

A G E N D A

Meeting Title	Governing Body Meeting	Date	Wednesday 13 May 2020	
Chair	Dr Julian Povey	Time	1.00pm	
Minute Taker	Mrs Sandra Stackhouse	Venue / Location	Via Teleconference	
Due to the COVID-19 pandemic, we are following Government advice on self-isolation, therefore members of the public will be unable to observe this meeting, Draft minutes of the meeting and questions and answers will be available on the CCG's website two weeks following the meeting.				
Reference	Agenda Item	Presenter	Time	Paper
GB-2020-05.048	<u>Apologies</u>	Julian Povey	1.00	verbal
GB-2020-05.049	<u>Members' Declaration of Interests</u>	Julian Povey	1.00	verbal
GB-2020-05.050	<u>Introductory Comments from the Chair</u>	Julian Povey	1.05	verbal
GB-2020-05.051	<u>Minutes of Previous Meeting</u> Meeting held on 11 March 2020	Julian Povey	1.10	enclosure
GB-2020-05.052	<u>Matters Arising</u>	Julian Povey	1.15	enclosure
GB-2020-05.053	<u>Questions from Members of the Public</u> Questions from members of the public will be accepted in writing 48 hours prior to the meeting and should be submitted by 12.00 noon on Monday 11 May to: Dr Julian Povey, Clinical Chair, Shropshire CCG, Somerby Suite, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL or via email: SHRCCG.govbody@nhs.net Guidelines on submitting questions can be found at: http://www.shropshireccg.nhs.uk/get-involved/meetings-and-events/governing-body-meetings/	Julian Povey	1.20	verbal
GB-2020-05.054	COVID-19 Update	David Evans/ Sam Tilley	1.25	presentation (to follow)
GB-2020-05.055	<u>Corporate Performance Reports</u> Performance and Quality Report to include integrated, secondary and primary care	Julie Davies/ Zena Young	1.40	enclosure

GB-2020-05.056	<u>Clinical and Financial Reports</u> Finance, Contracting Report incl. Quality, Innovation, Productivity & Prevention (QIPP) schemes <ul style="list-style-type: none"> • Final 2019/20 year end position (Month 12) • 2020/21 budgets 	Claire Skidmore	1.55	<i>enclosures</i>
GB-2020-05.057	<u>Governance & Engagement</u> Governing Body Assurance Framework (GBAF)	Alison Smith	2.05	<i>enclosure</i>
GB-2020-05.058	Single Strategic Commissioner Update	Alison Smith	2.10	<i>enclosure</i>
GB-2020-05.059	Temporary Changes to Governance arrangements to support Covid 19 response	Alison Smith	2.20	<i>enclosure</i>
GB-2020-05.060	Temporary Changes to Commissioning Intentions and Contract to support COVID-19	Steve Trenchard	2.30	<i>enclosure</i>
GB-2020-05.061	Audit Committee – 29 April (summary)	Keith Timmis	2.40	<i>enclosure</i>
GB-2020-05.062	<u>For Information Only/Exception Reporting</u> CCG Constitution amendments STW STP Primary Care Strategy Report Update Clinical Commissioning Committee – 19 February, 18 March Finance & Performance Committee – 26 February Quality Committee – 29 January, 26 February System A&E Delivery Board – 28 January South Locality Board – 9 January	Alison Smith	2.45	<i>enclosure</i>
GB-2020-05.063		Nicky Wilde		<i>enclosure</i>
GB-2020-05.064		Sarah Porter		<i>enclosure</i>
GB-2020-05.065		Kevin Morris		<i>enclosure</i>
GB-2020-05.066		Meredith Vivian		<i>enclosure</i>
GB-2020-05.067		Julie Davies		<i>enclosure</i>
GB-2020-05.068		Matthew Bird		<i>enclosure</i>
GB-2020-05.069	<u>Any Other Business</u>	Julian Povey	2.50	<i>verbal</i>
	<u>Date of Next Meeting</u> <ul style="list-style-type: none"> • Wednesday 8 July 2020 - time and venue to be confirmed 			



Dr Julian Povey
Clinical Chair



David Evans
Accountable Officer

Shropshire Clinical Commissioning Group

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

**HELD IN ROOM SGH026, THE UNIVERSITY CENTRE, GUILDHALL,
FRANKWELL, SHREWSBURY, SY3 8HQ**

AT 1.00 PM ON WEDNESDAY 11 MARCH 2020

Present

Dr Julian Povey	CCG Chair
Dr Finola Lynch	Deputy Clinical Chair
Mrs Claire Skidmore	Executive Director of Finance for Shropshire and Telford & Wrekin CCGs
Dr Jessica Sokolov	Executive Director of Transformation for Shropshire and Telford & Wrekin CCGs
Dr Stephen James	GP Governing Body Member & Clinical Director
Dr John Pepper	GP Governing Body Member & Clinical Director
Mr Kevin Morris	GP Practice Governing Body Member
Dr Deborah Shepherd	Locality Chair, Shrewsbury & Atcham Locality Board
Dr Matthew Bird	Locality Chair, South Locality Board
Dr Michael Matthee	Joint Locality Chair, North Locality Board
Dr Priya George	GP Governing Body Member & Clinical Director
Dr Alan Leaman	Secondary Care Member
Dr Julie Davies	Director of Performance for Shropshire and Telford & Wrekin CCGs
Mrs Christine Morris	Chief Nurse for Shropshire and Telford & Wrekin CCGs
Miss Alison Smith	Director of Corporate Affairs for Shropshire and Telford & Wrekin CCGs [<i>Item No: GB-2020-03.036 only</i>]
Mrs Sam Tilley	Director of Planning for Shropshire and Telford & Wrekin CCGs [<i>Item Nos: GB-2020-03.025-0.37 only</i>]
Mr Keith Timmis	Lay Member – Governance and Audit
Mrs Sarah Porter	Lay Member – Transformation
Mr Meredith Vivian	Lay Member – Patient and Public Involvement
Dr Colin Stanford	Lay Member

In Attendance

Mrs Sandra Stackhouse Corporate Services Officer – Minute Taker

- 1.1 Dr Povey welcomed members, observers and the public to the Shropshire Clinical Commissioning Group (CCG) Governing Body meeting being held in public.

Minute No. GB-2020-03.025 - Apologies

- 2.1 Apologies were noted from:

• Mr David Evans	Accountable Officer
• Mrs Fran Beck	Director of Partnerships
• Ms Maggie Bailey	Interim Chief Nurse for Shropshire and Telford & Wrekin CCGs
• Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire
• Ms Rachel Robinson	Director of Public Health, Shropshire Council

Minute No. GB-2020-03.026 - Declarations of Interests

- 3.1 Members had previously declared their interests, which were listed on the Governing Body Register of Interests and was available to view on the CCG's website at: <http://www.shropshireccg.nhs.uk/about-us/conflicts-of-interest/> However, Members were asked to confirm any additional conflicts of interest that they had relating to the agenda items. There were no other additional conflicts of interest declared.

Minute No. GB-2020-03.027 - Introductory Comments from the Chair

- 4.1 Those present were reminded that the meeting was being live streamed, which would be available to view on YouTube. Should there be any technical difficulties with the Wi-Fi signal connection affecting the streaming process, a recording of the meeting would be uploaded onto the CCG's website as soon as possible following the meeting.

Minute No. GB-2020-03.028 – Minutes of the Previous Meeting – 15 January 2020

- 5.1 The minutes of the previous meeting held on 15 January 2020 were presented and approved as a true and accurate record of the meeting following one amendment on: page 3, paragraph 8.1, 5th bullet point: change 'unfortunately' to 'fortunately'.

RESOLVE: MEMBERS FORMALLY RECEIVED AND APPROVED as an accurate record the minutes of the meeting of Shropshire Clinical Commissioning Group (CCG) held on 15 January 2020.

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

Minute No. GB-2020-03.029 – Matters Arising from the Minutes of the Previous Meeting

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

- a) **GB-2020-01.005 [~~GB-2019-07.097~~] – Ambulance Demand Deep Dive – Progress Update** – Mrs Morris read out a progress update received from Mrs Fortes-Mayer which reported that discussions and negotiations have been ongoing with neighbouring CCGs to agree what rural parts of the region required performance delivery targets and to develop community alternatives with the support of the ambulance service. Mrs Morris would forward the update to Mrs Stackhouse for circulation to Members for information.
- b) **GB-2020-01.009 – Performance and Quality Report** – Dr Povey reported that a formal letter to Sir Neil McKay, Chair of the Sustainability Transformation Partnership (STP) was in hand, to seek what further steps could be taken as a system to try and improve patient experience, performance of the hospital, and to improve the working lives of staff.
- c) **GB-2020-01.010 – Shropshire CCG Strategic Priorities** – Dr Davies gave a verbal update on the progress of work as a result of the alliance agreement with providers for the new model of care for the integrated provision of Musculoskeletal (MSK) services across Shropshire, Telford and Wrekin. The formal alliance agreement would be finalised by 31 March, which would include the budget allocation. Dr Davies would bring back an update to the next formal meeting, which would include the alliance agreement and the notes of the MSK Transformation Board meeting, which were still awaited.
- d) **GB-2020-01.015 – Healthwatch Shropshire (HWS) Report** – Ms Lynn Cawley was not in attendance at the meeting but would be asked outside of the meeting if the actions with regards to CCG support had been completed.

ACTIONS: Mrs Morris to forward the progress update to Mrs Stackhouse to circulate to Members for information.

Dr Davies to bring back a progress report on the MSK Alliance Agreement to the next formal meeting.

Ms Cawley to confirm whether HWS had received CCG support with the communications process for its event on 4 March and with writing its report on Access to Primary Care.

Minute No. GB-2020-03.030 – Public Questions

- 7.1 Dr Povey advised the meeting that a number of written questions had been received from the public, which would not be read out but hard copies of the questions and the CCG's responses had been provided at the meeting. These would also be attached to the draft minutes in readiness for the next meeting and would be available on the CCG's website. It was noted that a question had been received after the deadline for the submission of questions and this would be carried forward to the next meeting.

CLINICAL AND FINANCE REPORTS

Minute No. GB-2020-03.031 – Finance, Contracting Report including Quality, Innovation, Productivity & Prevention (QIPP) schemes

- 8.1 Mrs Skidmore presented the report which outlined the CCG's financial position as at 31 January 2020 (Month 10). It was reported that the CCG had held its forecast position and therefore the forecast position that had been made at Month 9 remained unchanged. As was expected there were areas that

had seen some fluctuations but this was considered to be manageable within the total budget. Therefore there were no particular concerns to be raised at this point on the year-end number that had been agreed.

- 8.2 The QIPP position had not moved materially and the CCG's forecast for delivering QIPP was on target to achieve approximately £16.4m. There was still an element of net risk associated with the QIPP programme but the management team were working to try and reduce that where possible so that there was no impact to the bottom line position.
- 8.3 Work had continued on the CCG's Financial Recovery Plan for 2020/21. The intention was for a report to be presented to the Finance and Performance Committee at the end of March, with a view to receiving sign-off of the budgets from the Governing Body in April. However, this was predicated on the CCG agreeing a position with NHS England and NHS Innovation (NHSE/I) that it could proceed with. Members were reminded that the CCG was still working towards quite a significant deficit and it needed to demonstrate to NHSE/I that it had a clear trajectory to revert back to a balanced position over a period of time.
- 8.4 Dr Leaman asked what the coronavirus outbreak would have on the CCG's finances and had there been any additional funding promised by central government.
- 8.5 Mrs Skidmore confirmed that the CCG had been asked to collate all costs associated with its work around the coronavirus impact. At the present time, the CCG was working on the assumption that this would be nationally funded and the CCG was keeping concise records of every cost attributed to this work.
- 8.6 As part of the year-end accounts process, Governing Body Members were asked if there were any exemptions to the declarations included in the Executive Summary. There were no exemptions raised. Members were advised that if any circumstances altered throughout the financial year and Members felt that this position had changed, they would be able to declare those changes.

RESOLVE: The Governing Body:

- ***NOTED the financial position at Month 10.***
- ***MADE the declarations NOTED in the Executive Summary in support of the annual accounts process.***

CORPORATE PERFORMANCE REPORTS

Minute No. GB-2020-03.032 – Performance and Quality Report

- 9.1 Dr Davies presented the CCG's integrated Performance and Quality Report, which contained the CCG's performance against all its key performance and quality indicators for Months 9 and 10 where available for 2019/20. The key standards that were not met year to date for the CCG were in the following areas:

62 day Referral to Treatment (RTT)
2wk wait (Breast)
2wk wait from GP referral
31 day where subsequent treatment is surgery
A&E 4hr target
Ambulance handovers >30mins and >1hr
RTT
Diagnostic waits
52wk waits

- 9.2 Cancer – There had been a positive improvement in cancer performance, particularly on the 2wk performance, and it was hoped that this would be maintained. There remained the challenge of the 62 day RTT rates still not achieving. The overall trajectory for the recovery of the 85% 62 day RTT target submitted to NHSE/I was based on the impact of the Urology service. Ongoing clearing of the backlog would keep this measure below target for the foreseeable future. Further improvement remained, which was dependent on the wider joint working with University Hospital North Midlands (UHNM) on Urology. However, this arrangement did have some limitations and the CCG needed to explore what options were available that could be taken through the regional alliance to improve the service.
- 9.3 Improving Access to Psychological Therapies (IAPT) – The CCG had raised from the Midlands Partnership Foundation Trust (MPFT) a query around why Shropshire CCG's IAPT access fluctuated and was not achieved as consistently as for Telford and Wrekin CCG. MPFT's response had been that the service in Telford and Wrekin was more established and that the communication and promotion of the service was more effective. MPFT was developing a similar plan for Shropshire CCG and access was expected to improve over the coming months to achieve the 22% target before the year-end.

- 9.4 A&E performance – Attention was drawn to the new process for the 12 hour breaches. The desk top review of the notes of the patients affected had shown a better view of patient care and the results of extended waits on trolleys, which would help to improve patient care and was a welcome change to the process.
- 9.5 Ambulance Handovers – A working group had been established with the ambulance service which would focus on work to support the reduction in conveyance rates and also to reduce the long ambulance waits that were still of significant concern to the local health economy.
- 9.6 Dr Matthee raised a concern about the IAPT service because although it had been reported that patients were receiving telephone calls quite quickly, counselling was taking five months or more for patients to be seen. Dr Davies confirmed this point had been discussed with the provider at the contract meeting and it was expected that there would be an improvement in that service.
- 9.7 Dr Povey referred to the 52 week wait for the patient in an out of area trust in Hampshire and sought further information because it was understood that the CCG was normally notified of patients with waits of over 40 weeks.
- 9.8 Dr Davies confirmed that this case would have been non-contracted activity. The CCG would not have had a contract with the Hampshire trust and it had been the patient's choice to receive their care in Hampshire. Unfortunately the CCG had not initially had sight of this patient before being notified but had checked with the trust to ensure it had followed the correct procedure in offering the patient care with an alternative provider but the patient had preferred to receive their care in Hampshire. It was a challenge for the CCG when patients choose to travel further to receive their treatment. For more local cases in the West Midlands there was good early surveillance of those patients waiting over 40 weeks.
- 9.9 Dr Povey asked whether the number of patients currently waiting over 40 weeks involved a large or small number of patients.
- 9.10 Dr Davies reported that the patients waiting over 40 weeks were becoming more of a challenge to avoid the >52 week breaches. The two specialties that were most affected were: Oral Surgery, which was commissioned by NHSE; and the Urology service, which the CCG commissioned. At the present time, the challenge was around the limited capacity and the demands for Urology services partly as a result of the community promoted Prostate Specific Antigen (PSA) testing. The CCG was working with the charity organisations to support them in their aims but also to look at the consequences of the promotion of PSA testing. The CCG was tracking on a patient by patient basis to avoid >52 week waits.
- 9.11 Dr Stanford referred to page 15 of the report, where it was reported that there had been 850 trolley waits in the Emergency Department (ED) at Shrewsbury and Telford Hospital Trust (SaTH) in Q3 in 2019/20, which equated to approximately 10 patient trolley waits in one 24 hour period. This was a large number and the question was asked what measures had there been for the CCG to be assured that steps were being taken to decrease this number because the situation was also distressing for patients.
- 9.12 Dr Davies referred to the last Governing Body meeting where the significant increase in 12 hour trolley breaches had been seen at The Royal Shrewsbury Hospital (RSH) in December and January, which had decreased in February and the numbers were showing a reduction so far in March. The Governing Body was assured that the CCG considered that this level of breaches was not acceptable. The CCG was concerned that the actual relative demand had decreased in January and yet there had still been a significant number of 12 hour trolley breaches. The levels had improved but there were differences in the hospital sites because the transfers appeared to be better managed at The Princess Hospital (PRH), Telford. The issue would be discussed at the A&E Delivery Board and Mrs Morris would be raising this at the Clinical Quality Review meeting (CQRM).
- 9.13 Mrs Morris confirmed that the quality of care delivered to those patients were in the themes of the risk summits that would be discussed in the next paper. Shropshire, Telford and Wrekin was one of the worst performing systems in the country for this number of trolley breaches and it was of concern for the CCG.
- 9.14 Dr Pepper also referred to the 850 trolley waits and asked whether the cause of the high number of trolley waits was known; for example, was the problem caused by lack of capacity or an efficiency problem or both. Dr Pepper noted that the ambulance handover times had decreased, which was positive and asked how that work had been achieved.
- 9.15 Dr Davies explained that the causes of the 12 hour trolley breaches were multi-factorial. There were demand and capacity issues within SaTH, which had been previously reported. In January the demand and capacity had not been as high and SaTH had still experienced problems. The A&E Delivery Group

was prioritising work, which for 2021 was to focus on flow, including the systems and processes. A report produced by the Commissioning Support Unit (CSU) had shown that the single biggest determinant of excessive waits for ambulances was volume and volume per hour because of the logistics of the two EDs and how many ambulances they can physically manage. Work was in progress looking at the options around the logistics and the number of ambulance conveyances to manage the handovers within the 30 minutes expected time.

- 9.16 Dr Leaman asked that, upon addressing the long ambulance handover times and the long waits on trolleys for patients, what progress had been made in providing alternative assessment areas so that the patients did not have to present to the ED.
- 9.17 Dr Davies reported that there had been significant progress and the standard now was that the acute medical assessment area and the same day emergency care area were being used to take pressure off the ED. However, the challenge for the CCG's projects and priorities for next year was how to work differently with SaTH to protect those assessment areas and to ensure that they did not become embedded down in the ED. Work was being undertaken to look at the demand and capacity of those areas to protect that function. This had been identified as a priority and was linked to the work that the emergency care and support team have been doing with SaTH.
- 9.18 Dr Povey enquired about the position of the Neurology service within the boundaries of the STP.
- 9.19 Dr Davies reported that there had been some challenges experienced in the CCG's negotiations with the Royal Wolverhampton NHS Trust (RWT) and the CCG had escalated an issue in terms of a response. Dr Davies had recently been informed that this had now been dealt with. The Trust was finalising the detail of its offer to the CCG, which was expected imminently, and would then be presented to the Clinical Commissioning Committee (CCC). Members would be kept informed of the progress made.

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

Minute No. GB-2020-03.033 – Shrewsbury and Telford Hospitals NHS Trust Quality & Care Quality Commission (CQC) Update Report

- 10.1 Mrs Morris summarised the history relating to the CQC inspections within SaTH and highlighted the salient points contained in the report. A full CQC inspection took place in November 2019, which had resulted in the imposition of Section 31 breach notifications, the report of which, was expected to be with SaTH in the near future for accuracy checking followed by publication.
- 10.2 At the December summit, all systems partners had been asked to not only look at how they could help manage demand away from SaTH to try and reduce the number of 12 hour delays but also to give the departments the additional capacity to manage safe and effective care. An action plan had been put in place and a further risk summit had been convened in January. It had been evident that all system partners had delivered the actions on that plan but it had resulted in no impact because of the highest number of delayed patients waiting for admission that there had ever been at that point. It was clear that those actions had not been the right actions to address the root cause of the problem.
- 10.3 An inspection of the two EDs was carried out on 17 and 18 February 2020, which had resulted in further Section 31 breach notices. The conditions listed in the bullet points under paragraph 3.0 of the report were really serious options that the CQC were considering in relation to the provider's registration and have had considerable impact upon the local population.
- 10.4 A further risk summit took place on 25 February 2020, chaired by the NHSE/I Regional Medical Director, and attended by Mrs Morris, Ms Maggie Bayley and Mr David Stout. It was reported that this summit was of a different tone and involved a much wider stakeholder group with the question from NHSE/I of what could the system do to make a sustainable difference to the quality and safety of care at SaTH to enable the CQC to consider whether the actions listed in the report were actions it should be considering.
- 10.5 Following the CQC visits, SaTH immediately put in place an action plan to strengthen safety over the weekend of the EDs. Mrs Morris and Joe Allan, Head of Quality, conducted unannounced visits over the weekend of 22-23 February to test out that plan to see in real time whether the steps SaTH had said it was going to do were in place.
- 10.6 CQC concerns remain around appropriate paediatric cover at the two EDs, which was a feature of SaTH's action plan but unfortunately had not been in place during Mrs Morris' unannounced visit to PRH, which was shared and discussed at the risk summit. UHNM have immediately stepped in to support SaTH and there have been some positive actions from providers around the border to support SaTH.

Peer support has been put in place for a consultant workforce from RWT, which will be reviewed at a further risk summit held in the near future. The risk summit will also discuss whether the actions that have been put in place will provide the assurance that care is safe and effective in the EDs. The CQC had been very clear that what they had witnessed was poor care and that SaTH needed to implement the changes. It was really positive that SaTH's new Chief Executive had been committed and very open and transparent to move this work forward.

- 10.7 The Safety Oversight and Assurance Group (SOAG), which has been in operation over the last 12 months and at which members of the Executive Team have been in attendance, had not delivered the improvements that had been expected. Therefore, the April meeting was being stood down and a System Improvement Board (SIG) would be established to oversee the improvement plan and actions that were going to be put in place. It was very clear that the onus was on all system partners to make the difference to support SaTH as well as SaTH reviewing their internal processes and procedures and monitoring and sustaining that for patient care.
- 10.8 Dr Lynch noted that on page 4 of the report, it stated that the unannounced weekend visit to both SaTH's EDs had concluded that paediatric nurse cover was not in place at PRH and that the audit outcomes from records reviewed continued to align with the CQC's previous findings. Dr Lynch asked that given the measures that the CQC was considering, how likely was it that those restrictions would be imposed.
- 10.9 Mrs Morris referred to the previous discussions which had considered the overnight closure of the ED at PRH. At that time there had been much public discussion and a lot of work carried out to consider whether the closure of the ED was the safest option for the local population. The decision had been not to close the ED at PRH because medical staff had been found to support the service. One of the actions had been to revisit that plan to see whether that was something that should be considered. The CQC had been very open and wanted to see the progress made before making any decisions for the future.
- 10.10 Dr Povey said it was a difficult decision when such a move involved the patients and neighbouring trusts and there was no easy answer. Dr Povey referred to page 4, paragraph 6.0, bullet point 1, where it stated that in the ED currently there were four substantive ED consultants in post supplemented by a locum workforce and there were mitigating actions in place. Dr Povey highlighted that the previous discussions had talked about tipping points and that having four ED consultants was well below the tipping point.
- 10.11 Mr Timmis said that he understood the points made but considered the report showed a deteriorated position and highlighted that poor care actually caused harm to patients. It was accepted that some of the actions imposed on SaTH might cause problems for other parts of the system, however, Mr Timmis asked what the CCG could do to protect the interests of the patients of Shropshire, Telford and Wrekin.
- 10.12 In order to improve the poor care, Mrs Morris said it was for individuals to accept the accountability of the care they delivered to patients. Mrs Morris accepted that no member of staff attended work with the intention of not to do a good job but it was really important that every member of staff working in the ED took responsibility for the care that they delivered to patients. It was accepted that staff did do this but sometimes when staff were under pressure, processes were not always followed through, examples of which Mrs Morris had witnessed on her weekend visit to SaTH.
- 10.13 Good practice had been shown in the audit process that SaTH had now put in place to audit sets of records in real time and to go back and to discuss those caring for patients at that time what had been found and actually how they can improve their documentation or their practice through that process. The real time feedback therefore was a really good way of improving the culture of improving standards. This work was seen in practice, which was a really positive endorsement of the work that SaTH had started to do.
- 10.14 Mr Leaman referred to the suggestion of RWT and UHNM assisting SaTH and asked what assistance might develop, for example, would the trusts be responsible for staffing SaTH's ED departments.
- 10.15 Mrs Morris confirmed that discussions were in progress with the respective Chief Executives of the trusts looking at supporting SaTH across a number of specialties.
- 10.16 Dr Pepper referred to the third bullet point in Section 3.0 where it stated that the CQC was considering imposing a condition which would restrict the number of ambulances being conveyed to one or both of the EDs. Previous assessments had been considered on whether both sites would remain open which had other consequences. Dr Pepper asked if this point had been raised as a result from a request by SaTH to be considered or was it generated as a potential solution by CQC in relation to the Section 31 breaches. If this was the case, how far had that idea been progressed and had it been modelled in any way.

