Health watch for both areas at Govenring body meetings/JSCC and Quality Committees Joint Lay Member for PPI and Joint Associate Lay Member for PPI - EDI in place on Governing Bodies to act as specific check and balance	IAF Engagement Rating of Outstanding for T&W and Good for Shropshire 18/19 Reporting to Assuring Involvement Committee Reporting on Engagement as part of wider reporting and decision making at JSCC	Gaps in controls: 1) Draft Communications and Engagement Strategy for single CCG continuing to be developed with a supporting action plan against which progress can be reported 2) Patient engagement events x 2 planned but yet to be delivered to input into the development of the Strategy above 3) Staff MOC creating new roles in existing Comms and Eng team which will need to be recruited to which will mean a leadtime of having full team Gaps in assurance: 4) CCGs to agree model of patient involvement in governance	possible x major = High 12	1) Draft communicatiosn startegy is ocntinuing to be developed as part of the programme to create a single CCG with a new version to be submitted to NHSEI at the end of December 2020. AS 2) Patient Engagement events are planned for November and March as part of the programme to create a single CCG. AS 3) MOC for staff due to complete in December, with possible recruitment to sdenior positions taking place later Decemebr early January 2021. AS 4) The model adopted will be informed by engagement with patients at the two events planned and internally with CCG colleagues.	Unlikely x major = Moderate 8	A Smith	A Smith 28/10/2020

7	SCCG - 4 TWCCG - 1	S Trenchard	Single Strategic Commissioner There is a risk that the CCGs fail to provide system leadership and the delivery of system transformation.	To ensure the system works together to achieve improvements for the population health within available resources	ICS Shadow Board Chief Executives Group STP Programme Boards CCG Directors weekly meeting Commissioning Strategy Operating Model Project plans for delivering required changes Agreement from system to have single leadership model for ICS and CCG	STP Programme Board Reporting	Gaps in control: - Comprehensive plans for all STP priorities - Single management structure for ICS and CCG - Full ICS development plan - Accountabilty framework for whole system and place based commissioning and delivery - Outcomes framework - Operating model in development Gaps in assurance: - Full cluster board reporting due to gaps in project plans - Monitoring of impact of accountability framework - Monitoring of impact of outcomes framework - Monitoring of improvements using accurate data	Likely x Major = High 16	Recruitment of a single Accountable Officer for CCG and STP by March 2021 (Owner: CCG Board) PMO programme management website to be updated with comprehensive project plans for all STP priorities by November 2020 (Owner: STP programme board SRO's) Full ICS Development Plan finalised and approved by <date> (Owner: CCG ACO) Development of appropriate accountability framework that accommodate whole system and place based commissioning and delivery by <date> (Owner: STr)	Possible x Major = High 12	S Trenchard	S Trenchard 30/10/2020

8	SCCG - 1 TWCCG - 2 & 3	Sam Tilley	Population Needs There is a risk that the CCGs fail to understand their populations needs that contribute to health inequalities across the County	To develop stronger partnerships with Local Authorities, public health and other stakeholders to develop a system strategy for health inequalities and population needs To tailor health and wellbeing services more accurately to populaton need ensuring they have a greater impact	Population Health management portfolio priortiy for Director of Planning.. Parnerships and relation ships developing with key stakeholders. JSNA for STW. Health Ineqiualities system strategy overseen by Director of Partnerships and feeds into governance of Care Closer to Home Programme Board. Links with Patient, parent and carer groups to embed specific groups i.e. SEND, Childrens, Mental health into strategies	Health Inequalities outline startegy and bid. Personalisation agenda to meet population needs supported by regional funding and bid. New partnership arrangements for SEND with both local authority groups. Shrropshire CCtH board and TWIPP working towards a place based delivery model on the needs of the populations.	Impact assesments needed to understand changes in new models of care and approach. Testing of governance processes to ensure accountability for stautory organisation. Lack of recurrent funding to ensure capacity in workforce to deliver needs of populations both internally and with providers. Comprehensive engagement and communication startegy required for the public patient engagement exercise Lack of Business Intelligence capacity and capacility Lack of system wide infrastructure to support full PHM approach	16 Major x Likely	Engagement strategies being developed with the SCCtH and TWIPP boards. Joint posts with Local Authority to develop partnership and place based working to deliver the needs of the population (November 2020) Joint PHM post with Local Authroties being planned Exploratory work commenced wiht CSU Strategy Unit regarding future BI requirements and infrastructure	12 Major x possible	S Tilley	Claire Parker 30/10/2020 S Tilley 30/10/20