- 10.17 Mrs Morris explained that when the ambulance service was under pressure it was known that patients were conveyed to the most appropriate ED for their care. The ambulance service was being encouraged to look at where they were conveying patients and this was a standard procedure for the CQC to look at for any trust in this position. It may be that ambulances would go to just one site and not to both sites as currently. The CQC was waiting for the system to set out alternatives before it considered imposing any of the actions.
- 10.18 Dr Shepherd highlighted that the Governing Body had been briefed for a long time about the issue of the number of ambulance conveyances, which had worsened. There also seemed to be repeated reference to what the system could do to ease the situation but a lot of the work needed to be carried out by SaTH because the actions were specific to SaTH and this did not seem to happen. As an example, there had been no paediatric trained nurse on duty at all times in the ED. The system was supporting SaTH but the organisation seemed to have a learned helplessness that needed to change.
- 10.19 Dr Povey referred to the report presented at the last meeting which had contained a list of completed actions, which SaTH had said had been completed. Following the CQC visits carried out, it was known that the list of actions had not been completed and the CCG was now looking at measures to place responsibility on individuals. Dr Povey viewed that it was not the fault of the individuals; they had a professional duty as healthcare workers to act within their professional responsibilities but ultimately they had been placed in difficult situations. Dr Povey voiced concern about how this would affect staff morale, the workforce and the CCG was part of that assurance process. It was admitted that the CCG would like to see change at SaTH but in order to do this the CCG should be looking at the leadership, capacity and capability within SaTH to bring about change, to embed change and to learn from its mistakes.
- 10.20 Mrs Morris highlighted that the CQC had said that a lot of the issues that were found were for SaTH to address. SaTH had acknowledged those points and had got policies and procedures in place but it had been evident that those protocols were not being followed. The reference to individual practice was that SaTH needed that leadership at every level in the organisation to ensure that the protocols and policies for safe and effective care were being put into use every day by every member of staff.
- 10.21 Dr Povey pointed out that one element of the CQC reports is the well-led section and asked if there was any indication as to the current rating for well-led. Mrs Morris confirmed that the feedback on this point was still awaited. SaTH would shortly be receiving a copy of the CQC report to check for accuracy and it was expected to be published once it was agreed.
- 10.22 Dr Povey referred to the positive reports previously received to the Board that had stated that SOAG was effective and there had been improvements in the service. However, following the visits conducted by the CQC and Mrs Morris' visit it was seen that there had been no improvement. Dr Povey asked if there was an understanding why the CCG had been told there had been improvements when it was evident there had been no improvements.
- 10.23 Mrs Morris reported that Mr Evans had written to NHSE/I to ask how the CCG could work more effectively with the regulators to receive more robust assurances because what was being discussed and presented in the SOAG was not always what was seen in practice.

RESOLVE: The Governing Body NOTED the content of the report and further assurances that may be required for wider system input.

Minute No. GB-2020-03.034 – Maternity Update

- 11.1 Mrs Ellis presented the Maternity Update report, which included the up-to-date positions on a number of key programmes relating to Maternity. The CCG continued to work closely with SaTH as the maternity provider as well as other providers to deliver progress on improvements across the maternity services. The report summarised the current position in relation to: The Ockenden Review; Transforming Midwifery Care; the Local Maternity System; and the CCG Assurance Processes. Maternity services were continuing to be under scrutiny and it was having an effect on the wider transformation programmes.
- 11.2 Dr Leaman noted that data had been provided at a recent Quality Committee meeting, which was of concern. The data had shown that there had been a few serious incidents in Maternity in December and SaTH's caesarean rate was still below national average. Dr Leaman asked what measures was the CCG applying to assure itself that SaTH's maternity care was improving and what did those measures show.
- 11.3 Mrs Ellis reported that the CCG had recently undertaken a quality assurance process as well as a programme of scheduled visits and an unannounced visit. There was also the Contract Quality Review Meeting (CQRM), where a broad range of information of maternity services was discussed, which also included SaTH's strengths and assurance of services. The CCG was working with SaTH to look at

different ways of reporting. More recently the CCG had secured the support from an experienced midwife to provide expert advice across the CCG's quality assurance processes for maternity services.

- 11.4 Dr Leaman queried how the CCG was measuring patient satisfaction. Mrs Ellis confirmed that patient satisfaction had been measured from a recent CQC questionnaire and there had been feedback received from the maternity services partnership through the local maternity system. The CCG was also in the process of recruiting a number of volunteers who would be routinely gathering information from across the county. Following a recent unannounced visit, it had been found that a number of families had been overwhelmingly positive about the services they had received.
- 11.5 Mrs Porter appreciated that there had been a delay but queried whether there was a timeline when the national panel might approve the transformation of care. Mrs Ellis reported that the CCG continued to follow-up through the regional team at NHSE/I to understand what the timeline might be.
- 11.6 Mr Timmis reiterated the point that the amount of time it was taking to receive an answer from NHSE/I, was unacceptable. Mr Timmis asked if a formal communication could be sent to NHSE/I from the Governing Body expressing its concern of the delay to try to move to the next stage of the Transforming Midwifery Care programme because this impacted on the CCG implementing improvements that affected the operation of the service across the whole area. Mr Timmis referred to feedback received from the CQC patient satisfaction survey where it described SaTH as being: 'among the pack' and given the circumstances, this was considered a really positive result and reflected on the whole of the team across SaTH, which should be recognised.
- 11.7 It was agreed that Dr Povey would write a letter to NHSE/I expressing the Governing Body's frustration in the delay in the time it was taking to receive confirmation of the proposals submitted to the national panel, which was originally scheduled for 28 November 2019, but no further information or a new date for a meeting of the national panel had been forthcoming.
- 11.8 Dr Povey queried the current status of the smoking cessation in pregnancy service moving forward into the next financial year.
- 11.9 Mrs Ellis confirmed the smoking cessation in pregnancy service was a key priority for the Local Maternity System (LMS). It currently was the responsibility of the local health authority to provide that service but in the long-term plan there was a suggestion that it would be NHSE/I's responsibility to commission that service. Discussions were taking place across both providers and commissioners. There was no resolution at present to smoking cessation provision but the LMS continued with the transformation activity around enhanced services for smoking cessation, including some social prescribing projects, up-skilling midwives, and providing training with a broad range of professionals.
- 11.10 Dr Matthee sought confirmation that the smoking cessation service was still being supported by the local authority. Mrs Ellis explained that at the present time, Telford and Wrekin Public Health continued to fund a post for Telford and Wrekin women. There was also presently a smoking cessation service for Shropshire women but that service was now at risk.
- 11.12 Dr Davies further clarified that it had been agreed that notice would be served and the service would continue for this current year. It had been the plan that an agreement would be reached about how the service would then be recurrently provided. An agreement had so far not been reached and so at present the service was in place until the end of March. Dr Davies understood that the local authority had agreed to continue to fund the community element of the service but the funding for the acute service was still to be agreed. It was understood that the Telford and Wrekin smoking cessation service had now been served notice and that service was also at risk from 1 April.
- 11.13 Mrs Morris reported that Mr Evans was in the process of writing to both local authority managing directors to gain a clear position from them to see how they can work together to provide this service. The CCG had also put in a challenge through the LMS escalation process to say that it did state in the long term plan that women should be able to access NHS funded smoking cessation services and it was hoped funding would follow that pledge and the CCG would be awaiting a response.

RESOLVE: The Governing Body NOTED the content of the report and AGREED to RECEIVE further updates at future Governing Body meetings.

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

Minute No. GB-2020-03.035 – Shropshire CCG Strategic Priorities Update

- 12.1 Mrs Skidmore presented the paper circulated, which gave the latest update on the strategic priorities that had been agreed at the start of the financial year, to which had now been added a high level Key Performance Indicator (KPI) to each of the areas. Mrs Skidmore took the paper as read and the discussion was opened to questions based on the content of the report.
- 12.2 Mrs Porter referred to the programme of transformation of planned care services, in particular for MSK services, and asked if the CCG was confident about the timeline for that service for 1 September.
- 12.3 Dr Davies confirmed that the CCG was as confident as it could be at this stage. Originally the providers had suggested a timeline for 1 July, which had felt too optimistic. Now that the plans had been reviewed in more detail, and the Alliance Group was expecting to hear the details of those plans at its next meeting, the collective view had been that the timeline for the new single model of care would be 1 September, which appeared to be a more realistic date.
- 12.4 Dr Sokolov reported that the Case Management pilots had shown much more robust data in the last week. This data would be presented to the Clinical Commissioning Committee (CCC) meeting, following which the CCG could share the data more widely once it had been tested. The evidence so far had been impressive and the project had been rolled out to 8 of the 53 practices. Currently 42% of the eligible patients had consented for case management and once the process had been tested, whilst recognising IT limitations, this percentage could be increased. There was a large capacity for significant impact of helping people stay well at home and to ensure that they did not need secondary care services as much as they were currently. Dr Sokolov had since been informed that a further 8 practices had agreed to be involved in the next phase, which was really positive news.

RESOLVE: The Governing Body NOTED the progress against the CCG's strategic priorities including the inclusion of a single high level KPI for each priority.

GOVERNANCE & ENGAGEMENT

Minute No. GB-2020-03.036 – Single Strategic Commissioner for Shropshire and Telford and Wrekin Update Report

- 13.1 Miss Smith presented the progress report on Shropshire CCG's and Telford and Wrekin CCG's application to become a Single Strategic Commissioner for Shropshire and Telford and Wrekin from April 2021 across the Shropshire and Telford and Wrekin footprint. The report was taken as read and the following points were highlighted:
- 13.2 Re: Paragraph 2.3 - Public Engagement. It was confirmed that the CCGs had undertaken the public engagement to seek the views of the public on the proposals to create one single CCG. The forms of engagement had included: a launch event; an online survey, which had also been completed in hard copy; and a number of pop-up events had been held across the Shropshire and Telford and Wrekin area.
- 13.3 The CCG was, at present, collating the responses from the survey and also the feedback received from the face to face discussions with the public. The general themes were being taken from the 71 completed surveys that had been received. The themes were that there was general support across all of the areas of Shropshire, Telford and Wrekin. There had been recognition that it was efficient for the CCGs to look internally at ways to achieve the savings required of them. Concerns had been raised, however, about whether there would be any impact on patients, directly or indirectly. Miss Smith suggested that the CCGs needed to respond very strongly in response to this concern stating that, as far as the CCGs were concerned, it was understood the proposals would not impact on patient care.
- 13.4 A further concern raised from some rural populations, for example, in Ludlow and Whitchurch and areas in Telford and Wrekin, was that the people's voice and their needs would become lost in a larger CCG. Miss Smith suggested that this was a further area where the CCGs needed to respond to explain that the CCGs would be able to ensure using a population health management approach that the health services that they commission in future would be based on patient need and would not be affected by where people currently live, whether in a rural or urban setting.
- 13.5 Re: Paragraph 2.9 – CCG Constitution. Specific changes to the current constitution of Shropshire CCG had been outlined in the report. Members were reminded that these changes had been agreed at the last Governing Body meeting held in January and had since been submitted to NHSE/I for ratification. NHSE/I had highlighted that the current CCG Constitution did not meet recent NHSE/I guidance on the decision-making ability and the chairing arrangements for the Remuneration Committee. This guidance stated that the Remuneration Committees should not be making decisions and could only make

recommendations to the Governing Body who would then make a decision based on the recommendations. The Audit Committee Chair also needed to be separate from the Remuneration Committee Chair and therefore the guidance stated that the Audit Committee Chair could not also chair the Remuneration Committee.

- 13.6 Miss Smith sought the Governing Body's approval of the amendments to the current CCG Constitution as outlined by the track changes marked in red included in Appendix 1.
- 13.7 Dr Povey thanked Mr Timmis for the work he had undertaken as Chair of the Remuneration Committee. The Remuneration Committee meetings would in future be chaired by Mrs Sarah Porter, Lay Member for Transformation.
- 13.8 Following the engagement work undertaken, Dr Povey sought clarification of the next steps.
- 13.9 Miss Smith explained that presently the CCG was collating the feedback for the engagement report and would be responding to the feedback received. This information would be included in the suite of documents that would be submitted to NHSE/I as part of the application process. It was proposed that the Engagement Report once finalised would be published on both CCGs' websites for transparency so that the public could view the feedback given and how that feedback was being used.

RESOLVE: THE GOVERNING BODY:

- ***NOTED the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin.***
- ***APPROVED the proposed amendments to the CCG's current Constitution to ensure that the terms of reference for the Remuneration Committee meet recent legal advice and best practice.***
- ***SUPPORTED the planned re-application to NHSE/I on 30 April 2020 to create a single CCG across the footprint of Shropshire, Telford and Wrekin.***

Minute No. GB-2020-03.037 – Emergency Preparedness, Resilience and Response (EPPR) Update

- 14.1 Mrs Tilley presented the paper previously circulated, which was taken as read. Mrs Tilley gave an overview of the local preparations to respond to the coronavirus outbreak.
- 14.2 The CCG have been following national guidance, which has been developing very rapidly as the situation evolves. It had responded to all the requests within that guidance in terms of local response arrangements and there was currently an assessment of quality in place at both hospital sites. Home testing arrangements were in place and there would be drive through testing available at Shrewsbury and plans were being implemented at Telford. An assessment would be undertaken as to whether there would be a need to roll out the drive through testing across the county.
- 14.3 The CCG had escalation arrangements in place with its providers should it need to implement that following government advice; therefore the CCG was in a good position locally in terms of its ability to respond.
- 14.4 It was reported that to date there were two confirmed cases of coronavirus within the Shropshire area, both of which had recently travelled from Italy; the cases, however, were not connected. The CCG was in contact with PHE who was carrying out the necessary contact tracing and support for these individuals in order to ensure that the impact is minimised.
- 14.5 Mrs Tilley felt it was important to reiterate that the UK was in line with international trends. It was likely there would be an escalation of people presenting for testing, although to date, the numbers presenting have been low and people should not be alarmed by this. If somebody presented for testing that did not mean they were a positive case. Positive cases were being looked at quickly and there were developments in place to ensure that positive results can be established within 24 hours. At present, the results were taking slightly longer than this.
- 14.6 The Governing Body and the public were assured that the situation currently in Shropshire was low risk. The CCG did expect the situation to evolve in the coming days and weeks and would continue to publish updates for the public and internally for staff. The message was reinforced that the best method for people to protect themselves was to practice regular hand hygiene.
- 14.7 The paper presented set out the range of partners that had been involved in the Local Health Resilience Partnership (LHRP) forum, which co-ordinates planning for emergencies impacting on the health of the local population. The LHRP had been mobilised and was meeting twice weekly in order to manage the situation as it evolves. The LHRP was in regular contact with system partners about their involvement in

the co-ordinated response. The Forum was therefore working very closely particularly with SaTH and Shropshire Community Health Trust (SCHT) and were fully involved in the assessments and testing arrangements that were being rolled out locally. Discussions were also taking place with the care homes sector and out of hours providers, to ensure that there was a fully co-ordinated service to respond to the coronavirus outbreak, which could be escalated in line with national guidance should there be a need to.

- 14.9 At the present time, the local position was that presentations for testing and the numbers of positive cases were very low and the response therefore was proportional. The CCG was in a position to escalate its response if it needed to do but was very much relying on business as usual until such time the guidance changed.
- 14.10 Dr Povey emphasised that patients were asked not to attend the medical centres, i.e. Minor Injury Units (MIUs), the EDs or the GP surgeries. The key message for patients was to consult the NHS 111 website or telephone NHS 111. Referrals into the assessment pods, community home testing, or drive through testing is all made through NHS 111 who will make an assessment as to whether patients need to self-isolate or be tested. Until such time there is a confirmed positive outcome, patients will be treated as a negative case. There is a list of countries that if patients have travelled back from will need to self-isolate, which currently include: Italy, China, parts of South Korea. Guidance for professionals was available on the government website.
- 14.11 Dr Leaman asked whether the Robert Jones and Agnes Hunt Orthopaedic Hospital (RJA) had been asked to consider how it might be able to help both in terms of bed capacity and aesthetic professional support for intensive care at SaTH. Mrs Tilley confirmed that RJA was engaged in discussions, particularly as the process was moving into a phase of looking at multi-agency work to ensure the appropriate response is embedded.
- 14.12 Mr Vivian highlighted that there was always a risk of imprecise information being leaked, which could lead to people acting on a misconception. Mr Vivian asked if the flow of information from other sources was being monitored.
- 14.13 Mrs Tilley advised that the CCG was attempting to monitor the flow of information within reason and was aware that there was a certain amount of misinformation that was circulated. The CCG was trying to counteract that with more official information that it circulated, and also from the local authority, to ensure that that information reiterated national guidance and pointed people in the right direction to obtain the appropriate evidence based advice to support their concerns.
- 14.14 There was now a more centralised route for the CCG to feed up to NHSE/I any issues in relation to social media that the CCG was concerned about around misinformation. It was stressed that people seeking up-to-date accurate information about the coronavirus epidemic should not visit social media channels but to consult the NHSE, government and Public Health England official websites.

RESOLVE: THE GOVERNING BODY:

- ***NOTED the content of the report, in particular the continued rating of Full Compliance; and***
- ***SUPPORTED an on-going programme of EPRR work to ensure the Full Compliance rating can be maintained.***

Minute No. GB-2020-03.38 – Audit Committee – 26 February (summary)

- 15.1 Mr Timmis presented the Audit Committee summary report, which was taken as read, and focussed on the following key points:
- It had been very encouraging to receive two more internal audit reports that confirmed significant assurance, which had shown a continuation of improvements in the CCG.
 - The draft plan from internal audit for the next financial year had been received but the Audit Committee had expressed some concerns about some of the changes that were contained within the plan. The Audit Committee had requested a review of this by the Lay Members to ensure that the plan meets all the issues that the Members consider needs to be covered. An updated version of the plan was expected to be presented to the next Audit Committee meeting in April.
 - The Audit Committee approved the external audit plan for the current year's accounts and there were no further concerns to report on at the present time.
 - The national fraud initiative was now complete and no incidences of fraud had been identified. This should give the CCG assurance about the processes that it had in place had made the organisation safe from risks of fraud.
 - The Audit Committee had agreed that it would no longer require reports on the approval process for interim staff. Members were reminded that the approval process had been introduced following concerns received from NHSE/I about whether the CCG prepared business cases at the appropriate

time and whether it was following all the rules. The Audit Committee was now assured that the number of interim staff had reduced dramatically and all the evidence showed that the process had been effective. It had been agreed, therefore, that this would still be an area that the Finance and Performance Committee would be sighted on and if there were concerns then this would need to be referred back to the Audit Committee to consider whether the CCG should reintroduce the approval process.

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

FOR INFORMATION ONLY/EXCEPTION REPORTING

Minute Nos. GB-2020-03.039 to GB-2020-03.046

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

- Clinical Commissioning Committee – 20 November, 22 January
- Finance & Performance Committee – 27 November 2019, 9 January, 29 January
- Primary Care Commissioning Committee – 4 December
- Quality Committee – 27 November
- System A&E Delivery Board – 19 November
- North Locality Board – 28 November, 23 January
- Shrewsbury & Atcham Locality Board – 21 November, 16 January
- South Locality Board – 6 November

16.2 There were no questions raised.

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

Minute No. GB-2020-03.047 – Any Other Business

17.1 Mr Vivian asked if everyone present could give Dr Sokolov and Mrs Morris a round of applause for all the work they had carried out on behalf of the CCG.

17.2 There were no further items raised.

DATE OF NEXT MEETING

It was confirmed that the next Governing Body meeting that was open to the public was scheduled to take place on:

- Wednesday 13 May 2020 – venue and time to be confirmed.

SIGNED **DATE**

Shropshire Clinical Commissioning Group

ACTIONS FROM THE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING – 11 MARCH 2020

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2020-03.028 – Minutes of Previous Meeting	Mrs Stackhouse to make the agreed amendment to the draft minutes as noted in paragraph 5.1.	Mrs Sandra Stackhouse	Complete	18.03.20
GB-2020-03.029 – Matters Arising [GB-2020-01.005 – Ambulance Deep Dive – Progress Update]	Mrs Morris to forward the progress update received from Mrs Fortes-Mayer to Mrs Stackhouse to circulate to Members for information.	Mrs Christine Morris / Mrs Sandra Stackhouse	Complete	19.03.20
[GB-2020-01.010 – CCG Strategic Priorities]	Dr Davies to bring back a progress report on the MSK Alliance Agreement to the next formal meeting in May.	Dr Julie Davies	Next meeting	Deferred to next meeting
[GB-2020-01.015 – Healthwatch Shropshire Report]	Ms Cawley to be contacted to confirm whether HWS had received CCG support with the communications process for their event on 4 March and with writing their report on Access to Primary Care.	Mrs Sandra Stackhouse	Complete	29.04.20
GB-2020-03.034 – Update on Transforming Midwifery Care	Dr Povey/Mr Evans to write to NHSE/I expressing the Governing Body's frustration that it had not received further information on the proposals submitted for consideration by the national panel.	Dr Julian Povey / Mr Dave Evans	As soon as possible	

**Submitted Questions by Members of the Public
 for the Governing Body meeting 11 March 2020**

Name Date & Time	Submitted Questions	CCG Summary Response
Gill George	<p>Maternity</p> <p>1 A CCG answer to a public question in January 2020 noted <i>'More recently, the CCGs have initiated a refreshed quality assurance process for maternity services'</i>. What does this consist of?</p>	<p>As well as continuing to work closely with a number of health partners, including the Shrewsbury and Telford Hospital NHS Trust (SaTH), Care Quality Commission (CQC), NHS England/Innovation (NHSE/I) and patient groups to triangulate information relating to the quality and safety of maternity services provided by SaTH in order to gain assurance in relation to the quality and safety of maternity services, the CCG has secured the support of an experienced midwife to provide expert advice across the CCGs quality assurance processes for maternity services.</p> <p>A maternity focused Clinical Quality Review meeting (CQRM) is held each month, chaired by the CCG Executive Nurse and attended by senior clinical staff from SaTH's maternity services team.</p> <p>The CCG also has in place a programme of Quality Assurance visits that take place throughout the year. Members of the CCG quality team, including the midwife advisor, visit each maternity setting over the course of a year. Each visit looks at a number of different factors including: clinical effectiveness; staff experience; patient safety and also incorporates a patient experience perspective through '15 steps to maternity' co-ordinated by the Maternity Voices Partnership.</p> <p>The CCG attends the monthly Safety Oversight Assurance Group (SOAG) meetings at SaTH that are chaired by the regional medical director for</p>

Name Date & Time	Submitted Questions	CCG Summary Response
		<p>NHSE/I and health partners, including Health Watch. The SOAG is a forum for SaTH to present updates on actions and progress being made towards improvement. The SOAG also gives health partners the opportunity to raise concerns or seek further assurance.</p> <p>The CCG investigate all serious incidents that are reported by SaTH in accordance with the NHS England (2015) Serious Incident Framework and the CCG will source the opinion of appropriate clinical experts. Action plans to address learning identified are monitored through the monthly clinical quality review meetings. The CCG quality assurance visits are used to ensure that the implementation of learning reported to CQRM is taking place in practice.</p> <p>Should the CCG identify a particular concern, unannounced quality assurance visits can be undertaken at any time.</p> <p><i>Mrs Christine Morris, Executive Director of Quality</i></p>
	<p>2 SaTH participates in the Maternity Incentive Scheme run by NHS Resolution. In June 2018, SaTH submitted a '10 out of 10' self-assessment of the safety of its maternity service. SaTH's submission was approved, and it was awarded just under £1 million on 10th September 2018. On 12th September 2018, SaTH was notified by the CQC of urgent enforcement action to be taken because of the CQC's serious concerns regarding maternity service safety.</p> <p>Was the CCG aware of SaTH's submission to the Maternity Incentive Scheme? Aware of SaTH's success in accessing funding because of its self-assessment of a safe service? Aware of the urgent enforcement action by the CQC (notified to the Trust on 12th September 2018 and made public on 19th September)?</p>	<p>The CCG was aware of SaTH's submission to the maternity incentive scheme and associated funding received. The CCG was also aware of the urgent enforcement action required by the CQC.</p> <p><i>Mrs Christine Morris, Executive Director of Quality</i></p>

Name Date & Time	Submitted Questions	CCG Summary Response
	<p>3 Did the CCG, between June and September 2018, question or challenge SaTH's Maternity Incentive Scheme self-assessment of the safety of its maternity service? Did the CCG subsequently raise with SaTH any concerns regarding the accuracy of SaTH's self-assessment? (The Board will know that SaTH has recently acknowledged that an 'incorrect submission' was made and will be repaying the money).</p>	<p>The CCG questioned some elements of the self-assessment in June 2018. Mrs Christine Morris, Executive Director of Quality</p>
	<p>4 SaTH no longer publishes its Maternity Dashboard (although the information is of course collected and submitted to NHS England). It is therefore now impossible for the public to access timely information on the safety of the local maternity service, including stillbirth and neonatal death rates. Will the CCG ask SaTH to share its Maternity Dashboard on a quarterly basis, as it did for many years?</p>	<p>This request needs to be asked of SATH as they are the owners of this information and not the CCG. Mrs Christine Morris, Executive Director of Quality</p>
	<p>SaTH Quality Report .033</p> <p>5 The report before you today notes: <i>The CCGs Executive Director of Quality and Head of Quality carried out unannounced visits to both emergency departments on the weekend of 22nd and 23rd February to test if the immediate actions put in place by the Trust were being enacted to manage patient safety, privacy and dignity. The outcome of this was that paediatric nurse cover was not in place at PRH and the audit outcomes from records reviewed continued to align with the CQC's previous findings.</i></p> <p>Can the CCG elaborate on what was meant by this, and what the consequences were/are for patient care?</p>	<p>The CQC said the Trust must ensure that there is an effective system in place to identify, escalate and manage all service users in line with the relevant national clinical guidelines who present with possible sepsis or a deteriorating medical condition. Non-compliance with the Trust's own protocol was seen on the visit.</p> <p>There should be effective management of service users under the age of 18 through the emergency care pathway – there was no trained paediatric nurse working on the Princess Royal Hospital (PRH) site on the 22nd February.</p> <p>The audit of the proportion of patients receiving a full set of observations on arrival at the Emergency Department showed deviation from the Trust's protocols.</p> <p>The impact of the above is potential delay in the management and treatment of a presenting person or one whose condition is deteriorating. Mrs Christine Morris, Executive Director of Quality</p>

Name Date & Time	Submitted Questions	CCG Summary Response
	<p>Joint HOSC</p> <p>6 The Chair of the Joint HOSC on 2nd March raised with David Evans a proposed protocol for joint working with NHS bodies, reflecting long-standing concern from the Joint HOSC around a lack of access to timely written information to enable it to carry out its scrutiny role effectively. Has the proposed protocol now been seen by the Accountable Officer and by the CCG Governing Body? Will the CCG agree to abide by the protocol?</p>	<p>Yes the proposed protocol has been seen by the Accountable Officer. It will be shared with Board members so they are aware, but it is a method of working between the local NHS and Joint HOSC. The CCG has been asked to feedback comments and that will take place this week.</p> <p>Mr David Evans, Accountable Officer</p>
Pete Gillard	<p>Finance & Future Fit</p> <p>1 Shropshire CCG was given a control total of £12.3m deficit for 2019/20, but set its own plan for £22.9m deficit. The prediction is now for an in-year deficit of £47.3m (a variance from plan of £24.4m, and close to four times the NHSE target).</p> <p>What was the cumulative deficit for the CCG at the start of this financial year, and what is the predicted cumulative deficit for the end of the financial year 2019/20?</p>	<p>The cumulative deficit brought forward into 2019/20 for SCCG was £76.7m. This will be £124m by the end of 2019/20 (£76.7m+£47.3m in year).</p> <p>Mrs Claire Skidmore, Executive Director of Finance</p>
	<p>2 The largest area of overspend for the CCG is acute services, driven by steadily increasing demand. (The predicted overspend on acute services is £16.6m this year.) The Future Fit Clinical Model was finalised in May 2014, with its work informed by 2013/14 data. Comparing 2013/14 data with the predicted out-turn for 2019/20:</p> <ul style="list-style-type: none"> • By what amount and by what percentage has CCG spending on acute services increased, comparing 2013/14 spend with 2019/20 (forecast spend)? • If available: for the Shropshire CCG population, what is the increase in emergency admissions to SaTH or more generally to acute services for that same period? Again, a comparison between 2013/14 data and 2019/20 data (forecast emergency admissions), with the answer showing the change in numbers and percentage change. If forecast emergency admissions are unavailable for 2019/20, I am happy to accept the most recent 'year-to-date' data. • By what amount and by what percentage has spending on out-of-hospital services increased, again comparing 2013/14 data with 2019/20 data (forecast spend)? • How many acute admissions does the CCG estimate have been avoided in total in that six year period as a direct result of the CCG's development of care closer to home/ out of hospital services? 	<p>Our expenditure is detailed in the CCGs annual accounts which are published on the CCGs website.</p> <ul style="list-style-type: none"> • Acute spending has increased in the period in question • Emergency admissions to SATH over the period have increased in percentage terms in line with spend • Spending on Community services has also increased over the period • We have early evidence that our initial acute admission avoidance schemes are successful in reducing non elective activity though as roll out is not yet complete we are unable at this time to assess the full impact. <p>Mrs Claire Skidmore, Executive Director of Finance</p>

Name Date & Time	Submitted Questions	CCG Summary Response
	<p>3 David Evans told the Joint HOSC of 2nd March that 70% of savings from avoided hospital admissions will be invested into community services. What will that '70% of savings' amount to in 2019/20 (forecast amount)? What does CCG modelling show as the '70% of savings' figure for community investment in the coming financial year, 2020/21?</p>	<p>The CCG has always been clear that providing care closer to home will require further investment in community services and has always used figure of 70-80% as an indicative level of investment. The Pilot Care Closer to Home project will enable the CCG to more accurately test the level of investment required Mr David Evans, Accountable Officer</p>
	<p>4 The Future Fit model of course depends on improving population health through investment in prevention and in out of hospital services, and on achieving a considerable 'left shift' of care from acute to community settings. After six years of work, is this necessary system change on track to succeed? What are the consequences for out of hospital care and for population health if implementation of the Future Fit model strengthens even further the existing local focus on acute services and acute spending?</p>	<p>The CCG and system partners are working to make sure that the assumptions included in the PCBC for Future Fit are right. Pilot schemes are in place and this will help inform how rapidly these can be rolled out and the benefit to patients. Mr David Evans, Accountable Officer</p>
	<p>5 The public has been advised that the Future Fit/Hospital Transformation Programme SOC cannot be shared until it has completed its journey through the NHSE/I assurance process. This is at odds with previous practice around key Future Fit documents (with the PCBC, for example, going very publicly through 31 different versions). Was there an instruction or directive from NHSE/I that the current SOC cannot be released until it has been approved by them? If so, is there documentary evidence of this instruction, and can this be shared? If there is no documentary evidence, can the CCG share who in NHSEI issued this instruction, and when? The concern here is that key information and key decisions around a troubled project are being made behind closed doors, with no possibility of public scrutiny.</p>	<p>The position on the SOC has been explained on a number of occasions both at Boards and to the Joint HOSC. Mr David Evans, Accountable Officer</p>

Agenda item: GB-2020-05.055
Shropshire CCG Governing Body meeting: 13.05.20

Title of the report:	Governing Body SCCG Performance & Quality Report 2019/20
Responsible Director:	Julie Davies, Director of Performance Zena Young, Chief Nurse
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Purpose of the report:

To update the governing body on the CCGs key quality and performance matters for 2019/20 against the key performance & quality indicators that the CCG is held accountable for with NHS England. This overview provides assurance on performance achievement against targets/standards at CCG, the quality of our commissioned services at provider level as appropriate, and the delivery and contractual actions in place to address areas of poor performance & quality.

Key issues or points to note:

The attached report is our integrated quality and performance reporting for the CCG and sets out Shropshire CCG's performance against all its key performance & quality indicators for Month 11 and 12 where available for 2019/20.

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

62 day RTT
31 day where subsequent treatment is surgery or radiotherapy
A&E 4hr target
Ambulance handovers >30mins and >1hr
RTT
Diagnostic waits

The 2wk Breast Symptoms was achieved in February and March. The 62day RTT is still not achieving and the overall trajectory for the recovery of 85% 62day RTT target submitted to NHSE/I is based on the on-going impact of Urology. On-going clearing of the backlog will keep this measure below target for the foreseeable future.

Further improvement remains dependent on the wider joint working with UHNM and the region on Urology. The overall position on cancer is improving and the improvements linked to cancer alliance work and optimized pathways is now having a positive impact on the cancer care delivered in Shropshire.

The merging impact of the Covid 19 emergency will need to be factored in to the forward planning for delivery of cancer and other services. . The CCGs overall cancer performance is also affected by out of county providers and this is continually progressed through the corresponding lead commissioners via our contract team with support as required from NHSI & NHSE.

The increased IAPT access target run rate of 22% in place for 2019/20 has slipped in February and now may just miss the annual target as a result of the impact of the Covid 19 situation. There were 4 serious incident reported by MPFT in February and these are being reviewed through the Quality monitoring structures.

A&E performance has improved in March albeit with considerably lower levels of activity in the second half of the month. Demand for Shropshire remains above plan YTD although ambulance conveyances have shown a decrease in numbers since the start of the calendar year even before numbers were impacted by the Covid situation in the second half of March. Transformation work in this and a number of other areas has suffered a temporary pause while services adjust to changing working arrangements arising from Covid 19. Workforce levels and increases in demand are the main issues although middle grade workforce has shown some signs of improvement but again will be impacted by restrictions on movement influencing the ability of new staff to take up posts. The Quality team continues to make daily visits to both sites while they are at heightened escalation levels to ensure care of patients on trolleys is being maintained at the highest levels.

The CCG has continued to fail the RTT target YTD as a result of emergency pressures at SaTH and on-going escalation into both sites Day Surgery Units. In addition the non admitted performance is now being impacted by the reduction in waiting list clinics being delivered due to the consultant pension tax issue. The impact of Covid 19 on waiting times and numbers is currently being assessed and will be factored into recovery plans for the restoration of key service levels. There were no 52 week wait patients reported in February.

The 99% Diagnostics wait target was also breached and is not expected to recover until the new financial year as a result of clearing the identified backlog and some further capacity issues

Actions required by Governing Body Members:

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

GOVERNING BODY
PERFORMANCE AND QUALITY REPORT
May 2020

1 INTRODUCTION

- 1.1 This performance and quality report provides an overview of the key performance indicators (KPIs) that the CCG is held accountable for with NHS England during 2019/20. Many of these are part of the CCG's NHS Oversight Framework (NHS OF) for 2019/20.
- 1.2 The monthly data reported is for February and March 2020 where data is available. March data is likely to be impacted by the on-going Covid 19 situation and this will clearly impact on measures going forward into the 2020/21 financial year.
- 1.3 Some of the CCG NHS Oversight Framework indicators have been updated where new data has been made available.
- 1.4 The oversight provides assurance on performance achievement against targets/standards at CCG level and the delivery of actions in place to mitigate.
- 1.5 The narrative includes details of the reasons for non-achievement of the standards and the actions in place to mitigate the risks.
- 1.6 Where key standards were not achieved in 2018/19, trajectories have been set as part of the Sustainability & Transformation Fund (STF), in the 2019/20 planning round. For Robert Jones & Agnes Hunt Hospital and Shrewsbury & Telford Hospital Trust, these included;
- A&E 4 Hour Wait
 - 18 Weeks RTT Incompletes
 - Cancer 62 days wait

2 EXECUTIVE SUMMARY

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

3 CANCER

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

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Cancer	Cancer Diagnosed at Early Stage - % of cancers diagnosed at Stage 1 & 2	2016	50.6% (CCG) 52.6% (England)		2017 49.2% (England 52.2%)												
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	2017/18	83.5%	85%	71.4%	76.6%	74.0%	70.2%	68.9%	66.0%	75.2%	74.7%	79.4%	68.0%	63.4%		71.6%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	2017/18	88.6%	90%	95.7%	76.5%	66.7%	100.0%	96.2%	90.0%	89.5%	72.7%	88.2%	72.2%	40.0%		85.1%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	2018/19	87.5%	No National Standard	87.8%	83.6%	81.5%	83.0%	93.3%	85.7%	83.9%	84.1%	86.7%	81.6%	80.0%		84.8%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for suspected cancer	2017/18	93.0%	93%	81.8%	80.0%	82.2%	81.3%	86.4%	91.6%	93.0%	90.6%	92.0%	93.4%	94.3%		87.9%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for breast symptoms	2017/18	91.5%	93%	31.6%	12.7%	18.2%	14.7%	50.5%	80.9%	95.1%	89.5%	93.2%	92.3%	96.0%		55.1%
	Cancer 31 Day Wait - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis	2017/18	99.0%	96%	96.5%	97.6%	96.2%	97.2%	98.0%	96.0%	97.4%	94.7%	98.3%	96.2%	93.5%		96.5%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	2017/18	97.3%	94%	100.0%	72.7%	95.6%	83.6%	87.9%	90.0%	92.5%	88.9%	87.0%	83.9%	85.2%		86.9%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is anti cancer drug regimen	2017/18	99.9%	98%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	97.5%	100.0%		99.6%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is radiotherapy treatment course	2017/18	99.3%	94%	100.0%	100.0%	100.0%	97.1%	98.0%	93.5%	98.4%	100.0%	98.1%	97.1%	93.9%		97.7%
	One-year survival for all cancer				2017 72.7% National 73.3%												
	Cancer patient experience of responses, which were positive to the question "Overall, how would you rate your care?"	2017	8.9 (CCG)		2018 8.8 (CCG)												

Cancer:	
Key Performance Headlines Risks and Issues	Actions to Address
<p>Performance on 14 day Breast has achieved target for the third time this financial year 96% the 14 day urgent standard was also achieved, for the second consecutive month, 94.3%, performance had increased month on month and exceeded the target (93%).</p> <p>62 day wait performance declined for the second consecutive month to 63.4% which is the lowest level of achievement in the current year.</p> <p>Staffing capacity remains a concern for Urology, Haematology and ENT</p> <p>31 day standards performance also declined for first definitive, surgery and radiotherapy, all failing to achieve target. For drug treatment, the standard was achieved.</p> <p>The cancer dashboard also details 3 further indicators, which are all reported on an annual basis. The indicators are; diagnosis at early stage 1&2 which has fallen to 49.2% , one year survival which has increased to 72.7% and cancer patient experience which remains at 8.8. Baselines and the latest position are shown. The patient experience RAG rating is based on a survey where patients are rating their care (excellent or very good).</p>	<p>Cancer performance generally has improved in the last few months, notably in the 2 week wait standards as a result of additional capacity becoming available and process improvements</p> <p>Performance in a number of tumour sites including UGI has improved significantly.</p> <p>Staffing issue are likely to be problematic in Haematology and Urology. Additional CT capacity has been made available to improve diagnostic ability and pathway changes introduced to improve triage.</p> <p>The Urology position continues to impact on the 62 day performance standard which is also being impacted by clearance of previous backlogs.</p> <p>Every effort is being made to sustain critical cancer care during the current Covid 19 situation and the CCG is working with SaTH to plan how cancer and other services can be maintained and restored as the Covid 19 position becomes manageable.</p> <p>As improvements begin to be seen in the 14 day and 31 day standards this will, in time, be expected to filter through to improvements in the 62 day standard performance.</p>

	SaTH continues to work with the Cancer Alliance to implement improvements to meet the faster diagnosis standards.
Key Quality Risks and Issues	
104+ day breaches were reported in March 2020 across urology, lung and breast. Causes of the delay in the main include patient choice, workforce and delayed diagnostics / pathways.	<p>The Trust's 104+ day harm review procedure is currently under review. The review is being led by the Clinical Lead for Cancer with support from the Lead Cancer Nurse, patient safety leads for Scheduled and Unscheduled Care and the Cancer Performance Manager. Further details will be included in this report on completion.</p> <p>2019/2020 Q3 cancer update presented at April 2020 CQRM.</p>

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

Feb-20	2 week performance			62 day performance		
Tumour Site	SaTH	National	Comparison	SaTH	National	Comparison
Breast	97.6%	91.6%	Better	82.4%	86.8%	Worse
Childrens cancer	100.0%	96.4%	Better			
Gynaecological	94.1%	95.3%	Similar			
Haematological	100.0%	96.4%	Better			
Head & Neck	95.2%	96.2%	Similar			
LGI	99.5%	87.7%	Better	91.7%	63.6%	Better
Lung	92.1%	94.9%	Worse	17.2%	62.8%	Worse
Skin	92.2%	94.3%	Worse	100.0%	92.8%	Better
Testicular	100%	98.4%	Better			
UGI	88.2%	91.6%	Worse			
Urological	95.0%	95.0%	Similar	48.8%	66.7%	Worse

4 MENTAL HEALTH

Mental Health	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG/SSSFT)	2018/19	16.4%	22%	1.5%	1.5%	1.8%	2.3%	1.7%	1.8%	1.9%	1.7%	1.5%	1.9%	1.8%		19.4%
	IAPT Recovery Rate (CCG/MPFT)	2018/19	53.8%	50%	57.9%	55.9%	50.6%	52.4%	52.3%	51.6%	51.1%	55.1%	50.4%	51.2%	53.2%		52.8%
	75% of people with relevant conditions to access talking therapies in 6 weeks (CCG/MPFT)	2018/19	95.4%	75%	95.9%	97.9%	95.6%	97.2%	99.5%	95.7%	94.3%	95.4%	96.2%	96.6%	96.1%		96.4%
	95% of people with relevant conditions to access talking therapies in 18 weeks (CCG/MPFT)	2018/19	98.8%	95%	100%	99.5%	98.3%	99.6%	100%	99.1%	99.1%	99.2%	98.7%	99.6%	99.4%		99.3%
	50% of people experiencing first episode of psychosis to access treatment within 2 weeks	2018/19		56%	100%	75.0%	-	50.0%	100%	66.7%	100%	100%	75.0%	100%	66.7%		85.2%
	Out of Area placements for acute mental health inpatient care - transformation				166	176	191	90	105	103	100	131					1062
	Mental Health - Care Programme Approach (CPA) - % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric patient care	2018/19		95%	99.1%			95.3%			96.1%						97.2%

Mental Health:	
Key Performance Headlines Risks and Issues	Actions to Address
<p>IAPT performance was reported at 1.8% in February. The monthly performance was below target. Prior to the onset of the Covid 19 situation the CCG was likely to just achieve the year-end target. This may be jeopardised by the current situation.</p> <p>The recovery rate target of 50% has been achieved consistently through the year.</p> <p>As at Q3, 2019/20, 96.1% patients on CPA were followed up within 7days against the 95% standard.</p> <p>As at the end of February the CCG is achieving a year to date performance of 85% against a target of 56% for EIP. The numbers of cases each month is small, so month on month percentage achievement is subject to variability due to small numbers.</p>	<p>The CCG has already invested additional funds into the service in the current year with a view to easing the step up to the 25% target for the 20/21 financial year.</p> <p>The CCG will be working closely with the provider to identify the impact of the Covid 19 situation on services and the CCG population.</p>
<p>Progress continues to be made with implementing the agreed Improvement plan for the Under 25 services and fortnightly reporting against this continues to be in place.</p> <p>The majority of the KPIs for the service are likely to be achieved at the year end with the exception of the 18 week waiting time standard.</p>	<p>The ability to recruit staff to maintain the current improvements seen in the KPIs is still seen as the main risk to the service delivery.</p>
Key Quality Risks and Issues	
<p>MPFT: 4 serious incidents were reported in February 2020, 3 were unexpected deaths and one slip/ trip/ fall. 11 SIs are over the 60 days. 6 RCAs have been submitted and are in the review process. Learning identified within RCAs is improving and themes are being identified.</p>	<p>There are ongoing plans with operational teams to address these areas. Further exploration is being planned to understand the links and gaps between substance misuse & alcohol services and mental health services. This has been discussed</p>

Communication between services and completion of risk assessments continue to be two key themes.

No Never Events reported.

with MPFT and Public health team.
MPFT CQRM continues bi-monthly.

5 LEARNING DISABILITIES (LD) Dementia and Maternity

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

Learning Disability	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	Proportion of people with a learning disability on the GP register receiving an annual health check	2017/18	51.4% (England)		52.7% (2019/20: CCG)												
	Completeness of the GP learning disability register	2017/18	0.49% (England)		0.52% (2018/19: CCG)												

Maternity	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	Maternal smoking at delivery	Q4 2019/20	10.4% (England)		11.0%			10.1%			11.0%			11.4%			
	Neonatal mortality and still births per 1,000 population	2015	4.64		4.3 (2017: CCG)												
	Women's experience of maternity services	2017	88		81 (2018: CCG)												
	Choices in Maternity Services	2017	66.2%		67.6% (2018 CCG)												

Dementia	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	Maintain a minimum of two thirds diagnosis rates for people with dementia	2018/19		67%	71.0%	71.0%	71.2%	70.8%	71.1%	71.0%	70.6%	70.5%	71.0%	69.8%	69.5%	69.0%	69.0%
	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	2018/19	78.0% (England)		79.31% (2018/19: CCG)												

Learning Disabilities:

Key Performance Headlines Risks and Issues

Actions to Address

Completeness of the GP Learning Disability Register – the CCG performs better than the England average	The CCG is comfortably within the top quartile nationally on this measure.
<p>Maternity</p> <p>Maternal smoking at time of delivery is reported on a quarterly basis. Q4 2019/20(11.4%) showed an increase against Q3 performance (11%).</p> <p>Preliminary recent data for Perinatal Mortality shows a slight improvement in the level, reversing the slight trend seen in the most recent published metric</p>	<p>The level is slightly better than the average rate for England as a whole.</p> <p>The Improving Births programme is targeting initiatives to improve the CCG's position relative to other parts of England.</p>
<p>Dementia diagnosis continues to perform above the national standard, March 2020 achievement was 69.0%</p> <p>The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months, was 79.31% for Shropshire CCG, with the England average being 78.0% (2018/19).</p>	<p>The CCG is the best performing in its peer group of most similar CCGs and sits slightly above the national average</p> <p>The CCG is in the top quartile nationally.</p>
Key Quality Risk and Issues	
The Mental Health Wellbeing provider commissioned to address the back log of 12 months + waiting list continue to work closely with MPFT, the teams are positively working towards the 6 month trajectory and the waiting list has now reduced by over 120 young people waiting to be seen for assessment.	The sustainable future model for the neurodevelopmental pathway has been agreed and financial approval is awaited. Work continues to take place across the wider health care and education system to achieve a multidisciplinary approach to neurological development support. This is monitored through the CQRM each month.
CQC inspected maternity services during the visits in April 2019 and November 2019. SaTH received the CQC report in April 2020 and maternity services had improved whilst overall rating for SaTH remains as Inadequate.	CQC acknowledged the delay in publishing findings from visit undertaken in April 2019 and recognised that improvements had been made and these improvements were observed during the visit in November 2019.

Maternity CQRM continues each month and the CCG has appointed an independent midwife for 2 days per month to support with assurance processes.

CCG unannounced quality visit to maternity in February 2020 that reported positive patient experiences.

6 URGENT AND EMERGENCY CARE -

6.1 A&E Performance and Ambulance Handover Delays

Urgent and Emergency Care	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	Achievement of milestones in the delivery of an integrated urgent care service				6	6	6	6	6	6	6	6	6	6	6	6	
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q1 2018/19	2074 (England)		Q1 2019/20 845			Q2 2019/20 965									
	A&E Waiting Time - % of people who spend 4 hours or less in A&E (SaTH)	2017/18	71.0%	95%	68.2%	73.0%	71.1%	73.2%	73.4%	65.9%	64.4%	65.6%	60.5%	65.0%	63.2%	71.2%	67.9%
	Trolley Waits in A&E - Number of patients who have waited over 12 hours in A&E from decision to admit to admission (SaTH)	2017/18	62	Zero Tolerance	15	0	0	1	1	1	44	61	348	411	187	94	1163
	Ambulance Handover time - Number of handover delays of >30 minutes (RSH + PRH)	2017/18	8997	Zero Tolerance	806	627	629	608	571	813	897	991	1118	770	785	575	9190
	Ambulance Handover time - Number of handover delays of > 1 hour (RSH + PRH)	2017/18	2562	Zero Tolerance	349	132	122	89	115	155	219	341	605	232	236	119	2714

URGENT AND EMERGENCY CARE:	
Key Performance Headlines Risks and Issues	Actions to Address
The SaTH A&E 4 Hour Wait target has not been achieved and is reported as 63.2% in February and 71.2% in March. This is below the target trajectory.	<p>The action plan agreed through the A&E Delivery Board has identified 6 key action areas:</p> <ul style="list-style-type: none"> • Ambulance Demand • Frailty • ED Systems & Processes • Same Day Emergency Care • Home First – Pathway Zero • Integrated Discharge Management <p>Work was being progressed against these target areas with progress being made in improving ED Systems and Processes. This has been paused whilst the trust deals with the impact of Covid 19.</p>
Workforce limitations continue to be the key problem for SaTH.	<p>Recruitment initiatives were beginning to show some improvement in numbers of middle grade medical staff and additional nursing staff. Covid 19 travel restrictions will delay the arrival of previously recruited staff from abroad.</p> <p>There are still concerns around availability of consultant cover with a high proportion of capacity being provided through bank and agency routes.</p> <p>Activity in A&E has shown a significant reduction since the middle of March due to the Covid 19 situation. The CCG is working with saTh to assess the implications of the necessary changes to working practices in ED as a result of the current situation.</p>
Numbers of Super Stranded patients (>21days LOS) have reduced in the current situation though they do remain relatively high at PRH.	Performance relating to Delayed Discharges and the contribution from local authorities and the SCHAT remains amongst the best in England.

	<p>Work is being progressed to move more stroke patients to the community hospitals and to undertake more frailty assessments in a community setting.</p> <p>Joint planning work is being undertaken to assess how discharge processes need to change in the light of the Covid 19 position and to ensure there is sufficient capacity in the community to facilitate discharge of both Covid positive and Covid Negative patients in a safe and appropriate manner.</p>
<p>Reported Ambulance handover delays (over 60mins) have improved in March from the February numbers against the background of lower numbers of conveyances</p> <p>Walk In demand to A&E has reduced dramatically since mid March.</p>	<p>With fewer ambulance conveyances, handover delays have substantially reduced.</p> <p>ED Processes are being reviewed to reflect the changed circumstances with respect to Covid 19</p>
Key Quality Risk and Issues	
<p>CQC placed SaTH into special measures following their inspection in September 2018. Further CQC inspections took place in April 2019 and November 2019 to review maternity services and urgent and emergency care. CQC report published April 2020 demonstrated improvements within maternity although the Trust was rated Inadequate overall.</p> <p>CQC imposed the powers of Section 31 of the Health and Social Care Act (2008) as they are concerned that patients will or may be exposed to risk of harm. In total there are currently 21 conditions in place.</p> <p>CQC identified the following issues of concern:</p> <ul style="list-style-type: none"> Managing the deteriorating patient and sepsis 	<p>SaTH has been in special measures since September 2018 and is struggling to deliver safe and effective care and treatment. The conditions in place are not driving the required improvement at SaTH and as a result NHSE/I has held three Risk Summits (December 2019, January 2020, February 2020 and April 2020).</p> <p>The Risk Summits identified a number of actions for all partners and stakeholders to consider / implement to support SaTH and CQC will continue to inspect, and or take necessary action, as required, should sufficient improvements not be clearly evidenced.</p> <p>CQC actions are presented to the System Oversight and Assurance Group (SOAG) and to the CQRM each month.</p> <p>Safe Today weekly calls have not been reviewed and held as a joint assurance call each week with NHSE/I.</p>

<ul style="list-style-type: none"> • Triage of children with ED • Basic nursing care being delivered by ED staff • Children leaving ED before being seen • Restraint of patients not in line with guidance • Lack of mental health risk assessments <p>A number of other concerns were identified across the organisation relating to documentation, incomplete risk assessments and governance.</p>	<p>CCG quality assurance visits to SaTH continue, including unannounced visits. QA visit to ED took place over weekend of 22nd & 23rd February 2020 which identified on-going issues around documentation and appropriate clinical assessment not completed.</p>
<p>Workforce limitations continue to be the key problem for SaTH, with the level of nursing vacancies remaining a significant concern.</p>	<p>The Trust reported a successful recruitment campaign in India with the appointment of 186 registered nurses (cohorts arriving each month in Shropshire). However, due to travel restrictions associated with Cov-19, nurses have not been able to travel and the arrival of the nurses has been pushed back to summer 2020.</p> <p>CQC raised further concerns about the low numbers of paediatric trained nurses within ED. SaTH have developed an action plan to cover each shift with appropriate levels of paediatric trained nurses or trained nurses with advanced skills in paediatric nursing.</p> <p>Medical staff recruitment and retention remains a significant risk to the Trust. Vacancies advertised are receiving little or no interest. Agency usage remains a significant number of the consultant workforce, in particular, within ED.</p> <p>SaTH director of workforce updates CQRM each month.</p>
<p>There were 850 12 hour trolley waits reported in A&E at SaTH in Q3 for 2019/20. The increased number being reported due to demand and capacity issues.</p>	<p>The CCG is continuing to support SaTH with a 'desktop' exercise to review patient records following a 12-hour trolley wait. A summary report is to be presented at May 2020 CQRM.</p>

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

Urgent and Emergency Care	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	Category 1 (mm:ss): 90th Percentile	WMAS	11:47	15mins	11:39	11:51	11:56	12:00	11:39	12:10	12:13	12:15	12:15	12:03	12:33	12:38	12:05
		SCCG	20:26		20:16	19:46	23:25	22:52	20:38	21:00	22:43	22:50	21:29	23:29	23:55	23:12	22:06
	Category 2 (mm:ss): 90th Percentile	WMAS	22:12	36mins	22:22	21:31	23:57	23:44	23:06	24:10	25:21	27:06	28:09	22:45	24:03	27:40	24:37
		SCCG	33:29		34:51	32:21	36:54	37:08	39:09	39:38	38:10	41:54	45:09	38:07	37:57	45:03	39:02
	Category 3 (mm:ss): 90th Percentile	WMAS	76:14	90mins	78:47	69:49	99:36	109:47	88:08	109:15	121:43	136:52	144:05	71:44	92:27	113:44	103:43
		SCCG	71:19		81:14	71:59	95:54	106:25	89:30	134:01	129:48	149:01	168:15	87:00	104:58	125:23	111:26
	Category 4 (hh:mm:ss) : 90th Percentile	WMAS	120:23	180mins	115:46	104:08	141:26	185:42	127:18	175:44	178:49	198:23	193:27	114:58	132:12	156:57	149:39
		SCCG	101:36		122:44	111:52	163:58	144:28	90:49	165:10	175:21	180:56	209:21	108:49	108:31	141:43	140:10
	Crew Clear delays of > 30 minutes (RSH + PRH)	2018/19	709	Zero Tolerance	40	12	12	13	9	14	13	15	13	14	15	15	185
	Crew Clear delays of >1 hour (RSH + PRH)	2018/19	15	Zero Tolerance	3	0	0	0	0	1	2	2	0	0	0	1	9
	Delayed Transfers of care attributable to the NHS (LA)	2017/18	3381	Reduction 2016/17 Outturn	274	281	223	281	284	324	571	647	560	521	530		4496
	DTOC Rate (SaTH)			3.5%	1.3%	0.8%	1.5%	1.7%	1.1%	1.6%	1.6%	2.4%	1.2%	1.2%	1.4%		1.4%
	DTOC Rate (RJAH)			3.5%	6.4%	3.4%	4.4%	6.4%	4.0%	4.9%	5.8%	5.9%	5.7%	4.4%	3.6%		3.6%
Population use of hospital beds following emergency admission	Q2 2018/19	500.5 (England)		Q1 2019/20 799			Q2 2019/20 815										

Ambulance Response Times, Crew Clear and Delayed transfers of care

Key Performance Headlines Risks and Issues

The CCG achieved the standards for the Category 4 calls in March but, failed the standards for categories 1, 2 and 3 calls.