9	SCCG - 4 & 5 TWCCG - 1 & 5	Exec	ICS Development There is a risk that the CCGs fail to support and lead the development of ICS/ICP which then compromises the capacity and capability of a new singel CCG in the future.	The CCGs to lead the development, with partners of the ICS, to plan and deliver improved services for the population.	CCG AO is interim ICS Lead Director.	1. ICS Shadow Board. 2. Regular reports to CCG Governing Bodies. 3. Programme Boards of the ICS reporting to the ICS Shadow Board.	1. Capacity within the system. 2. No integrated data source.	4 x 2 = 8 Likely x Minor	1. ICS Plan to gain authorisation has been developed. 2. Checkpoint meetings with NHSE/I. 3. Monitoring through the ICS Shadow Board.	1x2 = 2 Rare x Minor	D Evans	D Evans 05.11.20
10	SCCG - 1 TWCCG - 1	Exec	Sustainable Services If CCGs fail to maintian sustainable acute services within the county, there is a risk that patients will have to receive healthcare outside of the county; there is a risk of clinical safety associated with longer travel times; there is a risk of adverse publicity.	Opportunity to transform acute services to be sustainable and high quality for the future and to ensure safe and high quality acute care for our population To improve quality of care, patient experience and patient safety. To improve recruitment and retention. To reduce health inequalities in health access and reduce unwarranted variation to improve health and outcomes. To deliver the right care, in the right place, at the right time.	1. Current contract and quality monitoring arrangements including : - CQRM (including workforce reports) - QA visits - SI reporting and meetings monthly - Monitoring of NHS2NHS Concerns. - staff survey - F&F - Patients experience/ stories 2. Fortnightly ED/ SaTH Assurance call with Exec / SMT leads 3. Monthly SOAG meetings to drive system approach to support in relieving the pressure at the front and back door of SaTH. 4. During Covid the quality team have been working with the Trusts quality team, joining Exemplar visits. 5. Informal drop in/ ad hoc visits take place as required based on Horizon scanning of soft intelliegence, data, SI's, N2Ns, complaints etc. CCG led meetings - CCG Board, CQRM, Planned Care Working Group STP / ICS meetings - ICS Shadow Board, STP Programme Boards, STP enabling groups, Planned Care Working Group, Elective Care Transformation Group, A&E Delivery Group, Hospital Transformation Programme Strategies/Policies/Plans - STP project plans, Cancer strategy System Improvement Plan Other: Quality assurance visits Winter Plan Finance Strategy	1. Monthly Quality & Performance Committee 2. Board reporting and scrutiny 4. SaTH CQC assurance action plan is shared weekly with CCG and the information scurtinised to inform the weekly assurance calls. 5. Engagement with CQC and external bodies on providers/ NHSEI 6. Robust Monitoring processes of SI's following the NHSE SI framework, with much improved systems and processes now in place to progress the completion and submission of RCAs. 7. Patient Safety Group - system group to review themes from SI's and share learning 8. Quality Surveillance Group is in the process of being established to provide system quality oversight. Providing opportunity to share, drive and monitor quality priorities. 9. Workforce plan monitoring to include vacancy rates, recruitment progress and the use of temporary staff per division to allow correlation between quality and incidents with CQRM reporting Planned care working group reporting STP Programme Board reporting Hospital Transformation Programme A&E Delivery Group reporting Cancer strategy implementation reporting Quality assurance visit outputs	1. Shortages of key clinical staff and shortages within the nursing workforce 2. Lack of staff engagement in a culture of continuous improvement and learning. 3. Repeated themes in SI's are a cause for concern that learning is not embedded to sustain improvements required. 4. Data received e.g inital assessment times; triage times; 12 hour trolley breeches; number of falls; does not provide full assurance that SaTH is able to sustain improvement in the reduction of harms or high quality patient experience. 5. CQC visits have identified multiple areas of unsafe care (issued Section 31 notices in December 2019, February 2020, April 2020 and August 2020) and the Trust's action plan has been received. Progress has been made but this has not been fully implemented therefore remains a gap in assurances. 6. IT infasture is not fit for purpose for sharing of pateint information between departments leading to cases of delayed diagnostics. 7.The trusts governance and risk systems are not effective in controlling and mitigating risks. . Gaps in controls: - Full workforce strategies and plans - Full digital strategies and plans - Seamless links between programmes and enabling groups - Full cancer plan for delivering the strategy - Full elective care transformation plan - Full Digital Strategy - Full decision making escalation plan aligned to Covid Surge Plan	16 Likely x Major	1.Both CCGs, via the current control mechanisms, will continue to robustly encourage SaTH to make improvements across the trust to achieve improvements on all quality key indicators. 2. Continue with enhanced monitoring and surveillance as per quality assurance framework 3.Oversight of quality management processes at the Trust continues via CQRM. 3. agree system quality matrix , Triangulation with CQC and NHSI. 4. continuously review the assurance calls template/ data capture to provide assurances that the Emergency Departments are providing safe care and are appropriately staffed. 4. Continue to attend SOAG and gain assurances required in relation to all ED concerns. 5. Robust monitoring of workforce modelling - recruitment and retention plans 6. Continue to support and challenge implementation of CQC action plans 7. Escalate to NHSEI, Board, PSG, as appropriate. 8.Local QSG in development to ensure a system approach to quality and demand issues. 9. The People Board continues to identify and plan for the workforce gaps across the STP footprint. The CCG is an active part of this process. 10. The CCG is working closely with the Trust, NHSEI, ECIST and partners to provide support and Implement new service model for neurology by 1 April 2021 (Owner: HR) Develop full workforce strategy by Dec 2020 (Owner: VR) Implement plan to deliver workforce strategy by March 2021 (Owner: VR) Develop full digital strategy by Jan 2021 (Owner: SJ) Implement plan to deliver digital strategy by April 2021 (Owner: SJ/ STr) Develop process for programme leads to link with enabling workstreams by Dec 2020 (Owner: STr) Implemention plan to delivering cancer strategy by Jan 2021 (Owner: STr) Develop plan to deliver elective care transformation by 30 November (Owner: AP)	12 High x Major	Z Young and S Tilley and S Trenchard	Z Young 02.11.20 S Tilley 30.10.20 Steve Trenchard 30.10.20

11	SCCG 1 TWCCG 1	Exec	EU Exit There is a risk that the CCGs fail to manage the impact of EU Exit on the adequacy of patient care.		1. CCG attendance at all regional and national pharmacy leads briefings 2. National planning and stockpile of medicines to ensure supply over first stages of Brexit 3. National shortage supply protocols implemented 4. Medicines team will support practices with information and to respond to shortages 5. POD can be utilised to shorten prescribing duration to ensure stock is equitable distributed 6. Financial impact on NCSO and Cat M price changes are monitored monthly 7.System EU Exit Lead identified 8. Engagement with NHSE/I on EU Exit planning 9. System poricurement and supply chain Task & Finish Group in place	1. Monthly Quality & Performance Committee 2. Board reporting and scrutiny 3. Monthly finance meetings 4. Area Prescribing Committee to agree system response and amendments to formulary 5. An STP Medicines Safety Group is proposed to be established to provide system medicines safety oversight. 6.Silver Command 7. Gold Command	1. This is largely outside of CCG control and is dependant on national planning and procurement 2. Negative impacts on patient care may be unavoidable if there is not an equally effective alternative 3. Potential financial impacts are unclear and difficult to plan for with any degree of accuracy. 4. This is likely to be managed responsively rather than have ability to plan proactively in advance 5. Likely to have negative impact on patient experience and confidence and lead to a rise in complaints and concerns	16 Major x Likely	System EU Exit Lead in place and organisation ICC's in place to receive communications and directives from NHSE/I System Procurement and Supply chain Task & Finish Group meeting regularly and providing updated to Silver Command twice a week as well as a weekly SitRep. System will continue to monitor the posiiton as it develops anbd request input/ flag issues as required	9 possible x moderate	S Tilley	Elizabeth Walker 26.10.20 S Tilley 30.10.20