Ambulance demand has shown a slight decrease in Q4,asignificant proportion

Actions to Address

Performance issues are raised regularly with the Regional lead commissioner

of which was evident prior to the onset of Covid 19.	
DTOC (SaTH) – In February 2020, the number of delayed days was 1.4% of patients delayed. This is ahead of the 3.5% target at SaTH. The RJAH improved to 3.6%, though this figure includes complex spinal patients. At SCHAT, the March value deteriorated to 7.1%. The SaTH values are amongst the best performers in England	Normal choice policies in respect of discharges have been suspended during the Covid 19 situation
Key Quality Risk and Issues	
No quality concerns / risks to report at present as Covid-19 measures in place	

7 Primary Medical Care, Community Services and Elective Access

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Primary Medical Care	Patient Experience of GP Services	2019	82.9% England		87.99%												
	Last time you had a general practice appointment, how good was the healthcare professional at giving you enough time	2018 GP Patient Survey	87% England (Good)		91% Good												
	Last time you had a general practice appointment, how good was the healthcare professional at listening to you		89% England (Good)		92% Good												
	Last time you had a general practice appointment, how good was the healthcare professional at treating you with care and concern		87% England (Good)		92% Good												
	How would you describe your experience of your GP Practice		84% England (Good)		89% Good												
	Overall, how would you describe your experience of making an appointment?		69% England (Good)		76% Good												
	Were you satisfied with the type of appointment offered?		94% England (Good)		96% Good												
	Primary care access - proportion of population benefitting from extended access services	Oct-18	98.4% (England)		50%	49%	49%	51%	51%	51%	100%	100%	100%	100%	100%	100%	
	Primary care workforce	Mar 2019	1.06 (England)		1.21 (March 2019)												
	Count of total investment in primary care transformation made by CCGs compared with £3 head commitment made in the General Practice Forward View	Qtr 2 2018	Green (England)		Green												
Elective Access	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	RTT - incompletes (CCG)	2018/19	91.0%	92%	89.7%	90.2%	89.9%	89.4%	88.7%	89.2%	88.5%	87.9%	87.3%	86.9%	85.4%		88.6%
	RTT - incompletes (SaTH)	2018/19	92.3%	92%	87.5%	87.8%	87.0%	86.0%	85.8%	86.1%	85.0%	83.9%	82.8%	82.0%	81.0%		85.3%
	RTT - incompletes (RIAH)	2018/19	89.8%	92%	87.5%	87.2%	86.6%	85.1%	83.6%	88.5%	88.0%	82.1%	82.2%	82.3%	81.4%		85.4%
	No. of 52 Week Waiters (CCG)	2018/19	56	Zero Tolerance	0	0	0	0	0	0	0	0	1	0	0		1
	Diagnostic Test Waiting Time < 6 weeks (CCG)	2018/19	0.9%	1%	1.2%	1.3%	0.9%	1.7%	2.3%	2.7%	0.9%	1.1%	1.5%	5.7%	5.5%		2.4%
	Diagnostic Test Waiting Time < 6 weeks (SaTH)	2018/19	0.3%	1%	0.8%	0.7%	0.5%	1.2%	2.4%	2.7%	0.6%	1.6%	1.4%	5.7%	6.0%		2.0%
	Diagnostic Test Waiting Time < 6 weeks (RIAH)	2018/19	1.0%	1%	2.4%	2.9%	1.7%	1.5%	1.2%	1.1%	0.1%	0.1%	2.0%	1.3%	1.1%		1.5%
	Cancelled Operations - no. of patients re-admitted within 28 days (SaTH)	2018/19	5	Zero Tolerance	2			1			2						5
	Cancelled Operations - no. of patients re-admitted within 28 days (RIAH)	2018/19	1	Zero Tolerance	0			0			0						0

Primary Medical Care, Community Services and Elective Access

Key Performance Headlines Risks and Issues	Actions to Address
<p>Access to, and satisfaction with, Primary care services continues to be rated highly by Shropshire patients and compares well with the overall England position.</p> <p>Comparing the CCG with others in nationally published data, continues to show the Shropshire practices, in general, are rated at the positive end of the national spectrum on almost all available measures.</p> <p>Practices that show as outliers against these measures are supported by the Primary Care Team, via their Locality Managers, to work on improving access, quality and patient satisfaction.</p>	<p>Extended access at weekends and evenings was introduced from the 1st of October 2018 and continues to run smoothly. Additional extended hours are also being delivered via the Primary Care Networks.</p> <p>Primary care has responded to the Covid emergency by significantly switching appointments from face to face to telephone and on line methods</p>
<p>The CCG failed to achieve the RTT 18 week performance (incompletes) in February (85.4%).</p> <p>The CCG failed to achieve the Diagnostics Wait target in February.</p>	<p>Winter overspill, increased cancer referrals and reduction in outpatient capacity are impacting on performance. These issues are expected to remain through February and March.</p> <p>The Covid 19 emergency is creating the opportunity to move a number of outpatient appointments on line, but inevitably is impacting on elective and diagnostic activity. Work is underway between providers and the CCG to identify how services can be re-shaped to adapt to a 'new normal' position and access for patients be restored. It is likely that waiting times and numbers will deteriorate at least in the medium term.</p> <p>Data validation issues were encountered in SaTH relating to Echocardiography and the recovery from this is still impacting on</p>

	performance. In addition, increased demand from A&E is impacting on capacity particularly for CT and MRI. Changes to working practices are being identified including pre-screening of patients for Covid 19.
SaTH failed to achieve their overall RTT target in February at 81.0%. This is largely due to the overspill from emergency cases limiting elective capacity and capacity limitations in outpatients.	Additional bed capacity for the winter months was planned at SaTH to protect some elective capacity though it did not materialise as quickly as originally planned.
At the end of February there were 0 x 52 week waiters reported for the CCG.	The CCG actively manages the position with long waiters.
	The CCG works with providers to ensure recorded numbers are as accurate as possible. The impact of some providers commencing to submit RTT data for the first time in April has lessened. .
Cancelled Operations –SaTH failed the target in Q3, SaTH reported 2 cancelled operations.	Any patient safety issues relating to cancelled operations are managed through the contractual quality processes.
Key Quality Risk and Issues	
Primary care quality dashboard development.	The CCG is continuing to develop a Primary care dashboard
No quality concerns / risks to report at present as Covid-19 measures in place.	

8 NHS Continuing Health Care and HCAIs

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

Additional Indicators Requiring Focus	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
	Healthcare acquired infection (HCAI) measure (MRSA)	2017/18	3	0	0	0	0	0	0	0	0	1	0	0	0	0	1
	Healthcare acquired infection (HCAI) measure (Clostridium difficile infection)	2017/18	46	43	3	5	8	5	2	6	3	4	6	6	4	3	55

9 Recommendation

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

Agenda item: GB-2020-05.056
Shropshire CCG Governing Body meeting: 13.05.20

Title of the report:	Financial Position Month 12, 2019/20 (unaudited)
Responsible Director:	Claire Skidmore – Executive Director of Finance
Author of the report:	Laura Clare - Deputy Chief Finance Officer
Presenter:	Claire Skidmore – Executive Director of Finance

Purpose of the report:

The purpose of this report is to articulate the 2019-20 year end financial position subject to external audit.

The CCG submitted an application at Q3 to reforecast outturn at £47.3m deficit. This position was discussed and agreed with NHSE/I and signed off by the CCG AO, CFO, CCG chair, Audit Committee chair and STP finance lead who had all been engaged throughout the process. The final Month 12 position (subject to external audit) is consistent with the Q3 forecast.

Although the forecast has not changed overall, there have been movements in expenditure categories during Month 12 as set out below:

	£m
Month 11 FOT	(47.3)
<i>Adverse Movements:</i>	
Deterioration in Individual Commissioning position	(0.2)
Deterioration in Mental Health position	(0.2)
Deterioration in Primary Care position	(0.8)
<i>Favourable Movements:</i>	
Improvement in acute forecast	0.7
Improvement in community forecast	0.4
Improvement in running costs forecast	0.1
Month 12 position	(47.3)

The final year end QIPP position shows delivery of £16m of QIPP against a target of £19.8m (81% delivery). Due to the impact of COVID-19 it has been difficult to capture some of the Month 12 savings. Prudent estimates have therefore been taken due to the limited availability of SUS data.

During Month 12 the CCG has begun to see the impact of COVID-19 in a number of ways. £193k of specific costs have been included on the cost reimbursement submissions to NHSEI and the corresponding allocation adjustment to fund this has been included in the position.

Actions required by Finance and Performance Committee Members:

The Committee is asked to:

- **Note** the unaudited financial position at Month 12.

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications	No
	<i>If yes, please provide details of additional resources required</i>	
2	Health inequalities	No
	<i>If yes, please provide details of the effect upon health inequalities</i>	
3	Human Rights, equality and diversity requirements	No
	<i>If yes, please provide details of the effect upon these requirements</i>	
4	Clinical engagement	No
	<i>If yes, please provide details of the clinical engagement</i>	
5	Patient and public engagement	No
	<i>If yes, please provide details of the patient and public engagement</i>	
6	Risk to financial and clinical sustainability	Yes
	<i>If yes how will this be mitigated</i> The CCG has breached its agreed control total and the statutory duty to break even. Given the impact that this has had on the underlying position there is a risk that financial recovery will take even longer than originally anticipated. The financial recovery plan is being updated and CCG teams continue to work with system partners to seek ways to address the system deficit.	

Tables included in this report:

<i>Table 1: Performance against key financial objectives.....</i>	<i>3</i>
<i>Table 2: Month 12 Financial Position</i>	<i>4</i>
<i>Table 3: Movements in position at Month 12</i>	<i>5</i>
<i>Table 4: Summary of QIPP delivery</i>	<i>8</i>

Graphs included in this report:

<i>Figure 1: Month 12 Financial Position</i>	<i>4</i>
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Schedules appended to this report:

Appendix	Content
Appendix A	A1 Acute Services A2 Non Acute Services A3 Other A4 Running Costs A5 Better Care Fund A6 QIPP A7 Allocations A8 Statement of Financial Position
Appendix B	B1 Financial Summary Position B2 QIPP Detail B3 Allocations

NHS Shropshire CCG
Governing Body Meeting – 13th May 2020
Financial Position Month 12 - 2019/20

Financial Performance Dashboard

1. The CCG's overall performance at 2019/20 Month 12 against key financial objectives is shown below:

Table 1: Performance against key financial objectives

Target/ Duty	Target	RAG
Control Total Deficit	£12.3m deficit	R
Performance against submitted plan	£24.4m above planned deficit	R
Cash	1.25% monthly drawdown	G
Better Payment Practice (App B-7)	>=95%	G

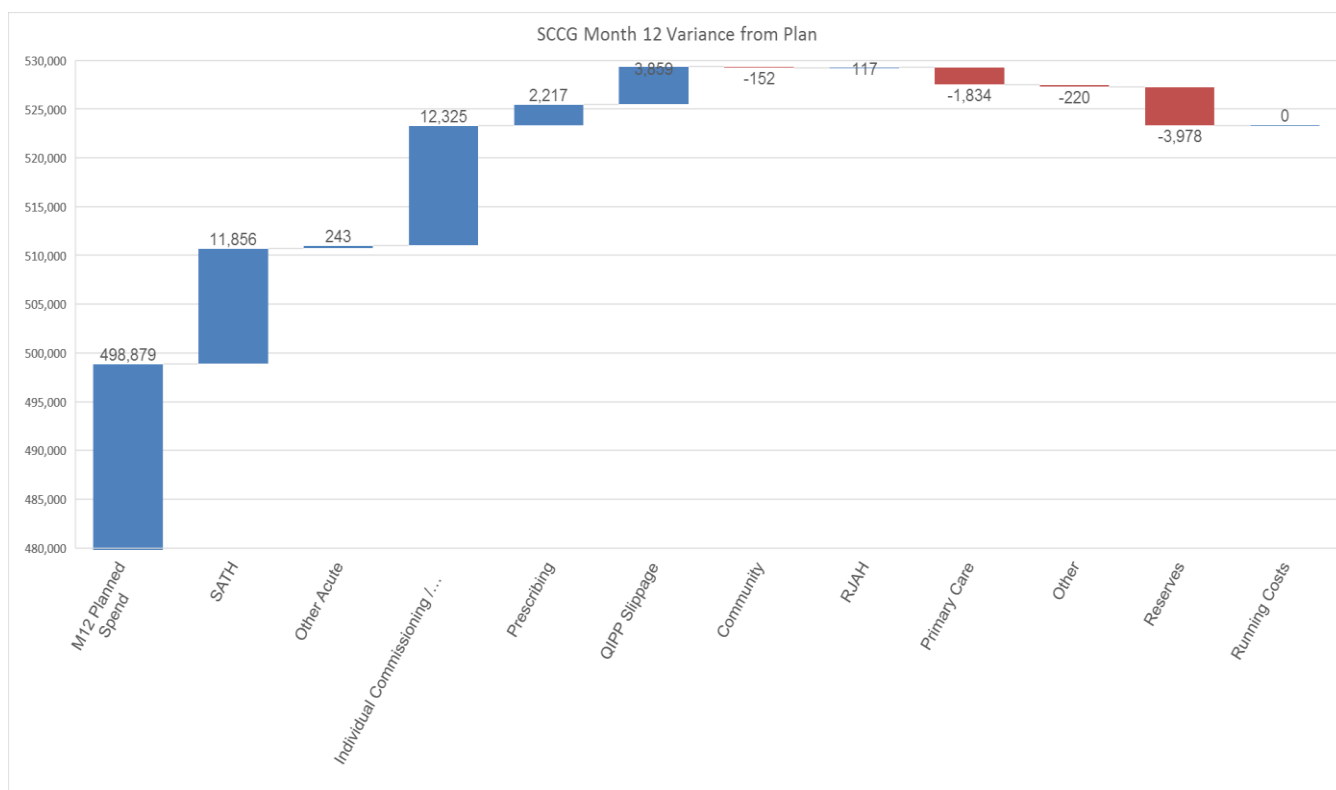
Summary Financial Position

2. At month 12 the CCG is showing a year end deficit of £47.3m. Further detail is provided at Appendix A.
3. The CCG formally amended its forecast at Month 9 to a deficit of £47.3m. This was agreed with NHSE/I and signed off by CCG Board and Committee members. The year end position is consistent with this amended forecast and represents a variance from plan of £24.4m.
4. The table below outlines the financial position at Month 12 and further detail is provided at Appendix B-1.

Table 2: Month 12 Financial Position

	2019/20 Budget		Actual Outturn	Actual Variance	
	£000		£000	£000	%
Total Resource Limit	476,025		476,025	0	0%
Acute Services	234,451		250,139	15,688	7%
Community Health Service	50,031		49,943	(89)	0%
Individual Commissioning	35,458		44,826	9,370	26%
Mental Health Services	43,351		46,627	3,276	8%
Primary Care Services	64,546		66,219	1,673	3%
Other	17,983		13,785	(4,199)	-23%
Running Costs	6,955		7,157	202	3%
Co-Commissioning	46,104		44,615	(1,489)	-3%
Total Expenditure	498,879		523,311	24,432	5%
Deficit/(Surplus)	22,854		47,286	24,432	

Figure 1: Month 12 Financial Position



- The bridge diagram above shows the difference between planned expenditure of £498.9m at Month 12 and reported actual expenditure of £523.3m.
- When the resulting £47.3m deficit is compared to the planned deficit for month 12 (£22.9m) this shows a £24.4m variance.

7. Although the forecast has not changed overall, there have been movements in expenditure categories during Month 12 as set out below:

Table 3: Movements in position at Month 12

	£m
Month 11 FOT	(47.3)
Adverse Movements:	
Deterioration in Individual Commissioning position	(0.2)
Deterioration in Mental Health position	(0.2)
Deterioration in Primary Care position	(0.8)
Favourable Movements:	
Improvement in acute forecast	0.7
Improvement in community forecast	0.4
Improvement in running costs forecast	0.1
Month 12 position	(47.3)

8. During Month 12 there were deteriorations in the Individual Commissioning and Mental health Positions due to high cost complex care patients and a significant increase in Mental Health Non Contracted Activity. Further detail is provided at Appendix A. £282k of the Individual Commissioning position relates to Betsi and was moved to the 'other' category at year end to be coded to the bad debt provision.
9. The other significant deterioration relates to an increase in March in expected prescribing costs due to volumes of requests for prescriptions increasing significantly in the latter part of the month. The estimate included in the accounts is based on local medicine management team intelligence and in the absence of any national guidance we have assumed this will not be supported from national COVID19 funding. This has been offset with some improvements elsewhere in primary care including Out of Hours and prescribing recharges.
10. There has been an improvement in month in the acute position due to improvements in costs associated with the STP, reduction in spend for winter schemes, acute high costs drugs and the West Midlands Ambulance contract.
11. The community position also improved due to slippage in Care Closer to Home investment due to delays in the programme due to the COVID-19 response. There were also small improvements in the Wye Valley and Severn hospice positions.
12. A level of expenditure for the likely cost of change as the CCG moves to become a strategic commissioning organisation has also been included in the position. This includes the likely costs associated with redundancy and MARS payments. The estimate for this improved slightly given updated information at the end of the year.

13. The final year end QIPP position shows delivery of £16m of QIPP against a target of £19.8m (81% delivery). Due to the impact of COVID-19 it has been difficult to capture some of the Month 12 savings. Prudent estimates have therefore been taken due to the limited availability of SUS data.
14. During Month 12 the CCG has begun to see the impact of COVID-19 in a number of ways. £193k of specific costs have been included on the cost reimbursement submissions to NHSEI and the corresponding allocation adjustment to fund this has been included in the position.

Contract Position Summary

15. Month 11 SUS data is now available and Month 12 contract positions have been calculated on this basis. Appendix A shows the detail around each of the contracts below. A full list of contracts is provided at Appendix B-4.

SATH- Shrewsbury and Telford Hospital

16. During Month 9 a year end agreement was reached between the CCG and Shrewsbury and Telford Hospitals NHS Trust providing a level of financial certainty for all parties and the health system as a whole.
17. The Month 12 position for SATH shows the total overspend of £12.1m (some of which is shown in QIPP slippage in Figure 1). Further detail is provided in Appendix A.
18. The CCG was in the final stages of negotiation with SATH for the 2020/21 contract when the contracting process was paused nationally due to the impact of COVID-19. An overall block contract value has been agreed with the trust. Further work and agreement around the indicative activity plan will continue with the trust when we return to business as usual arrangements. For the first few months of 2020/21 SATH will receive block payments from the CCG at a value prescribed by the national NHSE/I team.

RJAH- Robert Jones and Agnes Hunt

19. During Month 9 a year end agreement was also reached with Robert Jones and Agnes Hunt Orthopaedic Hospital.
20. The RJAH contract total over performance for the year was just over £1m.
21. Again, the CCG was in final stages of negotiation with RJAH for the 2020/21 contract when the contracting process was paused nationally due to COVID-19. The MSK alliance agreement has now been delayed by 3 months due to the impact of COVID-19 and the 'go live' date has therefore moved from 1st September 2020 to the 1st December 2020.

WMAS- West Midlands Ambulance Contract

22. The Month 12 position at WMAS is a total overspend of £292k. After the low cost month of January, activity in February was marginally below plan (0.16%), the over performance year to date reducing to 4.24%. The final position assumes an overall (prudent) level of 4.38% over performance for the year given the uncertainty around potential costs in March.

Out of Area Acute Contracts

23. The main area of overspend in other acute is Out of Area Acute Contracts. Further information is provided in Appendix A but the main contracts with over performance were University Hospital North Midlands (UHNM), Wye Valley, Royal Wolverhampton Hospitals and Dudley Group of Hospitals. The majority of the overspends at these trusts is in Emergency activity.

Community

24. The final overspend at Shropshire Community Trust for the year was £226k. The majority of this was due to the failure in year to agree and implement QIPP schemes with the Trust. The associated risk share in place led to a £175k cost pressure.
25. Again, the CCG was in the final stages of negotiation with Shropshire Community Trust for the 2020/21 contract when the contracting process was paused nationally due to COVID-19. The only outstanding area of dispute was the QIPP value to be included in the contract.

QIPP

26. Total QIPP savings for 2019/20 are reported as £16m. This is a shortfall of £3.8m from the original plan of £19.8m and represents 81% of achievement overall.
27. During Month 12 COVID-19 started to impact on some of the schemes as nursing staff were redeployed to other duties and scheme leads were focusing their priorities on COVID related issues. Therefore it has been necessary to revisit year end positions for some of the schemes.
28. There has been an overall success within the medicines management team where schemes have delivered greater savings than planned.
29. Individual commissioning fell short of fully delivering anticipated efficiencies although 89% of savings were achieved.
30. The PMO team have considered lessons learnt from this year's QIPP programme which will help to inform next year's scheme developments.

Table 4: Summary of QIPP delivery

	2019/20 Plan			19/20 Delivery			
QIPP Position M12	Gross	Investment	Net	Plan	Actual	Variance	
Category of Spend	£000's	£000's	£000's	£000's	£000's	£000's	% Achieved
Acute Services	10,959	1,773	9,186	9,186	5,238	-3,948	57%
Individual Commissioning	2,871	87	2,784	2,784	2,483	-301	89%
Contracting	3,138	0	3,138	3,138	3,138	0	100%
Corporate Services	1,000	0	1,000	1,000	798	-202	80%
Primary Care	4,397	691	3,706	3,706	4,299	593	116%
Total	22,365	2,550	19,815	19,815	15,956	-3,859	81%

Underlying Financial Position

31. The underlying position at Month 12 is broadly consistent with the position shown at Month 11, an underlying deficit of £49.9m. This is due to the in year position including a number of one off benefits, for example the use of non recurrent underspends in primary care co commissioning and balance sheet flexibility.
32. The CCG started the financial year with a cumulative deficit carried forward from 2018/19 of £76.6m, the revised formal forecast of £47.3m in year deficit will now take the CCG cumulative position to a £123.9m deficit.

Annual Accounts Process

33. The draft annual accounts were submitted on the 24th April 2020 in line with the original timetable as the CCG did not choose to use the extended timeline for COVID-19. External auditors are now conducting their audit and liaising with the CCG finance team.
34. The timetable for final accounts submission has been extended and final accounts are now due to be submitted on 25th June 2020.

Conclusion

35. 2019/20 has been a very challenging year financially for Shropshire CCG. From early in the year the CCG reported a significant deterioration from the planned deficit and at Month 9 the CCG submitted a formal financial reforecast which was agreed with NHSE/I. The CCG ended the financial year with a total in year deficit of £47.3m. The three main drivers of the deficit during 2019/20 have been:

- Emergency Activity (including A&E, NEL and ambulance)
- Individual Commissioning (including CHC and Mental Health)
- Slippage in QIPP delivery

36. Emergency care budgets significantly overspent. The final overspend was £7.6m (11%) in emergency spells of care in hospital, £0.8m (7%) in A&E attendances and £0.3m (2%) in ambulance conveyances.

37. Individual Commissioning Costs have also significantly risen in 2019/20. The overspend in this area was £12m (28% over budget). The CCG has seen a steep increase in costs particularly in the area of Mental Health, Adult Joint Funded and increase in Adult fully funded packages where both numbers and costs of care packages have risen.
38. At the time of the 2019/20 plan submission the CCG was able to identify QIPP schemes to fully meet the QIPP target. Significant progress has been made in year across a number of schemes and the CCG was able to deliver £16m of QIPP against the original target of £19.8m (81%). The remaining 19% slippage has contributed to the in year deficit.
39. Throughout 2019/20 the CCG put in place a number of financial recovery actions to attempt to tackle the growing deficit including 'grip and control' measures and enhanced financial governance procedures. The CCG held regular sessions with the governing body and membership to maintain focus on the financial position and to identify additional cost saving opportunities across the system. The wider healthcare system was also engaged throughout through STP DOFs meetings and the STP System Operation Sustainability Group (SOSG). The STP has established a medical and finance group bringing together senior leaders from all organisations to consider and progress opportunities to minimise costs and avoid high cost acute admissions.
40. The CCG recognises that the poor financial outturn of this year directly impacts on the underlying position moving into future years and the CCG financial recovery plan will need to address this.
41. As the CCG moves into 2020/21 it continues to work with NHSE/I locally to highlight areas of additional savings and improved governance. Recruitment to a single executive structure of the CCGs is now complete and in operation from January 2020, helping to enhance focus on the financial position and identification of QIPP/savings opportunities.

1. Appendix A

Contents page

Ref	Description	Page no.
A-1	Acute Services	2-12
A-2	Non Acute Services	13-18
A-3	Other	20
A-4	Running Cost Allowance	21
A-5	Better Care Fund	22
A-6	QIPP Position	23
A-7	Allocations	24
A-8	Statement of Financial Position	25

A-1 Acute Services

	2019/20 Budget £'000
SaTH	147,576
RJAH	32,673
WMAS	14,616
NCA's & Other	39,587
Total Acute Services	234,452

Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000
147,576	159,708	12,131
32,673	33,679	1,006
14,616	14,908	292
39,587	41,845	2,258
234,452	250,139	15,687

KEY MESSAGES

At Month 12 the CCG is reporting a year to date over performance of £15.7m. This is primarily being driven by SaTH and out of area contracts.

During Month 9 Year End agreements were reached with the two main acute providers, SaTH and RJAH.

The agreement with SaTH is for a total value of £159.7m which includes readmissions reinvestment and delivery of Care Closer to Home QIPP. This has therefore mitigated the financial risk with the CC2H QIPP in this financial year as well as removed the risk of further overperformance within the main contract.

In order to provide support to RJAH, the CCG has agreed to adjust the CCG element of the MSK QIPP risk share to 78% from 50%.

There has been a slight improvement in the WMAS contract as we have seen activity variance to plan decrease over the last few months.

In relation to the NCAs these have remained at the same level as previously reported months.

Shrewsbury and Telford Hospital Trust

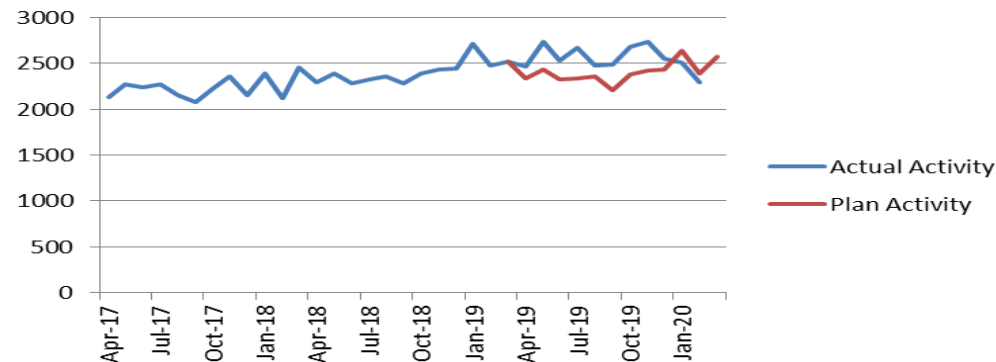
Shropshire CCG Position at Month 12 - Finance (Per Month 11 SATH Monitoring)

POD	Ytd Plan v Actual (£)				FOT 2019-20 Plan v Actual (£)			
	Ytd Cost Plan £	Ytd Cost Actual £	Ytd Cost Variance £	Cost Variance as % of Total Cost Variance	2019-20 Cost Plan £	2019-20 Cost FOT £	FOT Cost Variance £	FOT percentage Variance above Plan
Day Case	16,284,975	16,498,464	213,489	1.3%	16,284,975	16,498,464	213,489	1.3%
Elective	6,847,723	7,372,284	524,561	7.7%	6,847,723	7,372,284	524,561	7.7%
Emergency	61,576,687	68,010,417	6,433,730	10.4%	61,576,687	68,010,417	6,433,730	10.4%
Non Elective Other	6,371,825	6,167,140	(204,685)	(3.2%)	6,371,825	6,167,140	(204,685)	(3.2%)
CDU Adjustment	0	(508,138)	(508,138)	0.0%	0	(508,138)	(508,138)	0.0%
Critical Care	2,745,861	3,345,438	599,577	21.8%	2,745,861	3,345,438	599,577	21.8%
Outpatient Firsts	9,731,420	10,366,745	635,325	6.5%	9,731,420	10,366,745	635,325	6.5%
Outpatient Follow Ups	7,631,711	7,728,754	97,043	1.3%	7,631,711	7,728,754	97,043	1.3%
Outpatient Procedures	7,114,656	6,896,339	(218,317)	(3.1%)	7,114,656	6,896,339	(218,317)	(3.1%)
Accident and Emergency	10,424,707	11,122,197	697,490	6.7%	10,424,707	11,122,197	697,490	6.7%
Non PBR Variable	22,813,286	22,535,722	(277,564)	(1.2%)	22,813,286	22,535,722	(277,564)	(1.2%)
Non PBR Block	1,630,944	1,687,971	57,027	3.5%	1,630,944	1,687,971	57,027	3.5%
CQUIN	1,778,820	1,876,946	98,126	5.5%	1,778,820	1,876,946	98,126	5.5%
Blended Payment Rebate	0	(4,487,821)	(4,487,821)	0.0%	0	(4,487,821)	(4,487,821)	0.0%
MRET/Readmissions	(5,217,000)	0	5,217,000	(100.0%)	(5,217,000)	0	5,217,000	(100.0%)
Total	149,735,615	158,612,458	8,876,843	5.9%	149,735,615	158,612,458	8,876,843	5.9%

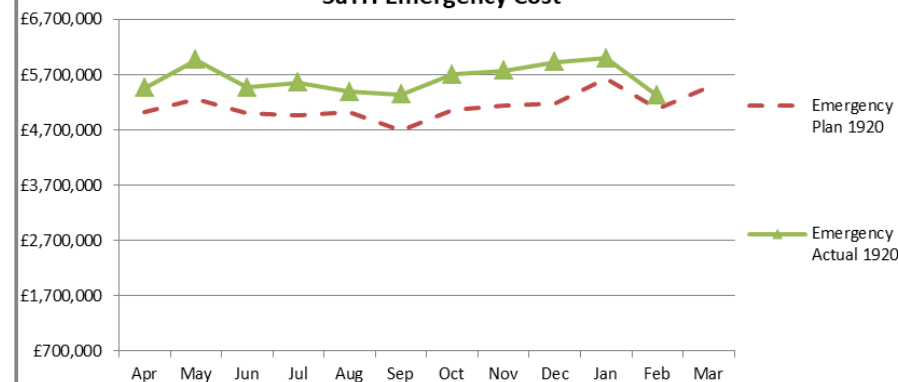
Prisoners	156,585	107,622	(48,963)		156,585	107,622	(48,963)	
Agreed Principles	0	(47,118)	(47,118)		0	(47,118)	(47,118)	
Penalties	0	(59,599)	(59,599)		0	(59,599)	(59,599)	
Phasing Correction	(5)	0	5		(5)	0	5	
Year End Deal	0	56,980	56,980		0	56,980	56,980	
Readmissions Reinvestment	360,259	360,259	0		360,259	360,259	0	
CC2H QIPP	(3,900,000)	0	3,900,000		(3,900,000)	0	3,900,000	
Service Developments	647,561	101,499	(546,062)		647,561	101,499	(546,062)	
Audiology AQP	575,899	575,899	0		575,899	575,899	0	
Total Over/(Under) performance	147,575,914	159,708,000	12,132,086	8.2%	147,575,914	159,708,000	12,132,086	8.2%

A Year End agreement has been reached between the respective organisations.

Emergency activity



SaTH Emergency Cost



SaTH Emergency Activity

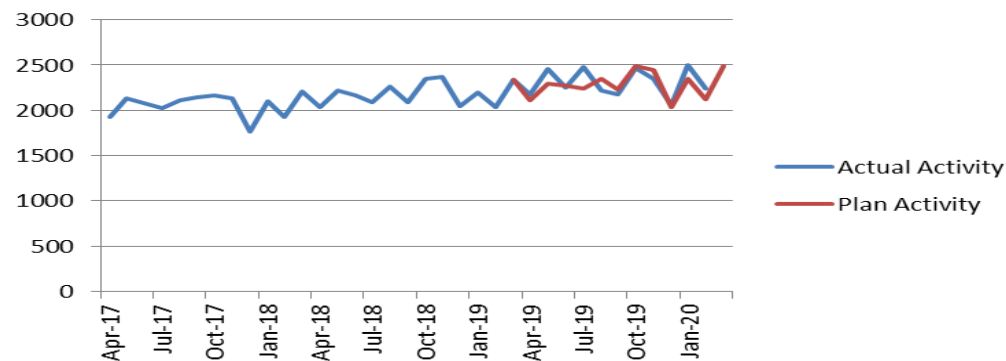
In February activity (including PRH CDU) was 4.1% under plan by 99 units where as to date activity is 1,866 over at 7.1% however this does include 661 units from CDU which were not in the plan as they are not currently paid for. In relation to the finances in February we were £242k over plan and year to date £5,863k before the CDU and blended payment adjustment is made. In relation to the drivers of the over performance these are shown below.

HRG Subchapter	Activity Plan	Activity Actual	Activity Variance	%age Activity Var	Price Plan	Price Actual	Price Variance	%age Price Var
Respiratory System Procedures and Disorders	3,258	4,054	796	24%	9,107,097	11,814,204	2,707,107	30%
Cardiac Disorders	3,260	3,607	347	11%	4,947,923	6,015,086	1,067,163	22%
Nervous System Procedures and Disorders	1,701	1,783	82	5%	4,102,400	5,040,805	938,405	23%
Skin Disorders	581	676	95	16%	1,364,019	1,712,225	348,206	26%
Renal Procedures and Disorders	1,388	1,492	104	7%	4,546,317	4,833,632	287,315	6%

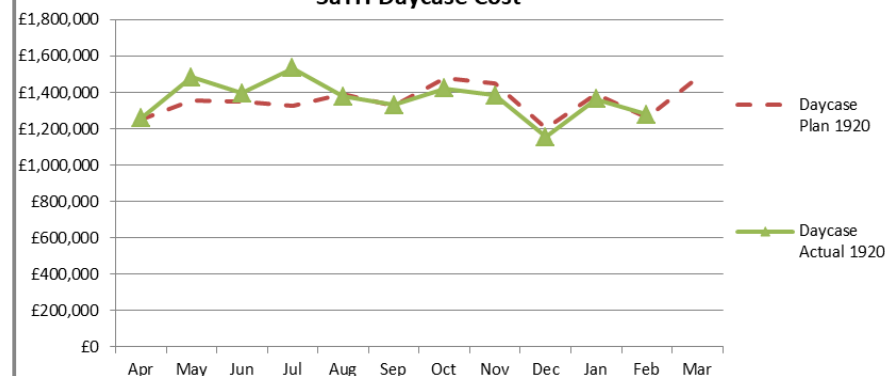
There are however several subchapters where activity is currently below plan, the main drivers of these are

HRG Subchapter	Activity Plan	Activity Actual	Activity Variance	%age Activity Var	Price Plan	Price Actual	Price Variance	%age Price Var
Hepatobiliary and Pancreatic System Disorders	677	619 -	58	-9%	1,829,820	1,653,953 -	175,867	-10%
Orthopaedic Non-Trauma Procedures	156	128 -	28	-18%	787,237	595,716 -	191,521	-24%
Hepatobiliary and Pancreatic System Endoscopic Procedures	108	76 -	32	-30%	575,849	379,475 -	196,374	-34%
Digestive System Open and Laparoscopic Procedures	593	558 -	35	-6%	2,827,020	2,592,725 -	234,295	-8%
Infectious Diseases and Immune System Disorders	610	490 -	120	-20%	1,704,512	1,121,468 -	583,044	-34%

Daycase activity



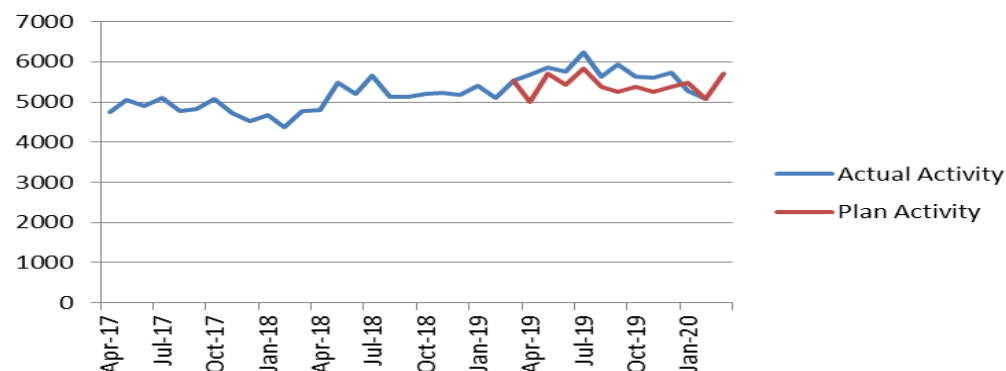
SaTH Daycase Cost



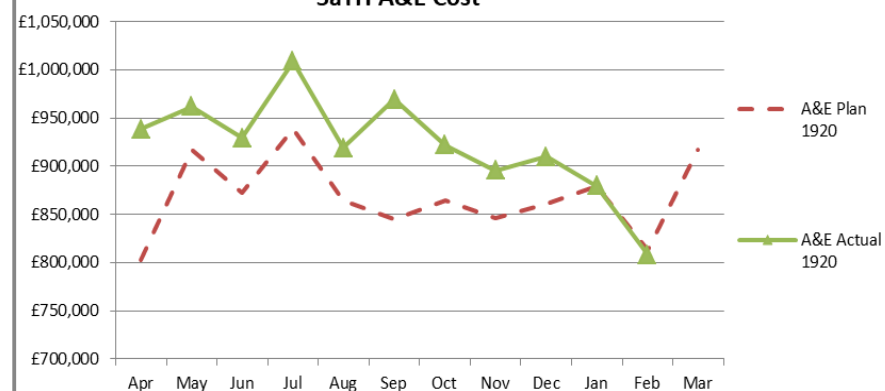
SaTH Daycase Activity

In February activity was 5% over plan which was 109 units bringing the YTD over performance to 422 units and 1.7% above plan. In relation to the finance February was £16k above plan which equates to 1.2% above plan. YTD Daycase is £193k over plan which is 1.3%. In terms of the drivers of this over performance the main HRG subchapters are Digestive System Endoscopic Procedures which is £172k over to date (1%) and Assisted Reproduction Medicine £89k (44%). We have however seen several areas significantly underperforming. These are Urological and Male Reproductive System Procedures and Disorders £-169k (-12%) and Hepatobiliary and Pancreatic System Open and Laparoscopic Procedures £-131k (-28%)

A&E activity



SaTH A&E Cost

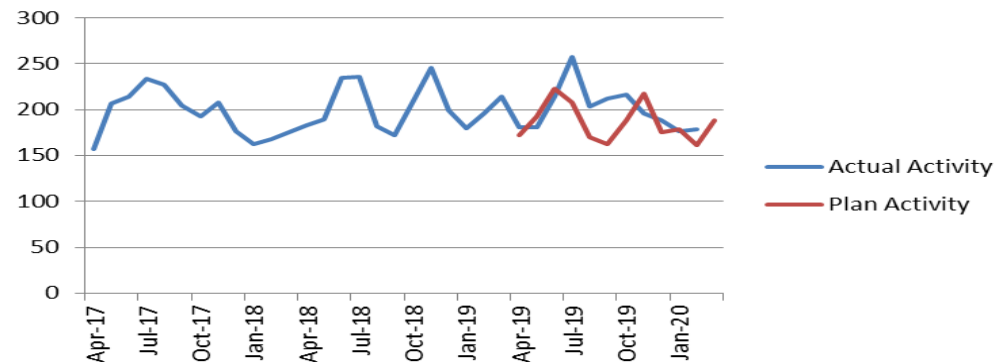


SaTH A&E Activity

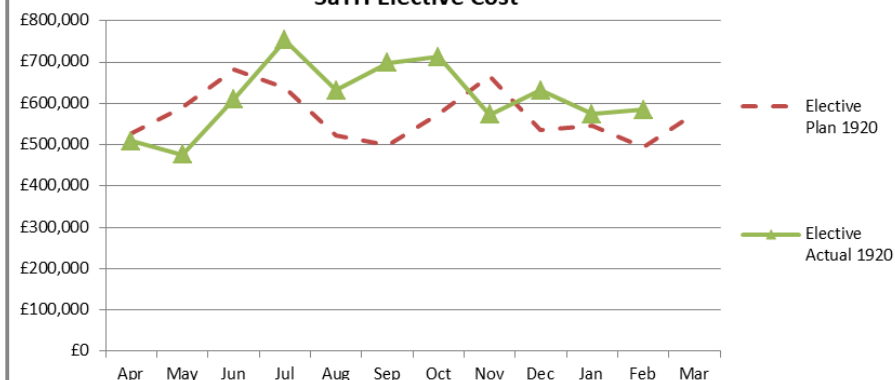
In February activity was almost exactly on plan with 7 units more than planned. YTD that brings activity to 3,270 units over (5%) in relation to finance February was £5k under however YTD it is £636k over plan which is 6.7%.

A-1a SaTH

Elective activity



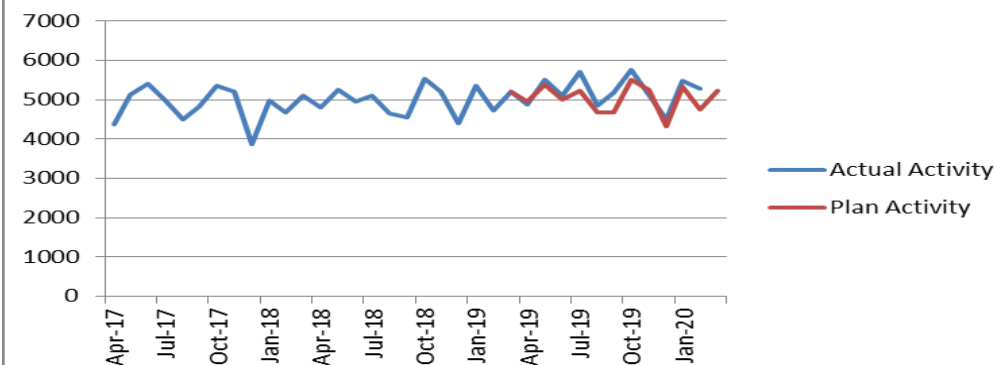
SaTH Elective Cost



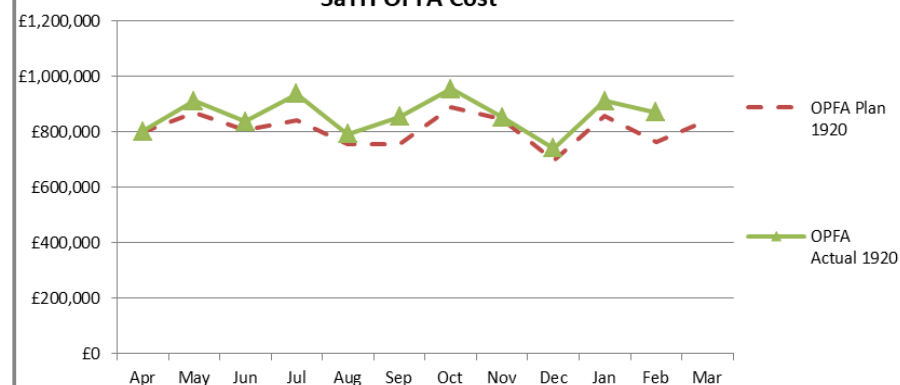
SaTH Elective Activity

In January activity was 18 units above plan which is 11% over plan. YTD we are 157 units over plan which equates to 7.7% over performance. In relation to finance in February Elective activity was £91k over plan which is 18.4% with YTD activity being £480k over plan which equates to 7.7%. In relation to the drivers of this performance the main areas are Haematological Procedures and Disorders £114k over plan (53%) and Orthopaedic Non-Trauma Procedures £65k (8%)

OPFA activity



SaTH OPFA Cost



SaTH OPFA Activity

In February activity was 527 units higher than planned which equates to over performance of 11%, YTD SaTH had undertaken 2,288 units higher than planned which equals 4% over performance. In relation to the finances February was £106k over plan (14%) with the finances YTD being £579k over (6.5%) In terms of the drivers of this activity they are Ophthalmology £654k over plan (89%) Gastroenterology £73k (17%) and Gynaecology £53k (12%). The Ophthalmology is partially offset by a significant reduction within Paediatric Ophthalmology £-151k under plan (-60%)

Robert Jones and Agnes Hunt Hospital Trust

Shropshire CCG Position at Month 12 - Finance (Per Month 11 RJAH Monitoring)

POD	Ytd Plan v Actual (£)				FOT 2019-20 Plan v Actual (£)			
	Ytd Cost Plan £	Ytd Cost Actual £	Ytd Cost Variance £	Cost Variance as % of Total Cost Variance	2019-20 Cost Plan £	2019-20 Cost FOT £	FOT Cost Variance £	FOT percentage Variance above Plan
Day Case	5,149,986	5,109,494	(40,492)	(0.8%)	5,149,986	5,109,494	(40,492)	(0.8%)
Elective	10,939,355	11,925,618	986,263	9.0%	10,939,355	11,925,618	986,263	9.0%
Non Elective Other	1,063,764	1,222,823	159,059	15.0%	1,063,764	1,222,823	159,059	15.0%
Regular Admissions	564,562	649,499	84,937	15.0%	564,562	649,499	84,937	15.0%
Outpatient Firsts	2,469,768	2,492,209	22,441	0.9%	2,469,768	2,492,209	22,441	0.9%
Outpatient Follow Ups	3,853,938	3,723,494	(130,444)	(3.4%)	3,853,938	3,723,494	(130,444)	(3.4%)
Outpatient Procedures	1,153,220	1,116,420	(36,800)	(3.2%)	1,153,220	1,116,420	(36,800)	(3.2%)
Non PBR Variable	4,228,852	4,684,108	455,256	10.8%	4,228,852	4,684,108	455,256	10.8%
Non PBR Block	2,874,219	2,725,605	(148,614)	(5.2%)	2,874,219	2,725,605	(148,614)	(5.2%)
CQUIN	375,677	379,714	4,037	1.1%	375,677	379,714	4,037	1.1%
Total	32,673,341	34,028,984	1,355,643	4.1%	32,673,341	34,028,984	1,355,643	4.1%
Riskshare	0	(396,173)	(396,173)		0	(396,173)	(396,173)	
Challenges	0	(35,240)	(35,240)		0	(35,240)	(35,240)	
CQUIN Adjustment	0	(75,943)	(75,943)		0	(75,943)	(75,943)	
YE Deal	0	157,372	157,372		0	157,372	157,372	
Total position	32,673,341	33,679,000	1,005,659	3.1%	32,673,341	33,679,000	1,005,659	3.1%

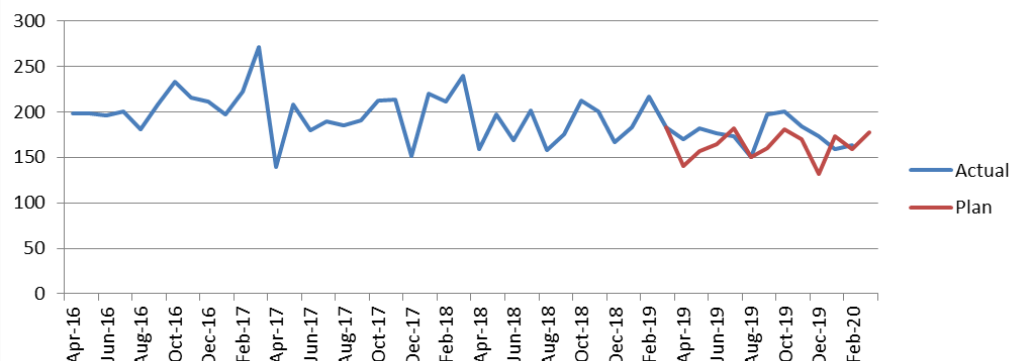
Shropshire CCG Position at Month 12 - Activity (Per Month 11 RJAH Monitoring)

POD	Ytd Plan v Actual (Activity)				FOT 2019-20 Plan v Actual (Activity)			
	Ytd Activity Plan	Ytd Activity Actual	Ytd Activity Variance	Activity Variance as % of Total Activity Variance	2019-20 Activity Plan	2019-20 Activity FOT	FOT Activity Variance	FOT percentage Variance above Plan
Day Case	2,279	2,270	(9)	(0.4%)	2,279	2,270	(9)	(0.4%)
Elective	1,947	2,121	174	8.9%	1,947	2,121	174	8.9%
Non Elective Other	228	243	15	6.6%	228	243	15	6.6%
Regular Admissions	563	635	72	12.8%	563	635	72	12.8%
Outpatient Firsts	20,304	21,399	1,095	5.4%	20,304	21,399	1,095	5.4%
Outpatient Follow Ups	58,435	56,181	(2,254)	(3.9%)	58,435	56,181	(2,254)	(3.9%)
Outpatient Procedures	4,422	4,329	(93)	(2.1%)	4,422	4,329	(93)	(2.1%)
Total	88,178	87,178	(1,000)	(1.1%)	88,178	87,178	(1,000)	(1.1%)

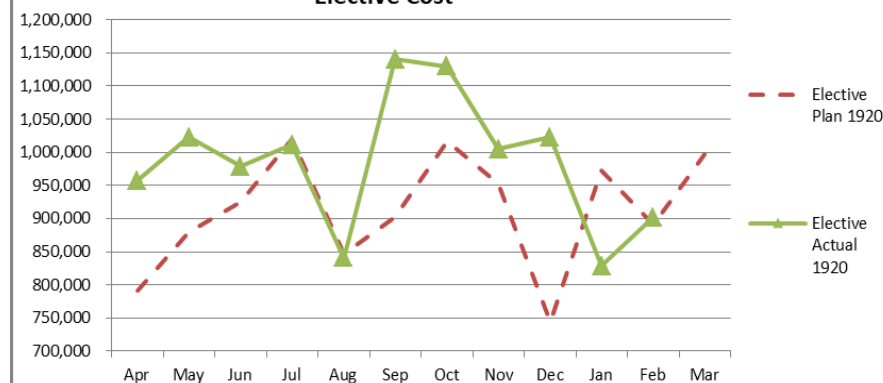
A Year End agreement was reached between the respective organisations.