RISK MANAGEMENT MATRIX

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

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

	Consequence score (severity levels) and examples of descriptions				
Domains	**1. Negligible**	**2. Minor**	**3. Moderate**	**4.Major**	**5. Extreme**
Impact on the safety of patients, staff or public (physical/psychological harm).	**Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.**	**Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.**	**Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.**	**Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.**	**Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.**
Quality/complaints/audit	**Peripheral element of treatment or service suboptimal. Informal complain/injury.**	**Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.**	**Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.**	**Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.**	**totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.**
Human resources/organisational/ development/staffing/ competence	**Short term low staffing that temporary reduces services quality (1< day).**	**Low staffing level that reduces the services quality.**	**Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.**	**Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.**	**Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.**
Statutory duty/inspections	**No or minimal impact or breach or guidance/statutory duty.**	**Breach of statutory legislation. Reduced performance rating if unresolved.**	**single breach in statutory duty. Challenging external recommendation/improvement notice.**	**Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.**	**Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.**
Adverse publicity	**Rumours. Potential for public concern.**	**Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.**	**Local media coverage - long-term reduction in public confidence.**	**National media coverage with >3 days service well below reasonable public expectation.**	**National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.**
Business objectives/projects	**Insignificant cost increase/schedule slippage**	**<5 per cent over project budget. Schedule slippage.**	**5-10 per cent over project budget. Schedule slippage.**	**Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.**	**Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.**
Finance including claims	**Small loss. Risk of claim remote.**	**Loss of 0.1 - 0.25 per cent of budget. Claim less than £10,000.**	**Loss of 0.25-0.5 per cent of budget. Claim (s) between £10,000 and £100,000.**	**Uncertain delivery of key objective/loss of .5 - 1.0 per cent of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.**	**Non-delivery of key objectives/loss of >1 per cent of budget. Failure to meet specification/slip page. Loss of contract/payment by results. Claim(s) > £1 million.**
Service/business interruption/environmental impact	**Loss/interruption of >1 hour. Minimal or no impact on the environment.**	**Loss/interruption of >8 hours. Minor impact on environment.**	**Loss/interruption of >1 day. Moderate impact on environment.**	**Loss/interruption of >1 week. Major impact on environment.**	**Permanent loss of service or facility. Catastrophic impact on environment.**

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 11th November 2020**

Item Number:	Agenda Item:
GB-20-11.129	Appointment of the Deputy Chair of the Governing Bodies of NHS Shropshire and NHS Telford and Wrekin CCGs

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

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

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

Executive Summary (key points in the report):
The Constitutions of both CCGs state a requirement for the Governing Body to appoint a Deputy Chair of the CCG Governing Body from amongst the Lay Members on the Governing Body at a meeting in public to chair the Governing Body meetings when the Chair is not in attendance. Mr Meredith Vivian, Joint Lay Member Patient and Public Involvement (PPI) has expressed an interest in being appointed to this role and the Governing Bodies are recommended to approve his appointment.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? Mr Meredith Vivien, Lay Member PPI has a conflict of interest with this item as he has expressed an interest in being appointed to the role of Deputy Chair of both CCGs. This conflict of interest will be managed by Mr Vivien leaving the meeting and taking no part in the discussion or decision for this agenda item.	Yes
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation? The joint appointment to this role for both CCG Governing bodies meets the requirements set out in the CCGs Constitutions.	Yes
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:

NHS Shropshire CCG Governing Body is recommended to:

Approve the appointment of Mr Meredith Vivien as the Deputy Chair of the Shropshire CCG Governing Body

NHS Telford and Wrekin CCG Governing Body is recommended to:

Approve the appointment of Mr Meredith Vivien as the Deputy Chair of the Telford and Wrekin CCG Governing Body

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 11 November 2020**

Item Number:	Agenda Item:
GB-20-11.130	Shropshire CCG and Telford and Wrekin CCG Workforce Race Equality Standard (WRES) Annual Data Submission and Action Plan 2020

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

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

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

Executive Summary (key points in the report):
The purpose of the report is to provide the CCG Governing Bodies with the draft Workforce Race Equality Standard (WRES) Annual Data Submission and draft Action Plan for approval.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication?	No
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation?	Yes
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:
NHS Shropshire CCG Governing Body is recommended to: 1) Note the WRES data submission made to NHSE/I at the end of August 2020. 2) Approve the draft action plan attached to this report that seeks to respond to the areas highlighted by the data submission.

NHS Telford and Wrekin CCG Governing Body is recommended to:

1) Note the WRES data submission made to NHSE/I at the end of August 2020.

2) Approve the draft action plan attached to this report that seeks to respond to the areas highlighted by the data submission.

Item Number:	Agenda Item:
GB-20-11.130	Shropshire CCG and Telford and Wrekin CCG Workforce Race Equality Standard (WRES) Annual Data Submission and Action Plan 2020

1. Introduction

The purpose of the report is to provide the CCG Governing Bodies with the Workforce Race Equality Standard (WRES) Annual Data Submission and draft Action Plan for approval.

2. Report

2.1 Workforce Race Equality Standard (WRES) is made up of nine indicators and is mandated by NHS England (NHSE). From 2019 onwards, CCGs are expected to submit their annual WRES data to NHS England by the end of August annually. Both CCGs submitted the data by 31st August 2020.

2.2 The main purpose of the NHS Workforce Race Equality Standard (WRES) is to:

- Help local and national NHS organisations (and other organisations providing NHS services) to review their data against the relevant indicators.
- Produce action plans to close the gaps in workplace experience between relevant groups of staff, and
- Improve BME representation at the Board level of the organisation.

2.3 As NHS organisations the CCGs are required to:

- Collect data on their workforce - this includes both workforce data and staff survey data with analysis of data for each of the relevant metrics.
- Produce an annual report and action plan – the report should show the results of the staff survey and workforce data for internal analyses and indicate the steps being taken to improve performance against the relevant indicators, and
- Publish the annual report and action plan - CCGs will need to give consideration to how such data is published and what conclusions are drawn.

2.4 The indicators of the standard are intended to highlight and reflect:

- The overall representation of black or minority ethnic (BME) staff in the CCGs, across the pay structure.
- The relative likelihood of BME candidates being shortlisted and appointed.
- BME staff entering the formal disciplinary process.
- Uptake of non-mandatory training.
- Staff experience of bullying and harassment.
- Staff experience of whether the organisation provides equal opportunities, and
- Board representation.

2.5 The set of indicators highlight any differences between the experience and treatment of BME, with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

2.6 An action plan to address issues highlighted by the data is required and this is given at Appendix 1.

2.7 There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions and one indicator focuses upon BME representation on Boards. The WRES highlights any differences between the experience and treatment of white staff and BME staff in the CCG with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

2.8 The WRES defines BME based on ethnic categories defined Office of National Statistics (ONS) and used in the 2011 Census. BME excludes A, B, C and Z in the table below. The category C 'Any other white background' contains minority groups including white European.

A – White -British
B – White -Irish
C – Any other white background
D – Mixed White and Black Caribbean
E – Mixed White and Black African
F – Mixed White and Asian
G – Any other mixed background
H – Asian or Asian British -Indian
J – Asian or Asian British -Pakistani
K – Asian or Asian British - Bangladeshi
L – Any other Asian background
M – Black or Black British -Caribbean
N – Black or Black British -African
P – Any other Black background
R – Chinese
S – Any other ethnic group
Z – not stated

2.9 The findings highlighted from each data submission appended to this report are summarised below and suggested actions to address these issues are contained in the appended draft action plan:

2.9.1 Shropshire CCG

- Proportion of staff self reporting is above 95%.
- Percentage of BME staff employed by the CCG has decreased slightly but is still comparable to the BME population in Shropshire.
- The data for the percentage of BME staff appointed from shortlisting has increased significantly but due to the small numbers of BME staff this should be treated with caution.
- No BME staff have entered the disciplinary process.
- The CCG does not record non mandatory training centrally. This will be explored with HR to see what options are open to the CCG to address this gap in information.
- Indicators 5 – 8 have not been completed because the CCG does not take part in the National NHS Staff Survey that takes place annually due to the small numbers of staff and the likelihood of identifying individuals. This means that collecting this data has to be done on a local basis which has been disrupted due to staff management of change and Covid. It is recommended that on creation of a single CCG the National staff survey is used as the numbers of staff will be large enough.
- The BME representation on the Governing Body as compared to the overall BME staff numbers is greater and static when compared to last year's position. It should be noted that this is based upon the Governing Body composition as of 31st March 2020 and as the Governing body has changed its members in August, this will not reflect the current position.