ELECTIVE POD

Elective Activity



Elective Cost



RJaH Elective Activity

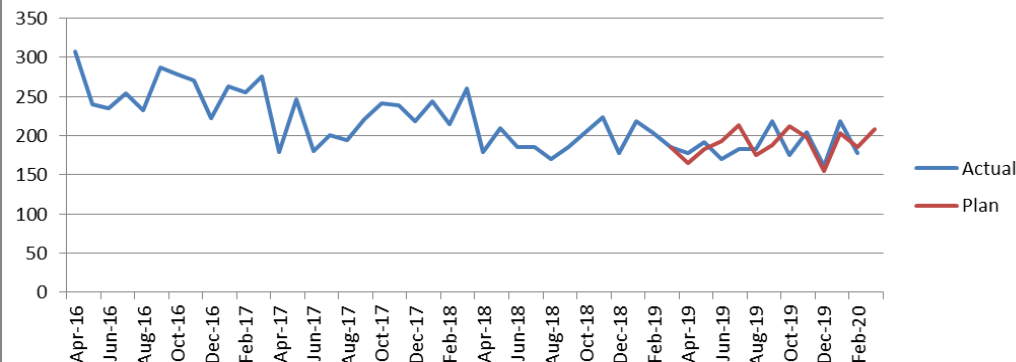
In February activity was in line with plan with four additional units of activity being undertaken (2.8%) taking the year to date over performance in activity being 8%. In relation to finance in February it was £11k above plan (1.2%) and YTD £896k which is 8%. The main driver of the over performance over the year has been a combination of Spinal Procedures and Disorders (£224k) as well as Orthopaedic Non-Trauma Procedures (£898k) As you can see below from a breakdown of the Orthopaedic procedures the main driver is those procedures relating to Hips.

Orthopaedic Non-Trauma Procedures split

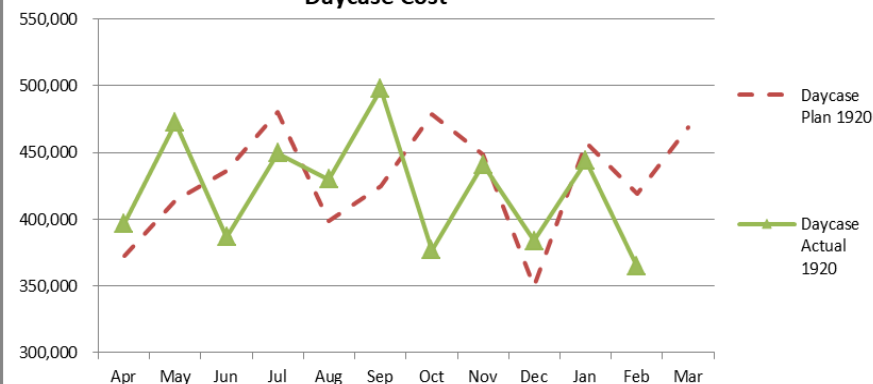
Body Part	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
Elbow	18.7	28.0	9.4	87,358	100,255	12,897
Foot	91.2	109.0	17.8	402,163	473,059	70,896
Hand	29.5	44.0	14.6	86,999	139,205	52,206
Hip	426.2	509.0	82.8	2,877,820	3,396,712	518,892
Knee	561.3	588.0	26.7	3,592,258	3,683,752	91,494
Shoulder	71.9	72.0	0.1	366,818	399,278	32,460
Other	85.2	104.0	18.8	861,827	976,604	114,777
Grand Total	1,283.9	1,454.0	170.1	8,275,243	9,168,865	893,622

A-1b RJAH

Daycase Activity



Daycase Cost



RJAH Daycase Activity

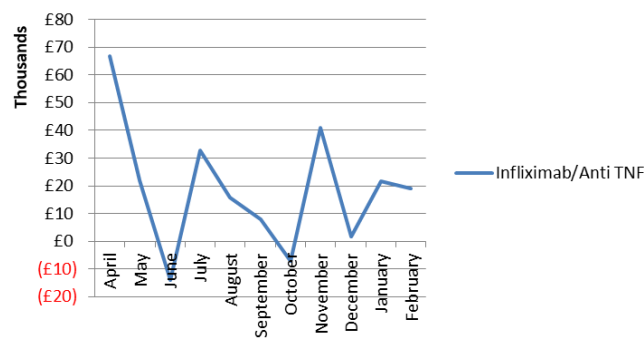
Within the Daycase POD in February we saw a small under performance of 8 units (4%) with activity being broadly on plan YTD. In terms of the finance we saw an under performance of £55k in February (13%) with the finance YTD £36k under which is 1%.

Whilst overall the activity has been on plan within the point of delivery we have seen over performance within the Spinal procedures and disorders subchapter (£30k) where we have also seen under performance relating to Orthopaedic Non-Trauma Procedures of £-45k).

RJAH Others

Within the 'other's the main over performance relates to the Infliximab/Anti TNF drugs. Whilst it is an area that can show fluctuation due to the nature of the service we did see a significant spike in April which we believe relates, at least in part to 18/19.

Infliximab/Anti TNF variance to plan

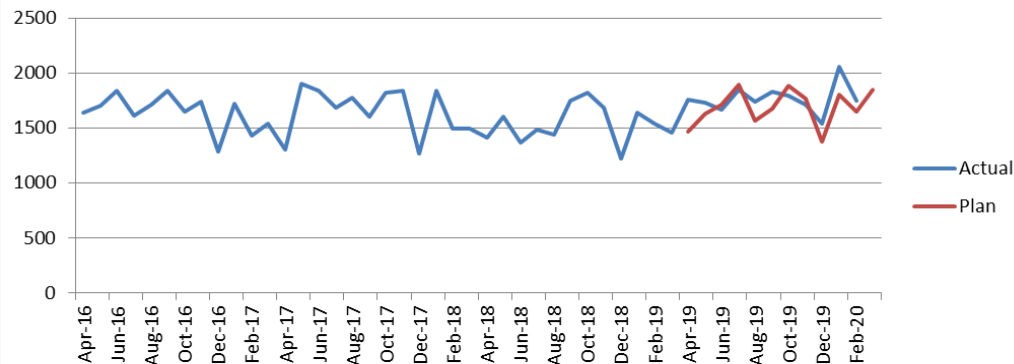


RJAH Others

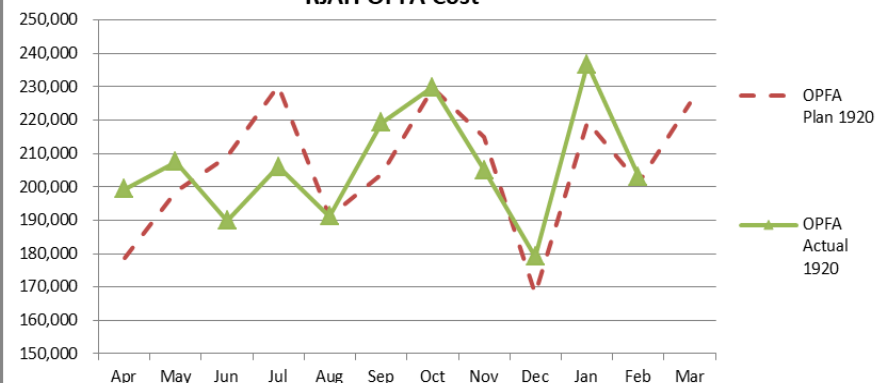
Month	Price Plan	Price Actual	Price Variance	Price Variance Excl Infliximab/Anti TNF
April	535,693	633,427	97,735	30,961
May	577,335	588,004	10,669	(11,193)
June	598,628	566,572	(32,056)	(18,057)
July	642,578	652,220	9,642	(23,149)
August	561,638	606,338	44,701	29,010
September	587,754	595,168	7,413	(490)
October	640,893	664,560	23,666	30,701
November	611,063	624,419	13,356	(27,783)
December	513,592	564,838	51,246	49,634
January	620,053	644,392	24,339	2,696
February	582,401	612,071	29,670	10,732
March	631,443	-	-	-
Grand Total	7,103,071	6,752,009	280,382	73,063

A-1b RJA

OPFA Activity



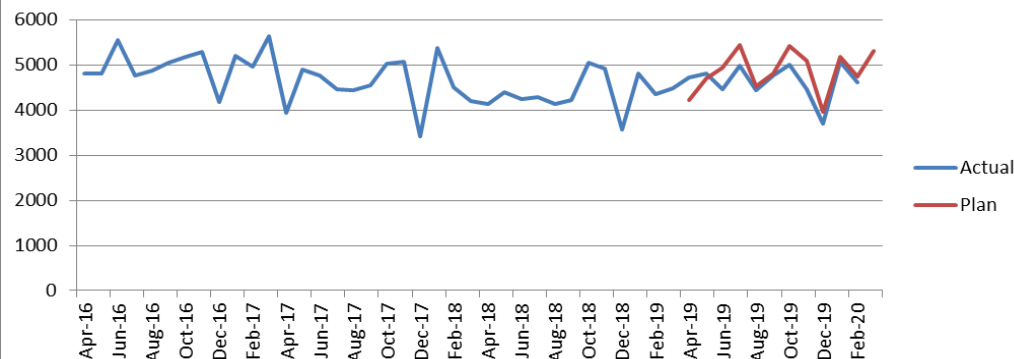
RJAH OPFA Cost



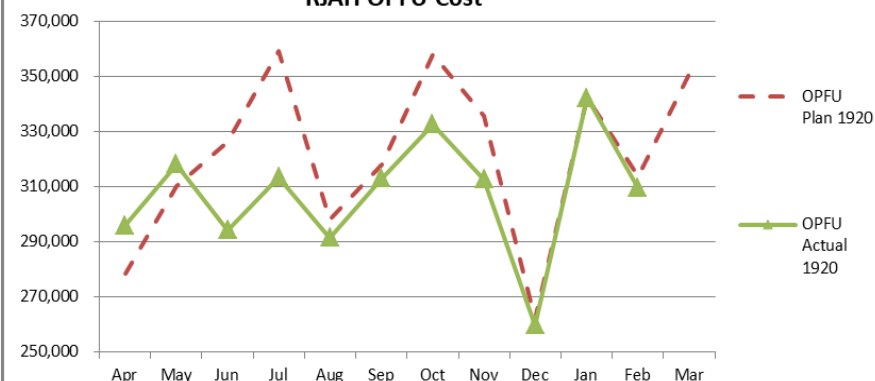
RJAH OPFA Activity

Within the Outpatient First Attendances in February 100 units of activity were taken above plan (6%) taking our YTD activity to 995 over plan (5%) in terms of finance we were £2k over in February (%) and £20k for the year which is just under 1%. Within this setting the main drivers are direct access physiotherapy, bone densitometry as well as consultant led first attendances.

OPFU Activity



RJAH OPFU Cost



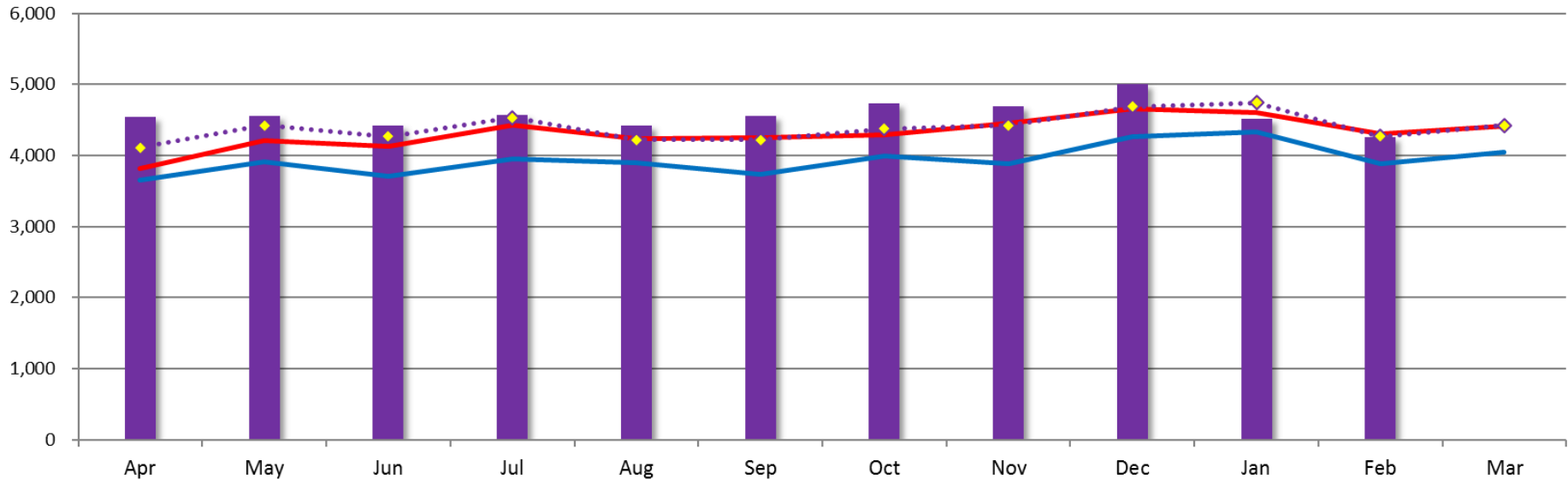
RJAH OPFU Activity

Within the Outpatient Follow Ups in February we saw 150 units less than planned (3% with YTD being 2050 under plan which is 3.5%. In relation to the finances in February we were £4k under which is 1.4% with the YTD being £1118k under (-3%) In terms of the drivers of this under performance the main driver is physiotherapy attendance and consultant led follow ups, however within this POD we have also seen over performance relating to DMARDS, Occupational therapy and direct access physiotherapy.

A-1c West Midlands Ambulance

WMAS Contracted Activity against Plan

19/20 Actual Activity 17/18 Actual activity 18/19 Actual activity 19/20 Contracted activity



Month 12 Shropshire

£

14,227,706 M12 Plan

553,786 FOT OP

93,185 HandChanges

31,877 Non Comp

14,906,554 M12 Position

1,021 Prior Year

41,285 CAS (SWBCCG)

14,948,860 M12 Position Final

14,656,991 Annual Plan

291,869 Variance

(11,813) FOT Movement

WMAS Activity 2019/2020

After the low cost month of January, activity in February was marginally below plan (0.16%), the over performance year to date reducing to 4.24%. Our forecast outturn position assumes an overall (prudent) level of 4.38% over performance for the year given the uncertainty around potential costs in March.

With the NHS 111 service now being undertaken by WMAS, all category 3 and 4 calls have been triaged from November 2019 onwards. It does appear at this early stage that this has resulted in a reduction in conveyances for January and February, with a corresponding fall in activity and costs from those previously predicted.

A-1d NCA and Others

	2019/20 Budget £000	2019/20 Actual £000	2019/20 Variance £000
Other Acute Contracts	32,031	34,270	2,239
Acute NCA's	3,741	4,551	811
Acute Special Placements	22	12	(10)
Winter Resilience	2,030	1,282	(748)
Future Fit	230	163	(66)
STP	230	341	111
Acute services - Other	168	178	9
High Cost Drugs	533	442	(91)
Acute Services Team	602	606	4
NCA & Others	39,587	41,845	2,258

The main driver of the overspend at year end is the over performance activity within our 'Other Acute Contracts'.

The main variances in this area are as follows :

University Hospitals of North Midlands Trust – A provisional overspend against contract of £1,508k, an adverse movement of £65k from last month. The variance includes over-performing emergency activity £614k as well as a small number of high cost long stay critical care patients totalling £300k in excess of plan).

Royal Wolverhampton Trust - A final agreed overspend against contract of £785k, primarily relating to an over-performance in emergency activity of £360k and in daycase/elective activity combined of £244k.

Wye Valley Trust – A final agreed overspend against contract of £615k, a favourable movement in month of £39k, the overall variance due to over-performances within emergency activity £409k and accident and emergency attendances £103k.

Dudley Group Foundation Trust – A provisional overspend against contract of £247k due to emergency activity over-performance of £112k and critical care of £53k.

QIPP slippage in the a) **Care Closer to Home** (CC2H) QIPP of £2.9m and b) slippage in **VBC/MSK** expected savings of £250k and £231k respectively are included within the trusts expenditure positions.

The prior year non recurrent benefit saw a further improvement at month 12, following the long awaited 18-19 outturn agreement between UHB and their host commissioner. The total figure has been finalised at £553k, primarily driven, as stated previously, by the finalised 18-19 UHNM position.

A-2 Non Acute Services

	2019/20 Budget £'000	Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000
Community	50,032	50,032	49,943	(89)
Mental Health	43,350	43,351	46,627	3,276
Individual Commissioning	35,432	35,432	44,823	9,391
Primary Care	64,377	64,377	66,219	1,842
Total Non Acute Services	193,191	193,192	207,612	14,420

Key Messages

- The Non Acute Services position at Month 12 shows a £14.4m overspend which has deteriorated from £13.4m forecast overspend last month. The majority of the overspend relates to significant over performance in terms of both activity and cost in relation to IC – under both the core IC budget line and Mental Health (£2.8m of the £3.3m MH overspend relates to IC). Further information on the overspend and mitigating actions is provided on the IC slide.
- Information regarding the Shropshire Community Health NHS Trust (SCHT) and Midlands Partnership NHS Foundation Trust (MPFT) contracts are provided on the following slides. The SCHT position shows £226k overspent compared to £304k forecast overspend last month. This is due to non-achievement of QIPP and over performance in MIU activity less CQUIN under-performance. The MPFT year end position is £158k overspent which reflects the agreement of a year end position with the trust.
- An overspend of £473k is built into the position for out of area (ooa) acute placements, including PICU. This is a deterioration of £518k from the previous month, and is currently being investigated.
- Community services overall is underspent by £89k. This includes £161k further slippage on Care Closer to home investment (£1.1m in total), unachieved QIPP of £175k, Shropshire Comm Trust contract estimated over performance of £161k, Hospice at Home additional costs of £333k and NHS contract over-performances for Wye Valley Trust (£202k) and Worcestershire (£78k). The position also includes overspends for Ophthalmology of £295k, and Dermatology £72k. Prior year expenditure is factored into the year to date position. Dermatology over performance has been investigated and a full report is awaited for final reporting & discussion through Contract Assurance group.
- The CCG is planning to meet the Mental Health Investment Standard in 2019/20 which means that Mental Health spend will have increased in line (or more) with CCG allocation growth.
- A breakdown of the primary care position is provided at A-2d; the majority of the overspend relates to GP prescribing.

A-2a Shropshire Community Trust

	2019/20 Budget		M12 YTD Actual	M12 YTD Variance		Budget Year To Date	Actual Year To Date	Variance Year To Date
	£'000		£'000	£'000		£'000	£'000	£'000
Main Contract	40,553		40,779	226		40,553	40,779	226
Out of Hours	3,150		3,103	-47		3,150	3,103	-47
Total SCHAT	43,703		43,882	179		43,703	43,882	179

The year end position for the Main Contract is £226k overspent (compared to last month's forecast of £304k.) Key reasons for the overspend include £161k of estimated contract over-performance, £175k non-achievement of QIPP (50% agreed Risk share), less CQUIN under-performance of £87k. Trends in activity are monitored monthly through the Contract Review Meetings (CRMs). The position includes a reduction for APCS Dermatology services which ceased in September. Estimated contract performance is based on the January contract monitoring report.

A summary of the activity performance to January is shown in the table opposite. Year to date and forecast overspends are based on current over-performance. MIU activity is estimated to be £122k over partly abated by Outpatient underperformance of £37k. Community Equipment and Continence lines are under-performing against plan and compared to last year, however these are part of the block contract.

The contract includes £350k QIPP target with no schemes identified so the agreed risk share has been enacted via a contract variation. The provider is disputing the service lines that have been identified by the CCG so this has been escalated for Exec discussion. Contract meetings to agree next year's contract including QIPP have been held and were in the final stages of negotiation when the contract process was paused nationally due to the impact of COVID-19.

There is a separate contract for Out of Hours which is an agreed fixed value less a recurrent contract reduction in respect of some weekend services (with a part year effect in 2019/20).

Summary	Activity Plan	Activity Actual	Variance
Hospital			
Imaging	7935	7929	(6)
Inpatients	1537	1447	(90)
MIU	22223	23884	1,661
Outpatients	10514	9747	(767)
Community			
Community	301,505	316,362	14,857
Equipment	167,347	139,745	(27,602)

A-2b Midlands Partnership Foundation Trust

	2019/20 Budget £'000	M12 YTD Actuals £'000	M12 YTD Variance £'000	Budget Year To Date £'000	Actual Year To Date £'000	Variance Year To Date £'000
Main Contract	30,439	30,597	158	30,439	30,597	158
0-25 Emotional Health & Wellbeing	3,016	3,032	15	3,016	3,032	15
Total MPFT	33,456	33,629	173	33,456	33,629	173

The MPFT (Main Contract) overspend of £158k matches last month's forecast and reflects the agreement of a year end position with the trust.

The two key over performing areas during 2019/20, reflected in the activity table, relate to PICU and dementia.

The 0-25 EHWS year end position is a small overspend of £15k.

Summary	M12 Activity Plan	M12 Activity Actual
MH PbR Admitted Care	21,860	20,170
MH PbR Non Admitted Care	1,300,038	1,735,254
MH Non PbR	34,748	30,545
Specialist and Family Care	3,213	2,110
LD Services	7,312	8,323

A-2c Individual Commissioning

At Month 12 the position across both core IC and Mental Health shows a final overspend of £12.03m.

Cost centre	Cost Centre Description	Annual Budget	YTD Budget M12	YTD Actual M12	YTD Variance M12
368522	Learning Difficulties S117	£506,924	£506,924	£1,047,601	£540,677
368541	Mental Health Collaborative Commissioning	£825,350	£825,350	£501,235	£(324,116)
368557	Mental Health S117	£5,092,738	£5,092,738	£7,233,235	£2,140,497
368561	Mental Health Specialist Services	£170,323	£170,323	£762,409	£592,086
	Mental Health	£6,595,335	£6,595,335	£9,544,479	£2,949,144
368682	IC Adult Fully Funded	£17,553,684	£17,553,684	£23,957,684	£6,404,000
368682	COVID 19 spending	£0	£0	£21,737	£21,737
368683	IC Adult Fully Funded PHB	£1,437,207	£1,437,207	£2,117,902	£680,695
368684	Adult Joint Funded	£5,116,873	£5,116,873	£6,495,046	£1,378,173
368685	Adult Joint Funded PHB	£0	£0	£71,396	£71,396
368687	Children's Joint Funded	£2,072,441	£2,072,441	£2,776,125	£703,684
368688	Children's Joint Funded PHB	£201,402	£201,402	£481,170	£279,768
368691	FNC	£7,939,684	£7,939,684	£7,407,257	£(532,427)
368796	Reablement	£523,567	£523,567	£595,202	£71,635
	Other CHC	£34,844,857	£34,844,857	£43,923,518	£9,078,661
	Grand Total	£41,440,192	£41,440,192	£53,467,998	£12,027,806

Note that the total costs for Other CHC differ from those shown for Individual Commissioning on slide A-2. This is due to the inclusion of Reablement costs in the table above which are shown within Other costs on slide A-3. In addition, the figures above exclude costs in relation to Individual Commissioning staffing costs.

A-2c Individual Commissioning

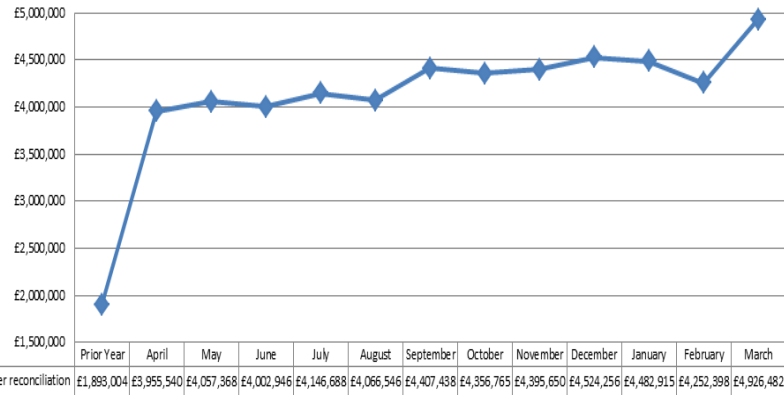
The year end position for Individual Commissioning has improved overall since last month by £0.261M when compared to last months risk adjusted forecast. The main reason for this overall movement is that £282k for the Betsi provision has been recoded to the bad debt provision in other. The main drivers of the change in reported over spend include:

1. Costs held within Broadcare increased by £420K. This was due to packages of care being updated in month for new cases but also for the differences in costs for some packages being backdated to early parts of the financial year.
2. Forecasts relating to Joint Funded patients have been reduced by £394K based on new information received from Shropshire Council and the results of two meetings between Council representatives and representatives from the CCG to confirm recharges. Whilst good progress was made during these meetings, it was not possible to discuss all patients due to commitments on both sides relating to the COVID 19 situation. The CCG and LA teams remain committed to resolving the balance of outstanding debt once the focus on COVID19 lessens.
3. We have reduced the future patient accrual by £361K based on updated information held within Broadcare which has given a benefit of the same amount.
4. In month 11, we had a provision here of £282K relating to risk around the receipt of payment for an old legal case with Betsi Cadwaladr. This provision has been moved to sit within Other Costs as a bad debt provision at year end.
5. We have increased the provision for outstanding appeals by £100k based on previously paid appeals costs. The total provision is now £200K.
6. There are now no outstanding ratifications as it is believed that all have been addressed within Broadcare. This is a reduction of £41K compared to month 11.
7. Due to the situation with COVID 19 throughout March, the previously forecast QIPP did not deliver in full and as such we have had to reduce the year end delivery by £297K which has given an increase in costs.
8. It is also worth noting that COVID 19 spending within this area totalled £22K which has been reimbursed to the CCG.

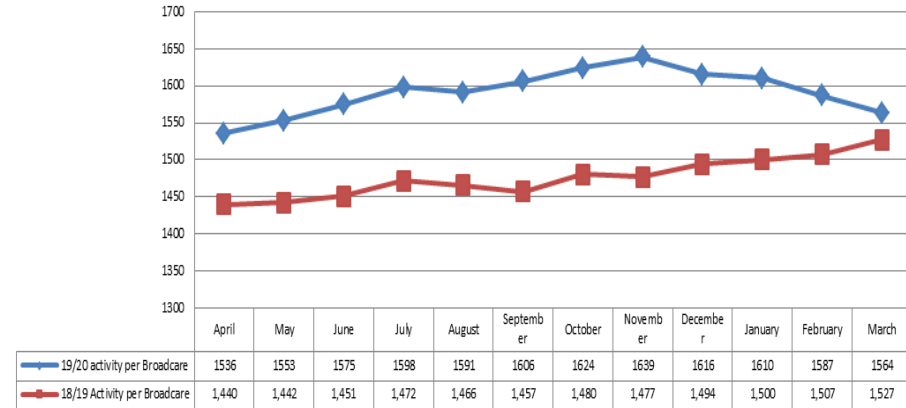
	Movement in month £'000
Individual Commissioning Deterioration	(156)
IC- captured in MH spend improvement	135
Betsi moved to other	282
TOTAL	261

A-2c Individual Commissioning

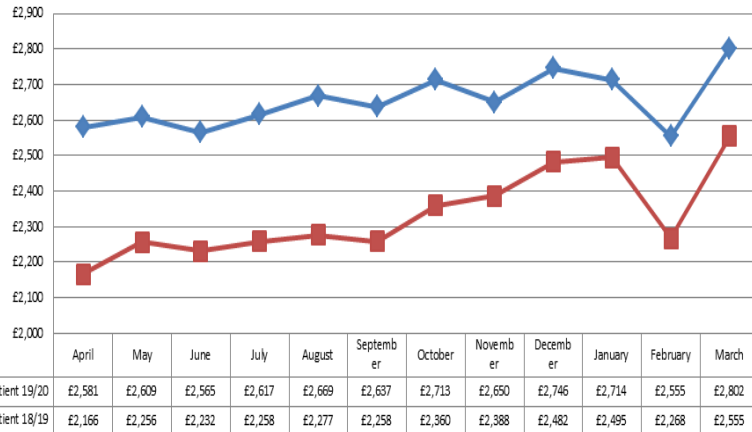
Total Costs £



Patient Numbers



Average cost per patient £



A-2d Primary Care Services

Key Messages:

Primary Care Delegated Commissioning

The CCG submitted a delegated commissioning expenditure plan that is £1.5m higher than the ring fenced allocation.

However, the final end of year position recorded is £11k higher as a result of a number non recurrent underspends in year.

The main savings variances in the M12 position are as follows:

- GP GMS – £169k, linked to PMS savings, partly offset by increased costs asso to list size recalculations as at Sep19/Dec19.
- G.P.APMS - £129k relate to the Practice closure.
- Enhanced Services - £680k (£514k regarding the PCN Pharmacy Posts, and delays in recruitment, £97k Learning Diff both P/Y and curr savings, plus £56k Minor Surgery).
- Premises - £445k savings reflects Rates underspend of £471k, asso with Rebates and practice closure, partly offset by overspend in Rents £20k re review provisions.
- Other GP Services - £154k relates to P/Y and current Locum savings £112k with the balance reflecting Seniority underspend.
- These savings were partly offset by a QOF cost pressure – £102k, linked to prior year payments £17k, plus current year Achievement costs and Aspiration accrual.

Prescribing

The M12 position is based on the Epact forecast from M10, plus an adjustment to reflect potential growth in the second half of March 20 linked to Covid19 demand. The position also includes the £250k benefit b/f from 18/19.

Primary Care Other

The main variances in this section are as follows:

- The Out of Hours saving is connected to the weekend cover reductions in the later part of the year.
- Enhanced Services savings reflects LCS activity levels slightly below plan.
- An overspend in Central Drugs which reflects the General Prescribing pattern,
- The Prescribing Incentives saving relates to the 18/19 scheme.
- Savings in CHAS reflect release of P/Y accrual and also in the new scheme in 19/20.
- Underspend in P.C. Team relating to vacancies
- P.C IT savings which reflects system maintenance costs that have been lower than initial projections.

Primary Care Delegated Commissioning	Opening Budget 19/20	Annual Budget	M12 YTD Budget	M12 YTD Actual	M12 YTD Variance
	£'000	£'000	£'000	£'000	£'000
General Practice - GMS	29,237	28,692	28,692	28,523	(169)
General Practice - PMS	375	375	375	358	(17)
General Practice - APMS	1,216	1,216	1,216	1,087	(129)
Enhanced Services	1,782	2,368	2,368	1,688	(680)
QOF	4,439	4,439	4,439	4,541	102
Premises cost reimbursements	5,420	5,420	5,420	4,975	(445)
Dispensing	2,508	2,508	2,508	2,526	18
Other - GP Services	1,071	1,071	1,071	917	(154)
Net Reserves	56	15	15	0	(15)
Co Commissioning Total	46,104	46,104	46,104	44,615	(1,489)

Other Primary Care Commissioning	£'000	£'000	£'000	£'000	£'000
Prescribing	49,603	48,948	48,948	50,966	2,018
Out Of Hours	3,150	3,150	3,150	3,103	(47)
Enhanced Services	2,696	5,599	5,695	5,650	(45)
			0		
Primary Care Other					
- Central Drugs	1,257	1,257	1,257	1,349	92
- Oxygen	605	605	605	598	(7)
- Primary Care Comm Schemes	1,414	54	54	50	(4)
- Hospice Drugs	75	75	75	68	(7)
- Prescribing Incentives	315	315	315	260	(55)
- Care Home Advanced Scheme	230	230	230	140	(90)
- Primary Care Team	1,935	2,057	2,069	1,924	(145)
- Primary Care IT	978	2,087	2,148	2,111	(37)
- Primary Care Reserves	242	0	0	0	0
Primary Care Other Total	7,051	6,680	6,753	6,500	(253)

Total Other P.C.Commissioning	62,500	64,377	64,546	66,219	1,673
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GRAND TOTAL	108,604	110,481	110,650	110,834	184
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A-3 Other

	2019/20 Budget £'000
Patient Transport	3,301
NHS 111	1,173
Referral Assessment Service Team	423
Community & Care Co-ordinators	370
NHS Property Services	225
Better Care Fund	7,779
Reablement	523
Other	211
Commissioning Reserve	1,874
0.5% Contingency	2,104
Other Total	17,983

Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000
3,301	3,104	(197)
1,173	1,236	63
423	362	(60)
370	370	0
225	197	(28)
7,779	7,779	0
524	595	72
211	140	(70)
1,874	0	(1,874)
2,104	0	(2,104)
17,983	13,785	(4,199)

Key Messages

- The year-end position of £4.2m underspend is due to the release of £4m of reserves.
- The underspend on Patient Transport reflects reduced activity levels against the budgeted level, following robust activity validation checks and appropriate recharges to other NHS bodies.
- During Month 12 £282k of Individual Commissioning spend was recoded to other as part of the bad debt provision relating to the Betsi Cadwaladr Contract.

A-4 Running Cost Allowance

Key Messages

- The CCG has a separate allocation for the running costs of the organisation (non clinical posts/support), which equates to £7m.
- At Month 12 running costs are overspent by £202k due to £399k cost of change expenditure incurred in the journey to becoming a Single Strategic Commissioning organisation off set by non recurrent Pay and Non-pay savings, These savings have occurred due to a reduction in non-discretionary spend as a result of the implementation of the expenditure controls.
- For 2020/21 the CCG will have a much lower running cost budget of £5,835k and we are working on plans with Telford and Wrekin CCG in order to address this reduction.

	2019/20 Budget £'000
Corporate Costs	3,692
Service Planning	767
Commissioning & Contracting	786
Strategy & Service Redesign	395
Finance	1,098
Governance	200
Nursing & Quality	149
Corporate Reserves	93
Cost of Change	0
Running Costs QIPP	(225)
Running Cost Total	6,955

Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000
3,692	4,015	323
767	838	71
786	568	(217)
395	377	(18)
1,098	1,012	(86)
200	194	(7)
149	153	3
(95)	0	95
0	0	0
(38)	0	38
6,955	7,157	202

Cost of Agency/Interim Staff
Programme Costs
Running Costs
Total

Actual Year to Date £'000	%
627	71%
263	30%
889	

There were 6 interim staff in post as at month 12. They are now reduced to 4 : 2 re CHC whose contract ends in April 2020, 2 POD to cover sickness due to COVID-19

A-5 Better Care Fund (BCF)

Summary Statement	Annual Budget £	Year to Date Budget £	Year to Date Expenditure £	Year to Date Variance £
<u>Prevention Programme</u>				
Care Navigation / Co Ordination	1,185,828	1,185,828	1,193,522	7,694
Total Prevention Programme	1,185,828	1,185,828	1,193,522	7,694
<u>Admissions Avoidance</u>				
Assistive Technologies	1,613,090	1,613,090	1,613,090	-
Care Navigation / Co Ordination	649,175	649,175	649,175	-
Enablers for Intergration	3,666,234	3,666,234	3,666,234	-
Healthcare services to Care Homess	230,000	230,000	140,000	- 90,000
Intermediate Care Services	3,171,187	3,171,187	3,232,810	61,623
Personailised Healthcare at Home	331,501	331,501	288,975	- 42,526
Total Admissions Avoidance	9,661,187	9,661,187	9,590,284	- 70,903
<u>Early Supportive Discharge</u>				
Integrated Care Plannning	2,992,005	2,992,005	2,992,005	-
Total Early Supportive Discharge	2,992,005	2,992,005	2,992,005	-
<u>Other</u>				
SCCG funded LA expenditure	7,779,300	7,779,300	7,779,300	-
LA Funding expenditure	9,235,247	9,235,247	9,235,247	-
i BCF	10,120,779	10,120,779	10,120,779	-
Total Early Supportive Discharge	27,135,326	27,135,326	27,135,326	-
Grand Total:	40,974,346	40,974,346	40,911,137	(63,209)

Funding Breakdown:	£
CCG Funded - Minimum	13,839,020
LA Funded via CCG	7,779,300
	21,618,320
Additional LA Funding, seperately allocated to the funds above	
LA Contribution	9,235,247
i BCF	10,120,779
	19,356,026
Total Joint CCG / LA Fund	40,974,346
Note	
The budget figures are in line with 19/20 Joint SCCG/Local Authority BCF Template Submitted in September 19 to NHSE.	

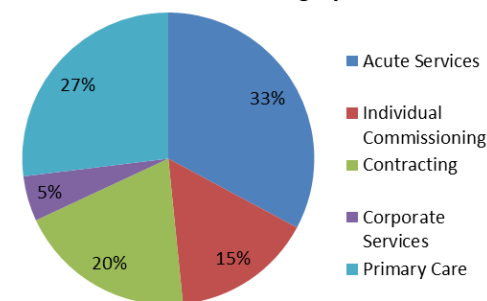
	2019/20 Plan			19/20 Delivery			
QIPP Position M12	Gross	Investment	Net	Plan	Actual	Variance	
Category of Spend	£000's	£000's	£000's	£000's	£000's	£000's	% Achieved
Acute Services	10,959	1,773	9,186	9,186	5,238	-3,948	57%
Individual Commissioning	2,871	87	2,784	2,784	2,483	-301	89%
Contracting	3,138	0	3,138	3,138	3,138	0	100%
Corporate Services	1,000	0	1,000	1,000	798	-202	80%
Primary Care	4,397	691	3,706	3,706	4,299	593	116%
Total	22,365	2,550	19,815	19,815	15,956	-3,859	81%

The information above details the 2019/20 QIPP Plan and position as at Month 12. The CCG is reporting £16m of QIPP against a target of £19.8m

Key messages

- M12 represents a reduced savings position of -£114k when compared to Month 11 risk adjusted forecast.
- Covid-19 has impacted on the delivery of some schemes during March and will continue to reshape projects throughout 2020/21
- Overall Success Stories throughout the year are within Medicines management teams where schemes have delivered greater savings than planned
- Overall risks that have materialised throughout the year are within the Acute Services, a number of schemes have not delivered.
- Lessons learnt for next year would be to ensure that robust data monitoring mechanisms are set up and tested prior to scheme live date to ensure these capture patient flow and evidence efficiencies.
- During 2020/21 CCG's will need to work together with the system to progress on the priorities that have been set out in the Long Term plan.
- Further detail is provided at Appendix B-2

Shropshire CCG - 2019/20 QIPP Delivery by Category



A- 7 Allocations

The CCG allocations at Month 12 are shown below:

	Recurrent £000	Non Recurrent £000	Total £000
Cumulative Allocations to Month 11	466,654	8,825	475,479
<u>Month 12 allocation adjustments:</u>			
POLYP SURVEILLANCE		34	34
TIMED PATHWAYS - WMCA		35	35
Q3 FTA performance		23	23
Diab Transf: STW System		49	49
CYP Green Paper Mental Health Support Teams Wave 2 comm 19/20		51	51
Q3 Flash Glucose sensor reimbursement		44	44
PCN Support		7	7
Diabetes Prevention Programme		60	60
Diabetes Prevention Programme		3	3
Flash Glucose monitoring 1920 Q4		45	45
2019/20 Armed Forces CCG OOH addiional funding - inflation uplift on alloc transfer		2	2
Covid 19 - Payment on account - payment 2		193	193
Total In-Year Resources 2019/20	466,654	9,371	476,025
Return of Cumulative Deficit		(76,726)	(76,726)
Total Cumulative Resources 2019/20	466,654	(67,355)	399,299

Appendix B-3 provides further detail of the allocations received in year.

A-8 Statement of Financial Position

The table below illustrates the CCGs Statement of Financial Position or Balance Sheet at month 12.

	FEB-20	MAR-20	Movement
PPE	0	0	0
Accumulated Depreciation	0	0	0
Net PPE	0	0	0
Intangible Assets	0	0	0
Intangible Assets Depreciation	0	0	0
Net Intangible Assets	0	0	0
Investment Property	0	0	0
Non-Current Assets Held for Sale	0	0	0
Non-Current Financial Assets	0	0	0
Other Receivables Non-Current	0	0	0
Total Other Non-Current Assets	0	0	0
Non-Current Assets	0	0	0
Cash	22,666	37,476	14,810
Accounts Receivable	3,840,731	1,807,418	(2,033,313)
Inventory	0	0	0
Investments	0	0	0
Other Current Assets	3,863,397	1,844,894	(2,018,503)
Current Assets	3,863,397	1,844,894	(2,018,503)
TOTAL ASSETS	3,863,397	1,844,894	(2,018,503)
Accounts Payable	40,384,979	36,646,055	(3,738,924)
Accrued Liabilities	200,000	599,000	399,000
Short Term Borrowing	0	0	0
Current Liabilities	40,584,979	37,245,055	(3,339,924)
Non-Current Payables	0	0	0
Non-Current Borrowing	0	0	0
Other Liabilities	0	0	0
Long Term Liabilities	0	0	0
General Fund	0	0	0
Share Capital	0	0	0
Revaluation Reserve	0	0	0
Donated Assets Reserve	0	0	0
Government Grants Reserve	0	0	0
Other Reserves	0	0	0
Retained Earnings incl. In Year	(36,721,582)	(35,400,162)	1,321,420
Total Taxpayers Equity	(36,721,582)	(35,400,162)	1,321,420
TOTAL EQUITY + LIABILITIES	3,863,397	1,844,894	(2,018,503)

Appendix B-1
Shropshire CCG
2019/20 Financial Summary Position as at Month 12

	2019/20		
	Recurrent Budget	Non Recurrent Budget	Annual Budget
	£000	£000	£000
RESOURCES			
Programme Allocation	415,129	9,371	424,500
Deficit Brought Forward		(76,726)	(76,726)
Co-Commissioning Allocation	44,570		44,570
Running Costs Allocation	6,955		6,955
Total resource limit	466,654	(67,355)	399,299
EXPENDITURE			
Acute Services			
Shrewsbury and Telford Hospitals NHS Trust	147,576		147,576
Robert Jones and Agnes Hunt FT	32,673		32,673
West Midlands Ambulance Service Contract	14,615		14,615
Other Acute Contracts	29,682	2,349	32,031
Acute NCA's	3,741		3,741
Acute Special Placements	22		22
Winter Resilience	2,030		2,030
Future Fit	230		230
STP	175	55	230
Acute services - Other	168		168
High Cost Drugs	533		533
Acute Services Team	586	16	602
Acute Reserves	0		0
Acute Services Total	232,031	2,420	234,451
Community Health Services			
Shropshire Community Trust	40,553		40,553
Other Community Services	6,721	314	7,035
Palliative Care	2,311	132	2,443
Care closer to home reserve	0		0
Community Health Services Total	49,585	446	50,031
Individual Commissioning			
Complex Care	26,360	22	26,382
Funded Nursing Care	7,940	0	7,940
Complex Care Team	1,133	3	1,136
Continuing Care Reserves	0	0	0
Individual Commissioning Total	35,433	25	35,458
Mental Health Services			
Midland Partnership FT	33,314	142	33,456
Other NHS Mental Health Contracts	(424)	0	(424)
Mental Health NCA's	1,195	0	1,195
Mental Health - Other	1,871	658	2,529
Mental Health - TCP	0	0	0
S117 Placements	6,595	0	6,595
Mental Health Reserves	0	0	0
Mental Health Services Total	42,551	800	43,351
Primary Care Services			
Prescribing	48,824	124	48,948
Central Drugs	1,257	0	1,257
Oxygen	605	0	605
Enhanced Services	2,763	2,932	5,695
Out Of Hours	3,150	0	3,150
Primary Care Commissioning Schemes (Dermatology)	54	0	54
Hospice Drugs	75	0	75
Prescribing Incentives	315	0	315
Care Home Advanced Scheme	230	0	230
Primary Care Team	1,986	83	2,069
Primary Care IT	1,158	990	2,148
Primary Care Reserves	0	0	0
Primary Care Services Total	60,417	4,129	64,546
Other			
Patient Transport	3,301	0	3,301
NHS 111	1,173	0	1,173
Referral Assessment Service Team	423	0	423
Community & Care Co-ordinators	370	0	370
NHS Property Services	225	0	225
Better Care Fund	7,779	0	7,779
Reablement	523	0	523
Cost of Change	0	0	0
Other	211	0	211
Other Total	14,005	0	14,005
Reserves			
Commissioning Reserve	668	1,206	1,874
0.5% Contingency	2,104	0	2,104
Reserves Total	2,772	1,206	3,978
Running Costs			
Corporate Costs	3,692	0	3,692
Service Planning	767	0	767
Commissioning & Contracting	777	9	786
Strategy & Service Redesign	395	0	395
Finance	762	336	1,098
Governance	200	0	200
Nursing & Quality	149	0	149
Cost of Change	0	0	0
Corporate Reserves	(132)	0	(132)
Running Cost Total	6,610	345	6,955
Co-Commissioning	45,873	0	45,873
Co-Commissioning Reserves	231	0	231
Co Commissioning Total	46,104	0	46,104
Total Expenditure	489,508	9,371	498,879
Budget (Surplus)/Deficit	22,854	76,726	99,580

Total Resource Limit	466,654	(67,355)	399,299
Total Expenditure	489,508	9,371	498,879
Budget (Surplus)/Deficit	22,854	76,726	99,580
Deficit Brought Forward			(76,726)
In Year (Surplus)/Deficit			22,854

	2019/20		
	Budget Year to Date - month 12	Actual Year to Date - month 12	Variance Year to Date - month 12
	£000	£000	£000
RESOURCES			
Programme Allocation	424,500	424,500	0
Deficit Brought Forward	(76,726)	(76,726)	0
Co-Commissioning Allocation	44,570	44,570	0
Running Costs Allocation	6,955	6,955	0
Total resource limit	399,299	399,299	0
EXPENDITURE			
Acute Services			
Shrewsbury and Telford Hospitals NHS Trust	147,576	159,708	12,132
Robert Jones and Agnes Hunt FT	32,673	33,679	1,006
West Midlands Ambulance Service Contract	14,616	14,908	292
Other Acute Contracts	32,031	34,270	2,239
Acute NCA's	3,741	4,551	811
Acute Special Placements	22	12	(10)
Winter Resilience	2,030	1,282	(748)
Future Fit	230	163	(66)
STP	230	341	111
Acute services - Other	168	178	9
High Cost Drugs	533	442	(91)
Acute Services Team	602	606	4
Acute Reserves	0	0	0
Acute Services Total	234,452	250,139	15,688
Community Health Services			
Shropshire Community Trust	40,553	40,779	226
Other Community Services	7,035	6,432	(603)
Palliative Care	2,444	2,732	289
Care closer to home reserve	0	0	0
Community Health Services Total	50,032	49,943	(89)
Individual Commissioning			
Complex Care	26,382	35,921	9,539
Funded Nursing Care	7,940	7,407	(532)
Complex Care Team	1,136	1,498	362
Continuing Care Reserves	0	0	0
Individual Commissioning Total	35,457	44,826	9,370
Mental Health Services			
Midland Partnership FT	33,456	33,629	173
Other NHS Mental Health Contracts	(424)	(557)	(133)
Mental Health NCA's	1,195	1,668	473
Mental Health - Other	2,529	2,343	(186)
Mental Health - TCP	0	0	0
S117 Placements	6,595	9,544	2,949
Mental Health Reserves	0	0	0
Mental Health Services Total	43,351	46,627	3,276
Primary Care Services			
Prescribing	48,948	50,966	2,018
Central Drugs	1,257	1,349	93
Oxygen	605	598	(6)
Enhanced Services	5,695	5,650	(44)
Out Of Hours	3,150	3,103	(47)
Primary Care Commissioning Schemes (Dermatology)	54	50	(4)
Hospice Drugs	75	68	(7)
Prescribing Incentives	315	260	(55)
Care Home Advanced Scheme	230	140	(90)
Primary Care Team	2,069	1,924	(145)
Primary Care IT	2,148	2,111	(37)
Primary Care Reserves	0	0	0
Primary Care Services Total	64,545	66,219	1,673
Other			
Patient Transport	3,301	3,104	(197)
NHS 111	1,173	1,236	63
Referral Assessment Service Team	423	362	(60)
Community & Care Co-ordinators	370	370	0
NHS Property Services	225	197	(28)
Better Care Fund	7,779	7,779	0
Reablement	524	595	72
Cost of Change	0	0	0
Other	211	140	(70)
Other Total	14,005	13,785	(220)
Reserves			
Commissioning Reserve	1,874	0	(1,874)
0.5% Contingency	2,104	0	(2,104)
Reserves Total	3,978	0	(3,978)
Running Costs			
Corporate Costs	3,692	4,015	323
Service Planning	767	838	71
Commissioning & Contracting	786	568	(217)
Strategy & Service Redesign	395	377	(18)
Finance	1,098	1,012	(86)
Governance	200	194	(7)
Nursing & Quality	149	153	3
Cost of Change	0	0	0
Corporate Reserves	(132)	0	132
Running Cost Total	6,955	7,157	202
Co-Commissioning	45,873	44,615	(1,258)
Co-Commissioning Reserves	231	0	(231)
Co Commissioning Total	46,104	44,615	(1,489)
Total Expenditure	498,879	523,311	24,432
Budget (Surplus)/Deficit	99,580	124,012	24,432

Total Resource Limit	399,299	399,299	0
Total Expenditure	498,879	523,311	24,432
Budget (Surplus)/Deficit	99,580	124,012	24,432
Deficit Brought Forward			(76,726)
In Year (Surplus)/Deficit	22,854	47,286	24,432

QIPP Month 12 Position		2019/20 Plan			2019/20 Delivery		
Budget Area	QIPP Scheme	Gross Savings	Investment	Net Savings	2019/20 Delivery	Variance from Plan	
Acute Services	Additional VBC	250	0	250	519	269	
	Autism and Aspergers Provision	20	0	20	0	-20	
	Category 1 PLCV Activity	35	0	35	39	4	
	COPD Admissions	656	0	656	0	-656	
	Dermatology Commissioning Options	42	0	42	42	0	
	Ex-Tel (Investment)		133	-133	0	133	
	Ex-Tel (SaTH)	764	0	764	0	-764	
	Fracture Liasion Service	115	220	-105	0	105	
	Frailty front door	420	420	0	620	620	
	Heart Failure	374	0	374	128	-247	
	HISU	120	0	120	82	-38	
	Home Oxygen Assessment and Review Service	51	0	51	30	-21	
	MSK Service Redesign EL other	232	0	232	136	-97	
	MSK Service Redesign DC Other	44	0	44	26	-18	
	MSK Service Redesign DC RIAH	305	0	305	25	-279	
	MSK Service Redesign DC SaTH	94	0	94	47	-47	
	MSK Service Redesign EL RIAH	2,043	0	2,043	1,529	-514	
	MSK Service Redesign EL SaTH	255	0	255	227	-29	
	MSK Service Redesign OPFA RIAH	98	0	98	7	-91	
	MSK Service Redesign OPFU RIAH	22	0	22	77	55	
	RTT Relaxed Target	770	0	770	770	0	
	SCHT (Contract 1) inc APCS	350	0	350	175	-175	
	Shropshire Care Closer to Home (Admissions Avoidance)	2,900	0	2,900	0	-2,900	
	Shropshire Care Closer to Home (Demonstrator Sites)	1,000	0	1,000	654	-346	
	Shropshire Care Closer to Home (Investment)	0	1,000	-1,000	-27	973	
	Commissioning Stretch	0	0	0	0	0	
	Big 6 Paediatrics	0	0	0	73	73	
	Dermatology APCS	0	0	0	61	61	
Total		10,959	1,773	9,186	5,238	-3,948	
Individual Commissioning	CHC AQP	329	0	329	0	-329	
	CHC Stretch Target	1,000	0	1,000	0	-1,000	
	Childrens Placements	500	0	500	205	-295	
	Collaborative Commissioning	300	0	300	0	-300	
	Review Programme	452	0	452	1,680	1,228	
	Mental Health Out of Area (Commissioning / Cygnet)	290	87	203	598	395	
	Total	2,871	87	2,784	2,483	-301	
Contracting Services	Mental Health Rebasing of the Contract	600	0	600	600	0	
	OOH Service	757	0	757	757	0	
	RIAH Contract	852	0	852	852	0	
	SaTH Contract	623	0	623	623	0	
	SCHT (Contract 2)	306	0	306	306	0	
Total	3,138	0	3,138	3,138	0		
Corporate	Running Costs Review in year	225	0	225	23	-202	
	Running Costs Review towards 20%	775	0	775	775	0	
Total	1,000	0	1,000	798	-202		
Primary Care Services	Appliances (Stoma)	40	22	18	60	42	
	Appliances (Wound)	180	0	180	0	-180	
	Biosimilars (RIAH)	431	0	431	372	-59	
	Biosimilars (SaTH)	386	0	386	759	372	
	Biosimilars (Other)				47	47	
	Biosimilars (Credits)				34	34	
	Care Home Prescribing	440	24	416	466	50	
	Co-Commissioning Efficiencies	216	0	216	216	0	
	Diabetes	150	47	103	103	0	
	DOLVs	100		100	120	20	
	Drug Switches	300		300	310	10	
	Prescribing Stretch Target	133	0	133	0	-133	
	Prescription Ordering Direct (POD)	1,030	578	452	982	530	
	Respiratory	220	20	200	165	-35	
	Scriptswitch	500	0	500	665	165	
	Self-Care (OTC)	100		100	0	-100	
	Self-Care (OTC) NHSE Stretch	170	0	170	0	-170	
	Total	4,397	691	3,706	4,299	593	
	Grand Total		22,365	2,550	19,815	15,956	-3,859