2.9.2 Telford and Wrekin CCG

- Proportion of staff self reporting is above 95%.
- Percentage of BME staff employed by the CCG has decreased slightly but is still comparable to the BME population in Telford and Wrekin.
- There is a decrease in the percentage of BME staff being appointed from shortlisting which needs to be addressed.
- No BME staff have entered the disciplinary process.
- The CCG does not record non mandatory training centrally. This will be explored with HR to see what options are open to the CCG to address this gap in information.
- Indicators 5 – 8 have not been completed because the CCG does not take part in the National NHS Staff Survey that takes place annually due to the small numbers of staff and the likelihood of identifying individuals. This means that collecting this data has to be done on a local basis which has been disrupted due to staff management of change and Covid. It is recommended that on creation of a single CCG the National staff survey is used as the numbers of staff will be large enough.
- The BME representation on the Governing Body as compared to the overall BME staff numbers is lower, although some improvement can be seen from last year's position. It should be noted that this is based upon the Governing Body composition as of 31st March 2020 and as the Governing body has changed its members in August, this will not reflect the current position.

3. Recommendations

NHS Shropshire CCG Governing Body is recommended to:

1) Note the WRES data submission made to NHSE/I at the end of August 2020.

2) Approve the draft action plan attached to this report that seeks to respond to the areas highlighted by the data submission.

NHS Telford and Wrekin CCG Governing Body is recommended to:

1) Note the WRES data submission made to NHSE/I at the end of August 2020.

2) Approve the draft action plan attached to this report that seeks to respond to the areas highlighted by the data submission.

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation	Date of report: month/year	
NHS Telford and Wrekin CCG	August	2020

Name and title of Board lead for the Workforce Race Equality Standard

Alison Smith

Name and contact details of lead manager compiling this report

Alison Smith alison.smith112@nhs.net

Names of commissioners this report has been sent to (complete as applicable)

n/a

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

n/a

Unique URL link on which this Report and associated Action Plan will be found

https://www.telfordccg.nhs.uk/who-we-are/equality-and-diversity/wres

This report has been signed off by on behalf of the Board on (insert name and date)

Draft due to be approved at Governing body on 11th November 2020

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

Some data relies on completion of the national NHS staff survey which the CCG is unable to participate in due to its low numbers of employed staff. The CCG has run its own staff survey every two years but due to Covid 19 and staff management of change this has been postponed.

The CCG does not record non mandatory training centrally.

All other data is taken from casework information and ESR (electronic staff record) declared data by Human Resources at Midlands and Lancashire Commissioning support Unit.

b. Any matters relating to reliability of comparisons with previous years

None

2. Total numbers of staff

a. Employed within this organisation at the date of the report

122

b. Proportion of BME staff employed within this organisation at the date of the report

9.83%

Report on the WRES indicators, continued

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

95.08%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

No as the focus for CCG over the last 6 months was responding to the Covid 19 pandemic.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

No as the focus still remains on Covid wave 2 response and restoration of services.

4. Workforce data

a. What period does the organisation's workforce data refer to?

2019/2020
Staff in post at 31.03.2019
Recruitment: April 2019 - March 2020

Report on the WRES indicators, continued

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	9.83% BME as compared to 85.25% White	10.43% BME as compared to 86.08% White	Broad representation of BME staff at all grades from 2 - VSM Small decrease on last years data and slightly below the percentage total of BME in the Telford and Wrekin population of 10.5%	Explore with HR, Engagement and STW STP BAME Network colleagues how links to our recruitment on NHS Jobs could be shared with local BME networks.
2	Relative likelihood of staff being appointed from shortlisting across all posts.	5.00% BME as compared to 25.00%	6.67% BME as compared to 13.11%	Gap widening between this years data and last years.	As part of OD support to become a single strategic commissioner work with HR colleagues to ensure there is robust recruitment training provided to recruitment managers that addressing unconscious bias and focusses on values based recruitment.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	0% BME as compared to 0% White	0% BME as compared to 0% White	No staff have entered the disciplinary process.	
4	Relative likelihood of staff accessing non-mandatory training and CPD.	information is not available	Information is not available	CCG does not record non-mandatory training centrally	Explore with HR how line managers could utilise the Easy HR system to record non mandatory training for staff.

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White BME	White BME	Data is not available as the CCG runs its own staff survey and this has not been completed due to staff management of change processes during 2019/20 which have been postponed due to Covid 19	As part of work to become a single strategic commissioner with Shropshire CCG, adopt the NHS staff survey.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White BME	White BME	Data is not available as the CCG runs its own staff survey and this has not been completed due to staff management of change processes during 2019/20 which have been postponed due to Covid 19	As part of work to become a single strategic commissioner with Shropshire CCG, adopt the NHS staff survey.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White BME	White BME	Data is not available as the CCG runs its own staff survey and this has not been completed due to staff management of change processes during 2019/20 which have been postponed due to Covid 19	As part of work to become a single strategic commissioner with Shropshire CCG, adopt the NHS staff survey.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White BME	White BME	Data is not available as the CCG runs its own staff survey and this has not been completed due to staff management of change processes during 2019/20 which have been postponed due to Covid 19	As part of work to become a single strategic commissioner with Shropshire CCG, adopt the NHS staff survey.
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	-3.2% difference between BME Board voting and overall BME workforce	-10.4% difference between BME Board voting and overall BME workforce	The percentage difference has improved albeit it remains lower for BME.	The CCG will continue to advertise Board positions and invite applications from different communities as vacancies arise.

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

6. Are there any other factors or data which should be taken into consideration in assessing progress?

None

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

See attached.

Click to lock all form fields and prevent future editing

Produced by NHS England, April 2016

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

NHS Shropshire CCG

Date of report: month/year

August 2020

Name and title of Board lead for the Workforce Race Equality Standard

Alison Smith

Name and contact details of lead manager compiling this report

Alison Smith alison.smith112@nhs.net

Names of commissioners this report has been sent to (complete as applicable)

n/a

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

n/a

Unique URL link on which this Report and associated Action Plan will be found

https://www.telfordccg.nhs.uk/who-we-are/equality-and-diversity/wres

This report has been signed off by on behalf of the Board on (insert name and date)

Draft due to be approved at Governing body on 11th November 2020

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

Some data relies on completion of the national NHS staff survey which the CCG is unable to participate in due to its low numbers of employed staff. The CCG has run its own staff survey every two years but due to Covid 19 and staff management of change this has been postponed.

The CCG does not record non mandatory training centrally.

All other data is taken from casework information and ESR (electronic staff record) declared data by Human Resources at Midlands and Lancashire Commissioning support Unit.

b. Any matters relating to reliability of comparisons with previous years

None

2. Total numbers of staff

a. Employed within this organisation at the date of the report

196

b. Proportion of BME staff employed within this organisation at the date of the report

2.04%

Report on the WRES indicators, continued

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

95.9%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

No as the focus for the CCG over the last 6 months was responding to the Covid 19 pandemic

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

No as the focus still remains on Covid 19 wave 2 response and restoration of services.

4. Workforce data

a. What period does the organisation's workforce data refer to?

2019/2020
Staff in post at 31.03.2019
Recruitment: April 2019 - March 2020

Report on the WRES indicators, continued

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	2.04% BME as compared to 93.87% White	2.18% BME as compared to 93.99% White	Small decrease on last years data and slightly below the percentage total of BME in the Shropshire population of 2.1%	Explore with HR, Engagement and STW STP BAME Network colleagues how links to our recruitment on NHS Jobs could be shared with local BME networks.
2	Relative likelihood of staff being appointed from shortlisting across all posts.	33.33% BME as compared to 38.78% White	3.70% BME as compared to 23.35% White	significant improvement but numbers are small so should be cautious when interpreting figures.	As part of OD support to become a single strategic commissioner work with HR colleagues to ensure there is robust recruitment training provided to recruitment managers that addressing unconscious bias and focusses on values based recruitment.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	0% BME as compared to 0.54% White	0% BME as compared to 0% White	No BME staff have entered the disciplinary process.	
4	Relative likelihood of staff accessing non-mandatory training and CPD.	Information is not available	Information is not available	CCG does not record non-mandatory training centrally	Explore with HR how line managers could utilise the Easy HR system to record non mandatory training for staff.

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White BME	White BME	Data is not available as the CCG runs its own staff survey and this has not been completed due to staff management of change processes during 2019/20 which have been postponed due to Covid 19	As part of work to become a single strategic commissioner with Shropshire CCG, adopt the NHS staff survey.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White BME	White BME	Data is not available as the CCG runs its own staff survey and this has not been completed due to staff management of change processes during 2019/20 which have been postponed due to Covid 19	As part of work to become a single strategic commissioner with Shropshire CCG, adopt the NHS staff survey.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White BME	White BME	Data is not available as the CCG runs its own staff survey and this has not been completed due to staff management of change processes during 2019/20 which have been postponed due to Covid 19	As part of work to become a single strategic commissioner with Shropshire CCG, adopt the NHS staff survey.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White BME	White BME	Data is not available as the CCG runs its own staff survey and this has not been completed due to staff management of change processes during 2019/20 which have been postponed due to Covid 19	As part of work to become a single strategic commissioner with Shropshire CCG, adopt the NHS staff survey.
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	2.3% difference between BME Board voting and overall BME workforce	2.4% difference between BME Board voting and overall BME workforce	Data remains static.	The CCG will continue to advertise Board positions and invite applications from different communities as vacancies arise.

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress?

None

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

See attached.

Click to lock all form fields and prevent future editing

Produced by NHS England, April 2016

Shropshire CCG and Telford and Wrekin CCG – WRES Action Plan 2020

WRES Indicator	Metrics	Recommended Actions	Responsible Officer	Target Completion date
1. Percentage of staff in each of the AFC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff	TWCCG 9.83% BME as compared to 85.25% White SCCG 2.04% BME as compared to 93.87%	Explore with HR, Engagement and STW STP BAME Network colleagues how links to our recruitment on NHS Jobs could be shared with local BME networks	A Smith/ L Kelly/ S Smith	31st December 2020
2. Relative likelihood of staff being appointed from shortlisting across all posts	TWCCG 5.00% BME as compared to 25.00% White SCCG 33.33% BME as compared to 0.54% White	As part of OD support to become a single strategic commissioner work with HR colleagues to ensure there is robust recruitment training provided to recruitment managers that addressing unconscious bias and focusses on values based recruitment.	A Smith/ L Kelly	31st March 2021
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year	TWCCG 0% BME as compared to 0% White SCCG 0% BME as compared to 0.54% White			
4. Relative likelihood of staff accessing non-mandatory training and CPD.	Information not available	Explore with HR how line managers could utilise the Easy HR system to record non mandatory training for staff	A Smith/ L Kelly	31st Dec ember 2021
5. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12	Information not available	As part of the work to become a single Strategic commissioner adopt the NHS Staff survey	A Smith/ L Kelly	31st March 2021

months				
6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Information not available			
7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	Information not available			
8. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following) Manager/team leader or other colleagues	Information not available			
9. Percentage difference between the organisations' Board voting membership and its overall workforce	TWCCG -3.2% difference between BME Board voting and overall BME workforce. SCCG 2.3% difference between BME Board voting and overall BME workforce.	The CCGs will continue to advertise Board positions and invite applications from different communities as vacancies arise.	A Smith/ L Kelly	31st March 2021

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 11 November 2020**

Item Number:	Agenda Item:
GB-20-11.131	Summary Report of the Shropshire CCG and Telford and Wrekin CCG Quality Performance Committees in Common dated 23 September 2020.

Executive Lead (s):	Author(s):
Mrs Zena Young Executive Director of Quality NHS Shropshire and NHS Telford & Wrekin CCGs zena.young@nhs.net	Mr Meredith Vivian Chair, Shropshire and Telford and Wrekin Quality and Performance Committees in Common

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Full minutes approved at the Shropshire CCG and Telford and Wrekin CCG Committees in Common	28 October 2020	See below

Purpose

To provide assurance to the Governing Bodies' Committees in Common that the safety and clinical effectiveness of services commissioned by Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group , and the experience of patients receiving those services, have been reviewed in accordance with the Quality and Performance Committees' Terms of Reference.

To provide a summary of the main items reviewed at the 23rd September 2020 meeting.

Executive Summary (key points in the report):

- The Committees requested that the Governing Body approve the addition of Telford and Wrekin Healthwatch and Shropshire Healthwatch to the list of attendees of the Quality and Performance Committees in Common and that they be added to the Governance Handbook and; that NHSE-I be notified accordingly.

- The Committees received a report on the time-limited solution to ensure that all children waiting for an autistic spectrum disorder assessment should receive one within six months. The waiting initiative commenced in November 2019 and has had a significant impact on reducing waiting times and lists. However, the Committees noted that the waiting times still exceeded twelve months and, despite the serious lack of capacity causing the delays, that this length of time to receive an assessment and appropriate interventions to support those children and families should be greatly reduced. The Committees requested a further update at the December meeting.

- The Committees heard that the continued funding of the High Intensity Service User (HISU) service was enabling those patients who rely on unscheduled acute care to access managed services in a way that benefits their overall health and well-being. The Committees recommended that work should be undertaken to develop a single HISU approach across the whole of Shropshire, Telford and Wrekin.

- Discussing the System Oversight and Assurance Group (SOAG)'s report the Committees heard that SaTH was putting in place new systems and procedures to improve performance and quality and these appeared, at an early stage, to be having a noticeable effect. The Committees remain alert to the need for evidence to support assurance on patient safety and quality of care.

- The Committees heard that 'Ulysses', a new system of raising concerns, had replaced 'Datix'. There was some concern that the new system was not being used consistently by practices and that it was not producing the same level of insight and evidence. The Committees requested that this be reviewed to ensure that the new system is capable of raising concerns effectively.

- The Committees considered the value of the Governing Body receiveing patient experience 'stories' to provide a greater level of qualitative information. It was agreed that the Governing Body Chair would pick this matter up for further consideration.

- There are large numbers of referrals to assess and put in place Continuing Healthcare (CHC) arrangements and interim resources are being funded to address the growing backlog.

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

Recommendations/Actions Required:

- The Governing Bodies were requested to approve the addition of both Telford and Wrekin Healthwatch and Shropshire Healthwatch representatives to the list of attendees of the Quality and Performance Committees in Common and that they be added to the Governance Handbook and amended accordingly; and shared with NHSE/I as required for information purposes.
- The Governing Bodies were asked to note the content of the report for assurance and information.

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 11 November 2020**

Item Number:	Agenda Item:
GB-20-11.132	Finance Committees in Common summary report

Executive Lead (s):	Author(s):
Claire Skidmore Executive Director of Finance	Keith Timmis Lay Member – Governance

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Finance committees in common	23 Sept 2020	S,D,I

Executive Summary (key points in the report):

- Concern over pace of delivery of transformation programmes across the system. Understand impact of covid but need to move on as soon as possible to achieve both financial and quality benefits.
- Unlikely to get either of the CCGs to breakeven position for year end. Trusts are under pressure too. System overall is in difficulty. Revised forecast outturn for this year will be submitted in October (now sent).
- Pressures on running costs because of the need to delay the management of change process.
- Complex/individual care is most significant area of concern, with higher unit costs as well as an increase in the number of cases. Backlog of reviews to be dealt with.
- Committee noted that updating our financial strategy is a condition of the approval for a merger of the two CCGs. The update needs to be credible and we will be reviewing drafts over the coming months ready to discuss the final version at the Governing Body.

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

Recommendations/Actions Required:
To note for information.

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 11 November 2020**

Item Number:	Agenda Item:
GB-20-11.133	Shropshire CCG & Telford and Wrekin CCG Joint Reports: Primary Care Commissioning Committee in Common – 7 October (Chaired by Mr Meredith Vivian)

Executive Lead (s):	Author(s):
Ms Claire Parker Director of Partnerships NHS Shropshire CCG and NHS Telford and Wrekin CCG Claire.parker2@nhs.net	Donna Macarthur Lay Member - Primary Care

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

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

Executive Summary (key points in the report):

The following are the key issues and points discussed at the meeting held on 7th October:

- The Terms of Reference were noted and accepted
- The Committee received a finance report which outlined the financial position for both CCGs up until 31/8/2020. The CCGs finance teams have been notified of a fixed allocation adjustment for months 7-12 are currently considering the implications. Initial estimates suggest this may be insufficient to cover forecast expenditure within delegated primary care
- The committee received a quality report. It was noted that due to Covid 19 a number of quality measures/indicators have been paused nationally but it was confirmed that the primary care teams have continued to offer remote support and have utilised alternative sources to obtain assurances from practices
- The Healthwatch leads for Shropshire and Telford and Wrekin provided the committee with an update on the activity they had been undertaking. Mrs Young also advised the committee that she had met with the leads to determine how the CCGs and Health Watch could work more closely together and triangulate information
- Mrs Ralph updated the committee on the work being undertaken to restore primary care across the system. With support from the quality team this would focus on prioritizing areas to maximise patient outcomes
- The committee received an update on primary care networks (PCNs). This noted the areas for delivery from 1st October:
    - Structured medication reviews
    - Enhanced Health in Care Homes
    - Early cancer diagnosis
    - Social prescribing
    - Domains in the investment and impact fund around the uptake of flu vaccinations, learning disability annual checks, and medical safety indicators

  It was noted that under the Additional Roles reimbursement scheme PCNs had indicated their commitment to recruit an additional 75 roles
  It was noted that two PCNs were providing services for patients of practices who had decided not to join a PCN this year. It was confirmed that service provision is for all patients irrespective of whether they are registered with the core practices or not

- A paper was presented outlining the Pharmacy workforce challenges with both recruitment and retention and looking into a creating an integrated pharmacy workforce. The committee raised a number of questions and further information was required so were unable to approve a joint working model at the meeting.
- An update on the delivery of the Primary Care Strategy was presented noting in particular the advances that had been made in technology and digital services in the previous 6 months
- A decision on the Court Street Boundary Change was deferred
- Dr Bufton joined the meeting to present the case for Dawley Medical Practice to increase space for its clinical services. A number of questions were raised and following discussion it was agreed that this should added to the agenda for the extra ordinary PCCC meeting being held in November for decision
- The committee received an update on the results of national GP survey
- The risk register was reviewed and updated – it was noted that the impact of Covid 19 was not currently included so it was agreed that the PCCC risk register and the Restore and Recovery Risk Registers should be aligned
- The committee were advised that Dodington had decided to their give up their contract as of 31st March 2021. The CCG is currently working through options and will be presented to the next committee. A communication was released in order to update patients.
- An extra ordinary meeting of eth PCCC in Common will take place on 4th November and the next formal PCCC in common will be held on Wednesday 2nd December

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

Recommendations/Actions Required:

To note the update and key points identified above

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Governing Body Meetings in Common held in Public on 11 November 2020**

Item Number:	Agenda Item:
GB-20-11.134	Audit Committees in Common Chair's Report

Executive Lead (s):	Author(s):
Claire Skidmore Executive Director of Finance	Geoff Braden Lay Member for Governance

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
A full copy of the minutes of the meeting may be obtained from the Executive Lead Governance and Performance prior to the Board meeting. Email: alison.smith112@nhs.net	16 Sept 2020	I

Executive Summary (key points in the report):

The Audit Committee provided scrutiny on a number of areas including:

- Board Assurance Framework and Executive Risk Register
- Raising Concerns at work policy
- Information Governance Update
- COVID 19 Financial Arrangements Update
- Review of Losses, Special Payments and Waivers
- Financial Governance COVID 19, Financial Outcome measures & KPIs and Progress report

The Audit Committees took these reports and accepted the recommended actions. No updates from External audit were received this month.

Board Assurance Framework & Executive Risk Register. No new risks have been identified since the last review on 9th September, with no escalation or de-escalation of any risks. Further work on the combining the joint BAF and ERR will take place in conjunction with the Board development work taking place. It was agreed that an executive team meeting would update and confirm the BAF's so that they can be assured. Best practice is available from other CCGs who have already combined their risk registers and support has been offered by Internal audit.

Raising Concerns at Work Policy was reviewed to ensure one consistent policy for the two CCG's. This required some small changes but focused particularly on moving from "Whistleblowing" and the negative connotations to speaking up and highlighting a more positive outcome. Communications are planned for staff later in October with the NHS staff survey providing feedback on how knowledgeable staff felt for this and wider counter fraud areas. The policy was approved as presented.

Discussion took place on scoping a Freedom to Speak Up Guardian role and the fact that this would be good for the two CCG's. Audit committee supported this recommendation.

Data Security and Protection toolkit has replaced the previous Information Governance toolkit. Confirmation that the key roles are in place for governance and data received and discussed with timescales for completion agreed. SIRO has received and signed off a report from the previous month.

Work was discussed on records management with details discussed and progress made. Confirmation was received of the work taking place to move away from non-NHS emails.

The reports were noted and accepted.

COVID 19 financial arrangements were discussed with updated guidance being given with confirmation that an internal audit process is now in place.

Review of Losses, Special Payments and Waivers with no additions since the last Audit Committee. These were updated with single waiver payments in relation to redundancy of Governing Body members from Shropshire CCG. The content of the report was noted and an action taken away in regards to whether this needed to go via the Remuneration Committees in Common.

Financial Governance COVID 19, Financial Outcome measures & KPI's and Progress reports were received from Internal audit. All were positive reports where the recommendations were owned and progress being made. It is worth noting that that because of COVID 19 the plan is necessarily a back ended plan for 2020/21.

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

Recommendations/Actions Required:

The Governing Bodies are recommended to note the work above and accept the report.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-20-11.135
Shropshire CCG Governing Body meeting: 11 November 2020

Meeting Summary Sheet	
Name of Committee:	North Shropshire Locality Forum
Date of Meeting:	24 September 2020
Chair:	Dr Katy Lewis

Key issues or points to note:

Dr Povey gave an update about the covid-19 rates and figures in the local area. A discussion took place about covid hot site planning and concerns due to the upcoming winter period. Concerns were also raised about problems with covid testing and patients having to travel long distances for tests. Dr Povey also gave an update on CCG finances and the ongoing process for approval of the two CCGs to become a single CCG.

The Locality Chair update included information from the respiratory transformation meeting. A discussion took place about 111 appointments and how to provide feedback about these appointments. Concerns were raised about information and advice given to patients with suspected covid symptoms as they had been booked appointments instead of being told to isolate. It was confirmed the issues would be looked into and correct process confirmed to Members.

Representatives from the Community Trust attended the meeting to give an update and overview of the Community Matron role and other roles within the community teams. Discussion took place about referral routes and plans for flu vaccinations. The team confirmed they would be happy to attend the locality meetings regularly.

The Medicines Management Team from the CCG attended and gave a presentation on GLP-1 analogue optimisation and an update on information from the Medicines and Healthcare products Regulatory Agency (MHRA) about lithium. A concern was raised about sodium valproate reviews as these were required to be completed by a specialist. The team confirmed an audit had been undertaken in relation to this and discussions were taking place with the appropriate organisations; a further update would be provided at the next meeting.

Cathy Davis, CCG Commissioning Lead for Mental Health; Paul Bowers, MPFT Head of Operations for STW Care Group and Dr Chandan Aladakatti, MPFT Psychiatrist and Medical Lead for Shropshire Care Group attended the meeting to give an update on mental health services. The group had an in-depth discussion about how the service operated during lockdown and plans for restoration and waiting lists. Members were extremely unhappy that services were stood down as this was not good for a large number of patients and also caused an increased amount of people to contact primary care. It was confirmed that all services were now restored along with increased digital support. Cathy and Paul talked through ongoing pieces of work to improve services and gave some information about recruitment that had started to increase the workforce capacity. Concerns were also raised about poor communication from mental health services, and difficulties faced by GPs in accessing clinicians to talk to. Cathy advised that Dr Priya George, Clinical Lead at the CCG, was conducting a questionnaire on mental health services that had been sent out to practices, and it was hoped this would enable improved scope for feedback and engagement in the future. Paul Bowers and Dr Aladakatti stated they would be happy to come back to the meetings regularly to help improve communication and relationships.

Actions required by Governing Body Members:

- To note information above. No actions required.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-20-11.136
Shropshire CCG Governing Body meeting: 11 November 2020

Meeting Summary Sheet	
Name of Committee:	Shrewsbury & Atcham Locality Forum
Date of Meeting:	24 September 2020
Chair:	Dr Ella Baines

Key issues or points to note:

Members discussed an issue raised at the previous meeting about spirometry and the advice given to carry on with this procedure in Primary Care. Members did not agree with the advice and thought that spirometry was an aerosol generating procedure, and therefore should not be done in practices at the moment due to covid concerns and the potential to put clinicians at risk. The CCG agreed to discuss this issue further.

Dr Povey gave an update about covid-19 rates and figures in the local area and information about hospital admissions. He explained the CCG was focusing on supporting the system with service recovery and restoration. An update was given about CCG finances and the plans in place for the rest of the year. Dr Povey also gave an update on the ongoing process for approval of the two CCGs to become a single CCG.

A discussion took place about a suggestion made by Consultants to review and reduce two week wait breast referrals due to an increase in referrals from Primary Care and the clinic feeling overwhelmed. Members were concerned with the advice and thought referrals should still be sent as appropriate. Members noted the two week wait pathway was designed to refer in patients where cancer should be excluded as a cause for symptoms, and should not just be for patients with suspected cancer. The CCG agreed to investigate this and confirm if it had been through the correct channels.

Corrine Ralph, Head of Primary Care in Telford & Wrekin CCG, attended the meeting to give an update on phlebotomy services. She gave a detailed explanation of the issues faced by phlebotomy services due to changes made because of covid and also the long term historic problems. Corrine gave an overview of the three areas of ongoing work which included Operational Delivery, Contingency Planning and System Redesign.

Claire Parker, Director of Partnerships, provided an update about the restoration of Primary Care services and the changes to the restoration and recovery governance processes. Members also discussed hot sites and Claire Parker advised there was a meeting planned to discussed this further at the CCG.

The Medicines Management Team from the CCG attended and gave a presentation on GLP-1 analogue optimisation and an update on information from the Medicines and Healthcare products Regulatory Agency (MHRA) about lithium. Members discussed other suitable lifestyle interventions such as very low calorie diets and the education packages available that provide information about coaching and motivational prescribing.

Actions required by Governing Body Members:

- To note information above. No actions required.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-20-11.137
Shropshire CCG Governing Body meeting: 11.11.20

Meeting Summary Sheet	
Name of Committee:	South Shropshire Locality Forum
Date of Meeting:	2 September 2020
Chair:	Dr Matthew Bird

Key issues or points to note:

Dr Povey gave an update about the establishment of the new Governing Body committees in common and appointed Members. An update was also given about the Management of Change process to align teams across the two CCGs, how contracts with main providers had been changed to block contracts and the improvement alliance between UHB and SaTH. Through the Locality Chair update it was explained that a meeting had taken place about diabetic foot screening and that there were still ongoing negotiations around this.

Members discussed adult and children mental health services with agreement that there were concerns around waiting times and communications that had been exacerbated by covid-19. It was recognised that when GPs had raised urgent concerns the responses had been very good. It was explained that the IAPT service had been restored with patients risk assessed and RAG rated, and that patients would continue to be supported virtually or where needed through face to face appointments. Members were also advised that additional capacity had been secured for the remainder of 2021. It was agreed to invite MPFT to the next locality meeting and also request information about waiting times for CMHT and IAPT.

Donna Jones (Operational Lead Community Nursing Teams / Locality Manager North West), Carla Satchwell (Matron South East) and Emma Parker (Team Leader South East) from Shropshire Community Health NHS Trust attended the meeting to give an update about the structure of their teams and the Community Matron role, with information about referral criteria and prescribing. It was noted that it would be useful for practices to receive regular lists of which patients the Matrons had on their caseloads. It was explained that a strategy was being developed for the Matron role and the comments made by Members would be taken into consideration during the review. There was agreement that relationships had improved over the covid period with better communication and support – this was made easier through the use of accuRx.

Members were reminded by the Medicines Management Team about the deadline to sign up to the Prescribing Development Scheme for the year. It was advised this would run for 6 months and information had been sent out to practices about this along with information about the Safe Prescribing Locally Commissioned Service.

It was explained that the CCG was looking into ways to improve the process for 111 direct booking and were looking for practices that would be interested in being involved in a pilot for this.

Actions required by Governing Body Members:

- No actions required.

NHS
Telford and Wrekin
Clinical Commissioning Group

CCG Board Meeting
Agenda Item: GB-20-11.138

CCG PRACTICE FORUM: CHAIRS REPORT

DATE:	*11th November 2020*
MINUTES OF MEETING	*15th September 2020* - A full copy of the minutes of the above meeting may be obtained from the Executive Lead Governance and Performance prior to the Board meeting. Email: alison.smith112@nhs.net
CHAIR **Contact Details:**	*Dr Ian Chan* Tel: Email:
CHAIRS ASSURANCE TO BOARD	**CCG Governing Body Meeting Update** Mrs Parker gave an overview of the areas discussed at the Joint Governing Body meeting, which had taken place on 9th September. The following key points were highlighted: • The meeting was the first meeting of the Joint Governing Body • Members had discussed alignment of the CCGs Board Assurance Framework (BAF) to produce a new set of outcomes • An update was received on the system restoration process. For primary care there is only one remaining service to be restored as the phlebotomy service had been restored. • Governing Body Members had talked, in some detail, about the phase three planning process; inputting into the operational plan and winter plan going forward. • SaTH - Mr Evans highlighted that NHSEI had provided funding for an Improvement Team within SaTH and there is now an Improvement Director working as part of the executive team. • An additional two CT scanners would be installed within SaTH, on a temporary basis, within the next few weeks. Also in the next few weeks work will begin to create additional modular capacity particularly at the Royal Shrewsbury Hospital for the use of same day emergency care. • Mr Evans also noted that SaTH had also received £2m from national funding to create more assessment unit capacity at the Princess Royal Hospital by moving the postnatal ward. **GP Practice Forum Chair's Update** Dr Chan introduced Shola Olowosale and Clare Harding-Mitchell from the Shropshire CCGs Medicines Management team to the members.

	Ms Harding-Mitchell is the Senior Project Lead Pharmacist for Shropshire CCG and will also be working across Telford. Ms Harding-Mitchell oversees clinical projects in primary care and will be providing support to the GP Practices. Over the next few months Ms Harding-Mitchell will be supporting the GP Practices along with Ms Olowosale and other members of the team. Ms Olowosale is the South Locality Pharmacist and will also be supporting the GP Practices in Telford. Ms Olowosale thanked Practices for signing up to the PDS scheme. Dr Chan gave an update in relation to the CCGs application to create a single strategic commissioning organisation. The process is ongoing and a recommendation would be made to NHS England Commissioning Board via virtual communication and the membership would be updated in due course. **Recovery and Restoration Primary Care Update** Mrs Corrine Ralph, Head of Primary Care, informed members that work was taking place to develop a dashboard, which identifies all the elements within the phase three response that are specifically related to primary care. In terms of restoring primary care services everything had been signed off by the system for the demand it places on other parts of the system. Work is ongoing around the backlog of work that had developed over the past few months. Mrs Parker had noted that it was still quite complicated getting some of the service back up and running. **Mental Health Update** Mrs Parker raised a number of issues that had been picked up in relation to mental health across both CCGs. Mr Evans informed members that he had, had a conversation with the Chief Executive of the Midlands Partnership NHS Foundation Trust (MPFT) in relation to issues relating to access to services for children and adults and this was being picked up by the Trust and the Trust had said they would be happy to talk to any GP Practices about the work they are doing and recognised that there are challenges within the services. **Any Other Business** Members were reminded that a meeting had been arranged with the Lead of the Health and Social Care Network (HSCN) Installation Programme, which is a new data network for health and care organisations, around any issues that had arisen or feedback with the rollout of HSCN.
RECOMMENDATIONS (requiring Board approval)	CCG Governing Body members are asked to note the content of the report.
PLANNED WORK	*None identified*

RISKS (Notification to board)	*As outlined above*
FINANCIAL IMPLICATIONS	*As outlined above*
CLINICAL IMPLICATIONS	*As outlined above*
PATIENT/PUBLIC IMPACT	*As outlined above*
LEGAL/ GOVERNANCE IMPLICATIONS	*None identified*
EQUALITY & HEALTH INEQUALITY IMPLICATIONS	*None identified*