M11 Forecast				variance from M11 Net Risk
Forecast Delivery M11	Risk	Mitigation	Net Risk	
519			519	0
0			0	0
39			39	-1
0			0	0
42			42	0
0			0	0
0			0	0
620			620	0
128			128	0
82			82	0
29			29	1
136			136	0
26			26	0
25			25	0
47			47	0
1,529			1,529	0
227			227	0
7			7	0
77			77	0
770			770	0
175			175	0
500	350		150	-150
654	150		504	150
-27			-27	0
0			0	0
71			71	2
61			61	0
5,736	500	0	5,236	2
0			0	0
0			0	0
205			205	0
0			0	0
1,821			1,821	-142
627			627	-29
2,654	0	0	2,654	-171
600			600	0
757			757	0
852			852	0
623			623	0
306			306	0
3,138	0	0	3,138	0
208			208	-185
775			775	0
983	0	0	983	-185
43			43	17
0			0	0
350			350	22
720			720	39
38			38	9
15			15	18
416			416	50
216			216	0
105			105	-2
120			120	0
304			304	6
0			0	0
982			982	0
137			137	28
613			613	52
0			0	0
0			0	0
4,060	0	0	4,060	239
16,571	500	0	16,071	-114

Appendix B-3
Shropshire CCG
Allocations 2019/20

Full list of current allocations and adjustments at Month 12

	Month	Programme		Admin		Delegated Co-Commissioning		Total		
		R	NR	R	NR	R	NR	R	NR	Total
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Baseline Allocation M01	1	415,448		6,610		44,570		466,628	0	466,628
Return of Cumulative Deficit	2		-76,726					0	-76,726	-76,726
Month 12 IR changes	3	16						16	0	16
Excess Treatment Costs	3		-19					0	-19	-19
Community transformation TCP 19/20 funding	3		32					0	32	32
IPS Wave 1 (Year 2) Transformation funding (Q1 & Q2)	3		145					0	145	145
GPFV - GP Retention - STP Funding	3		108					0	108	108
GPFV - Practice Resilience - STP Funding	3		68					0	68	68
GPFV - Reception & Clerical - STP Funding	3		84					0	84	84
GPFV - Online Consultation - STP Funding	3		136					0	136	136
GPFV - Primary Care Networks - STP Funding	3		374					0	374	374
Improving Access Allocations 19/20 from National Programme	3		1,807					0	1,807	1,807
MOCH 2019 Q1 and Q2	3		35					0	35	35
Phase 2 - Cancer Alliance Funding	3		213					0	213	213
2019/20 IR - PELs Changes	3	15						15	0	15
19/20 upfront FTA proposal - Shropshire TCP	4		1,260					0	1,260	1,260
Offender Health secondary care allocation - 1st tranche	4		78					0	78	78
GPFV - STP Funding - Workforce Training Hubs	4		85					0	85	85
GPFV - STP Funding - Fellowships Core Offer	4		77					0	77	77
GPFV - STP Funding - Fellowships Aspiring Leaders	4		98					0	98	98
2019/20 Armed Forces CCG OOH allocation	5		23					0	23	23
Q1 West Midlands Cancer Alliance Allocation	6		120					0	120	120

Agenda item: GB-2020-05.056
Shropshire CCG Governing Body meeting: 13.05.20

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

Purpose of the report:

This report is a summary of the 2020/21 planning process and plan submitted on 9th April 2020 to NHSE/I. It seeks endorsement for the plan from the Governing Body in order that we can operate with a draft budget whilst we seek further guidance from NHSEI on next steps to agree a plan for the year.

- The first draft of the CCG financial plan was submitted to NHSEI on 5th March 2020 in line with the national planning timetable.
- A system meeting took place with Julian Kelly (NHSEI National Director of Finance) on 11th March 2020 to discuss the plan. At this meeting Accountable Officers agreed to work together to try and bring the planned system deficit down with an aim of reducing towards the 2019/20 exit deficit.
- Accountable Officers met on the 18th March 2020 and discussed a number of options to reduce the system deficit. This included reviewing growth assumptions and investment requirements. The outcome of which was presented to NHSEI in a revised plan submission on 9th April 2020. At the time of writing this report there has been no formal approval of the plan from NHSEI.
- This plan was presented to Finance and Performance Committee on 25th March 2020. The committee agreed, in the absence of formal NHSEI sign off, to recommend to the Governing Body the approval of the budgets (which are in line with the proposed revision to the plan) so that these can be used as a CCG operational plan until further guidance is provided to the CCG from NHSEI. It was recognised that this position could be subject to change.
- This paper outlines the main principles of the planning guidance and the assumptions that have been made in the CCG plan submission.
- The plan submitted showed that the CCG could not meet the Financial Improvement Trajectory control total that NHSEI has set for 2020/21 which is a £22.7m deficit, nor the trajectory submitted as part of the January STP financial plan which showed a £44.1m deficit. The plan instead currently shows a year end deficit of £50.1m.
- Following March Finance and Performance Committee the impact of the COVID-19 pandemic has been seen in a number of ways. Organisations have stepped away from their original operating plans in order to support our response to COVID-19 and we are awaiting guidance on what is expected of systems with regard to financial modelling and targets for the rest of this financial year. A snapshot of the potential implications on the financial position for Months 1-4 is currently being worked up to be presented to Finance and Performance Committee in May.

Actions required by Finance and Performance Committee Members:

The Committee is asked to:

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

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications <i>If yes, please provide details of additional resources required</i>	No
2	Health inequalities <i>If yes, please provide details of the effect upon health inequalities</i>	No
3	Human Rights, equality and diversity requirements <i>If yes, please provide details of the effect upon these requirements</i>	No
4	Clinical engagement <i>If yes, please provide details of the clinical engagement</i>	No
5	Patient and public engagement <i>If yes, please provide details of the patient and public engagement</i>	No
6	Risk to financial and clinical sustainability <i>If yes how will this be mitigated</i> The CCG has both a significant cumulative deficit and also a significant planned in year deficit. This is one of the main CCG risks highlighted to Board as part of the Board Assurance Framework. The continued deterioration in the CCG underlying position will impact on the CCG's ability to recover financially over future years.	Yes

Tables included in this report:

Table 1: 2019/20 Recurrent Exit Position	4
Table 2: 2020/21 Allocation Breakdown.....	4
Table 3: National Tariff Net Uplift.....	5
Table 4: Total Acute Tariff Impact in Plan.....	5
Table 5: Growth applied in plan	6
Table 6: Summary of allocation increase versus cost pressures	7
Table 7: QIPP Plan Summary by STP Cluster	8
Table 8: Financial Plan Submission	9
Table 9: Risks and Mitigations	9

Schedules appended to this report:

Appendix	Content
Appendix A	QIPP Plan
Appendix B	2020/21 Budgets

NHS Shropshire CCG
Governing Body Meeting - 13th May 2020
2020/21 Financial Plan

Introduction

1. The 2020/21 Financial Plan incorporates a series of financial factors and assumptions. This includes the requirements set out in NHSEI guidance issued in January 2020.
2. This report provides detail behind each of the key areas of the plan's construction.

2019/20 Forecast Outturn

3. The CCG plan for 2019/20 was agreed with NHSEI at an in year deficit of £22.9m.
4. Early on in the financial year it was apparent that this plan would not be met due in the main to three drivers: increases in emergency acute activity, increases in individual commissioning expenditure and QIPP slippage. These are considered regularly by the Finance and Performance Committee and formed part of the evidence for consideration of a revised position.
5. In line with the NHSEI process to amend the forecast at the end of a quarter, the CCG submitted an application at Q3 and has been forecasting a £47.3m deficit since Month 9. This position was discussed and agreed with NHSE/I and signed off by the CCG AO, CFO, CCG chair, Audit Committee chair and STP finance lead. The Month 12 unaudited position is in line with this forecast.
6. The CCG exited 2019/20 with an underlying position of £49.6m deficit. The £2.3m difference between the in year outturn position and the recurrent exit position relates to non recurrent benefits used in year eg 2018-19 balance sheet reversals including the prescribing creditor plus the reflection of part to full year effect cost pressures. (Note that the plan was based on M9 FOT and therefore there is a small difference to the final M12 underlying position).

Table 1: 2019/20 Recurrent Exit Position

£m	2019/20 In year Outturn	2019/20 Recurrent Exit position
Allocation	£473.7	£466.7
Expenditure		
Acute	£249.3	£249.8
Mental Health	£46.2	£45.7
Community Health Services	£50.1	£49.7
Continuing Care	£43.6	£43.5
Prescribing	£51.8	£51.9
Primary Care Services	£12.7	£10.1
Primary Care Co-commissioning	£44.9	£45.8
Other programme	£15.8	£13.1
Contingency		£0.0
Running Costs	£6.6	£6.7
Unidentified QIPP		£0.0
Total spend	£521.0	£516.3
Q2-4 CSF		£0.0
Surplus/(deficit)	(£47.3)	(£49.6)

Allocations

- In January 2019 NHS England published five year allocations for CCGs. These allocations are part of NHS England's five year revenue funding settlement, averaging 3.4% a year in real terms and reaching £20.5bn a year extra by 2023/24. Table 2 shows the 2020/21 allocation published for NHS Shropshire CCG and the level of growth received. 2020/21 is the second year of the five year funding settlement.

Table 2: 2020/21 Allocation Breakdown

Allocation	2019/20	2020/21	Growth	
	£m	£m	£m	%
Programme	415,474	433,934	18,460	4.4%
Primary Care Co-Commissioning	44,570	46,299	1,729	3.9%
Running Cost	6,610	5,835	-775	-11.7%
Total	466,654	486,068	19,414	4.16%

- Running cost allocations have been set in line with the letter from NHS England informing CCGs that by 2020/21 running costs of organisations need to be 20% lower in real terms than in 2017/18.

Tariff

9. The National Tariff consultation document set out the uplift and efficiency to be applied to activity covered by payment by results. These are set out in the table and were applied to our original financial plan.

Table 3: National Tariff Net Uplift

	%
Price Uplift	2.5%
Efficiency	-1.1%
Net Uplift	1.4%

10. However, when the activity was actually modelled through the HRG grouper by both the provider and commissioner business intelligence teams, the impact of tariff has been significantly more than the 1.4% average net uplift. The table below summarises the impact modelled in the current plan.

Table 4: Total Acute Tariff Impact in Plan

Tariff Impact	£'000
Funding set aside in original financial plan modelled on national %'s above	3,826 (a)
Total impact of tariff uplift as per modelled activity through the new HRG grouper	5,707 (b)
Additional allocations received for increases in costs since original allocations published	313 (c)
Additional cost pressure factored into plans submitted 5 th March 2020	1,568 (b-a-c)

Commissioning for Quality and Innovation (CQUIN)

11. Full details of the 2020/21 CQUIN have been published. The simplified approach to CCG CQUIN that was initiated in 2019/20 will continue, targeting the faster uptake of clinical interventions aligned to key policy objectives drawn from the NHS Long Term Plan.

Growth

12. Demographic growth relates to increases in activity expected due to changes in the population. For the plan submissions the demographic growth increase expected has been taken from the information released with allocations from NHS England. For NHS Shropshire CCG the expected percentage increase in population for 2020/21 is 0.4% and therefore this has been applied to relevant expenditure for 2020/21.

13. In addition to demographic growth the CCG has looked at trends seen in the last 2 years against different types of activity to compute expected non-demographic activity growth due to changes in demand.

14. The combined growth rates that have been used in the financial plan for each category of expenditure are shown below.

Table 5: Growth applied in plan

Category of expenditure	Overall Growth applied (%)
Acute	2.8%*
Community	2.8%
Individual Commissioning	7.0%
Mental Health	0.9%
Prescribing	3.3%

15. *The only exception to this is for our main provider SATH where most recent modelling has suggested a move from the 2.8% growth applied to acute. In the 5th March plan submission this had been applied at an overall growth rate of 5.6%. System Chief Executives agreed to revisit this figure after their meeting with Julian Kelly and therefore this was reviewed and reduced to 4% overall in the latest submission to NHSE/I.

Investments

16. The planning guidance and Long Term Plan issued by NHSEI describe a number of specific focus areas and requirements for investment in 2020/21.

17. National Directives:

- £1.50 per head for primary care transformation to be set aside
- Investment in Mental Health must be at least in line with growth in programme allocations plus 1.7%
- Investment in Community and Primary care must be at least in line with growth in allocations.
- Cost pressure associated with funding new NICE drug approvals must be funded

18. In addition to these, the CCG has a number of other commitments under the headings of contractual obligations and specialised commissioning.

19. Contractual Obligations:

- Implementation of Urgent Treatment Centres
- Part to full year Patient Transport costs

20. Specialised Commissioning:

- Funding shortfall for TCP (Transforming Care Partnership) patients

21. When all of these requirements are taken into account, along with the significant increase in costs due to the tariff changes and growth plus the underlying position in 2019/20, it is clear that the increase to the CCG allocation is not enough to cover all of these requirements.

Table 6: Summary of allocation increase versus funding requirements

	£m
Increase in Allocation	19.4
Funding Requirements:	
Tariff	8.9
Growth	16.2
National Directives	3.9
Contractual Obligations	0.9
Specialised Commissioning	0.3
Ring fenced budgets	2.4
Contingency	2.4
	35.0
Difference	15.6

QIPP (Quality, Innovation, Productivity and Prevention)

22. In order to fund increases in activity, demography and service improvements the CCG will need to deliver recurrent QIPP plans year on year.

23. It is important to note that as time goes on QIPP savings are becoming increasingly difficult to achieve as many of the 'quick wins' have already been identified. Given the challenging financial environment the CCG has taken a robust approach to ensuring QIPP schemes that require investment will deliver a good return in terms of both patient and financial benefits.

24. The current plan submission sets a target for QIPP of 3% of allocation which is felt to be challenging but realistic. The latest version of the QIPP plan is outlined in the table below and full detail is provided at Appendix A. The current plan submission shows an opening £3.6m unidentified target.

Table 7: QIPP Plan Summary by STP Cluster

Shropshire CCG		Confidence			In Development	Aspirational
Cluster	Overall QIPP Target £000's	High	Some	Low		
ACD	-£3,868k	-£24k	£0k	£0k	-£1,209k	-£2,636k
Mental Health	-£41k	-£15k	£0k	£0k	-£26k	£0k
PPBC	-£6,722k	-£53k	-£2,972k	£0k	-£3,175k	-£522k
PPBC Investment	£2,423k	£0k	£0k	£0k	£2,423k	£0k
PPBC CHC	-£3,405k	£0k	-£3,405k	£0k	£0k	£0k
Clinical Support Services	-£2,648k	-£1,410k	-£345k		-£416k	-£477k
Running Costs	-£1,089k	£0k	-£1,089k	£0k	£0k	£0k
Total	-£15,351k	-£1,502k	-£7,811k	£0k	-£2,403k	-£3,635k

25. The CCG PMO have been meeting regularly with teams across both CCGs to help build up plans and risk assess the delivery of identified schemes.
26. There are a number of schemes that have been identified to bridge the £3.6m unidentified gap. The team were in the process of actively pursuing the details behind these schemes, ensuring that correct governance is followed although this work is currently paused due to the COVID-19 situation.

Reserves

27. In 2019/20 NHS England required all CCGs to maintain a recurrent 0.5% 'business rules' contingency reserve, this will still be required in 2020/21 and onwards.
28. With the increasing financial pressure facing the CCG and the level of unidentified QIPP in the plan, reserves are limited to this amount and the CCG has no additional recurrent operational risk reserve for in year cost pressures.

2020/21 Financial Plan Submission Summary

29. The plan submitted on the 9th April 2020 is shown in the table below. The submission showed that the CCG could not meet the Financial Improvement Trajectory control total that NHSEI has set for 2020/21 which is a £22.7m deficit, nor the trajectory submitted as part of the January STP financial plan which showed a £44.1m deficit. The plan instead currently shows a year end deficit of £50.1m.

Table 8: Financial Plan Submission

£m	2019/20 In year Outturn	2019/20 Recurrent Exit position	2020/21 Plan
Allocation	£473.7	£466.7	£486.1
Expenditure			
Acute	£249.3	£249.8	£258.6
Mental Health	£46.2	£45.7	£48.4
Community Health Services	£50.1	£49.7	£54.2
Continuing Care	£43.6	£43.5	£44.8
Prescribing	£51.8	£51.9	£53.2
Primary Care Services	£12.7	£10.1	£10.4
Primary Care Co-commissioning	£44.9	£45.8	£47.6
Other programme	£15.8	£13.1	£14.4
Contingency		£0.0	£2.4
Running Costs	£6.6	£6.7	£5.8
Unidentified QIPP		£0.0	(£3.6)
Total spend	£521.0	£516.3	£536.2
Q2-4 CSF		£0.0	
Surplus/(deficit)	(£47.3)	(£49.6)	(£50.1)

Risks and Mitigations

30. In addition to the current financial plan figures, Shropshire CCG has also identified a number of risks to the position and some potential mitigations. These are shown in the table below.

Table 9: Risks and Mitigations

RISK	£m
QIPP Risk	7.0
Contract/Budget Risk	5.6
Running Cost Risk	0.3
	12.9
MITIGATION	
Contingency	2.4
QIPP Investment	1.2
	3.6
NET RISK	9.3

31. The submitted plan (pre COVID-19) highlighted net risks of £9.3m which predominantly relate to unidentified QIPP schemes or schemes with low confidence and also risk associated with contracts and management of change.
32. Locally there are also a number of factors that could affect our expenditure. We currently operate within a fragile health and care system and our main acute provider continues to be under stress with quality, CQC and workforce pressures as well as facing major change under the Future Fit programme. The Local Authority is also in a fragile position, particularly within its social care budgets.
33. There were also a number of other significant risks that we were not able to quantify at the time of submission, including the impact of COVID- 19 and EU exit.
34. The COVID-19 situation fundamentally impacts on this plan and associated risk assessment and we await national guidance on how we might operate our spend and budgets for the year.

Budget Setting

35. The CCG finance team have now set detailed budgets based on the plan submitted and once supported by the Governing Body these will be signed off by the new executive director team and delegated to budget managers within their teams. A summary of budgets is attached at Appendix B.

Potential Impact of COVID-19

36. Following the submission of the plan, the COVID-19 pandemic has had a huge influence on the operations of both the CCG and the wider health and social care system. Guidance from NHSEI has been issued regularly and a number of new processes/ways of working have been implemented.
37. Key points to note include:
- The contract and planning round has been paused. The CCG was in final stages of negotiation with providers for 2020/21 contracts and therefore final contract values have not been agreed. In the meantime we have secured agreement that all parties still wish to operate block contracts once we resume usual activities.
 - The CCG has been instructed by NHSEI the value to pay NHS providers each month for the first four months of the year in order to provide certainty around cashflows. This is based on payment levels during 2019/20.
 - Payment terms have been revised so that payments should be made to all providers within 7 days rather than the normal 30.

- The CCG is completing regular cost reimbursement returns in relation to direct COVID related expenditure including additional staffing costs, IT expenditure and GP practice costs.
- The Section 75 agreement with the Local Authority is to have an addendum that includes the delivery of supported discharge so that budgets are pooled to assist patients as they are discharged from hospital. Joint packages of care are being funded through the COVID reimbursement process.
- Local intelligence suggests that prescribing costs have significantly increased as patients attempt to stockpile medication.
- Outpatient appointments and primary care attendances are primarily being completed on a virtual basis rather than face to face.
- Many QIPP schemes are now paused as providers do not have the capacity to implement the transformational changes planned. In some cases however, COVID-19 has accelerated the planned changes eg use of technology and reduction in face to face appointments.

38. All of the above issues will have an impact on the CCG financial position compared to the original plan described in this document. They will also have an impact on the QIPP plan delivery. As further information and guidance becomes available, the finance team are working through the implications in order to construct a Month 1- 4 snapshot of the likely financial position. This will be presented to Finance and Performance Committee in May.

39. We are also awaiting clarity from NHSEI on whether new guidance will be issued which will mean amending plans and budgets for 20/21.

Financial Recovery Plan

40. The longer term CCG financial strategy and recovery plan has been revised to align with the 20/21 operational plan and latest STP plan and will be put forward to NHSEI as part of the application to become a single Strategic Commissioning organisation. This document will also be presented to Finance and Performance Committee for information in May. It is recognised that this will require a refresh once we receive more certainty about financial requirements for 2020/21.

Recommendations

41. The Governing Body is asked to:

Approve the current 2020/21 financial plan submission and budgets to be used as the CCG's baseline operational plan pending the receipt of further guidance/instruction from NHSEI.

Note the impact on the CCG finances of COVID-19 and note that the CCG awaits national guidance on any updated financial requirements for 2020/21.

Appendix A

Shropshire CCG

2020/21 QIPP Plan

CCG	Provider	Spend Category	QIPP scheme	QIPP Value (£000's)	Confidence				
					High	Some	Low	In Development	Aspirational
SCCCG	RJAH	Acute	MSK (SCCG)	-£1,000k				-£1,000k	
SCCCG	RJAH	Acute	Outpatients - Reduction in MSK activity - Alliance contract (SCCG)	-£113k				-£113k	
SCCCG	RJAH	Acute	Outpatient Opportunities - Additional RJAH (SCCCG)	-£96k				-£96k	
SCCCG	SaTH	Acute	The Big 6 (SCCG)	-£24k	-£24k				
SCCCG	RJAH	Aspirational	LTP Stretch applied Jan 2020 - RJAH	-£428k					-£428k
SCCCG	SaTH	Aspirational	LTP Stretch applied Jan 2020 - SaTH	-£2,208k					-£2,208k
Subtotal				-£3,868k	-£24k	£0k	£0k	-£1,209k	-£2,636k
SCCCG	SaTH	Acute	Cognitive impairment (less dementia) (SCCCG)	-£26k				-£26k	
SCCCG	SaTH	Acute	MH Common disorders (SCCCG)	-£15k	-£15k				
Subtotal				-£41k	-£15k	£0k	£0k	-£26k	£0k
SCCCG	SaTH	Acute	Care Closer to Home Case Management (April - October x 16 sites)	-£2,972k		-£2,972k			
SCCCG	SaTH	Acute	Care Closer to Home - Winter Admission Avoidance Team	-£2,175k				-£2,175k	
SCCCG	SaTH	Acute	Care Closer to Home Phase 3 roll out of Sub Acute Work	-£1,000k				-£1,000k	
SCCCG	Other	Other	Care Closer to home Investment	£1,084k				£1,084k	
SCCCG	SCOM	Community	Care Closer to home Investment	£1,339k				£1,339k	
SCCCG	SCOM	Community	Dermatology APCS (PYE)	-£53k	-£53k				
SCCCG	SCOM	Aspirational	LTP Stretch applied Jan 2020 - SCHT	-£522k					-£522k
Subtotal				-£4,299k	-£53k	-£2,972k	£0k	-£752k	-£522k
SCCCG	CHC	CHC	Review Programme / Mental Health	-£100k		-£100k			
SCCCG	Other	CHC	Review Programme (SCCCG)	-£3,305k		-£3,305k			
Subtotal				-£3,405k	£0k	-£3,405k	£0k	£0k	£0k
SCCCG	Other	Meds Management	Biosimilars (SCCCG)	-£5k	-£5k				
SCCCG	Other	Meds Management	Wound Care (incl Silver dressings) (SCCCG)	-£125k		-£125k			
SCCCG	Other	Meds Management	Appliances (Stoma) (SCCCG)	-£30k				-£30k	
SCCCG	Other	Meds Management	Care Home Prescribing (SCCCG)	-£340k	-£340k				
SCCCG	Other	Meds Management	DoLVs (SCCCG)	-£70k	-£70k				
SCCCG	Other	Meds Management	Drug Switches (direct interventions in practices/generic prescribing/ED)	-£195k	-£195k				
SCCCG	Other	Meds Management	POD (Prescription Ordering Direct) SC	-£300k	-£300k				
SCCCG	Other	Meds Management	Scriptswitch (SCCCG)	-£400k	-£400k				
SCCCG	Other	Meds Management	Selfcare (OTC) (SCCCG)	-£100k	-£100k				
SCCCG	Other	Meds Management	Oral contraception guideline (SCCCG)	-£10k	-£10k				
SCCCG	SaTH	Acute	Deprescribing / Polypharmacy (reduction in NEL) (SCCCG) GROSS	-£457k				-£457k	
SCCCG	Other	Community	Deprescribing / Polypharmacy (reduction in NEL) (SCCCG) INVESTMENT	£136k				£136k	
SCCCG	Other	Meds Management	Respiratory	-£50k		-£50k			
SCCCG	Other	Meds Management	Pain management (Opioid deprescribing) Rightcare	-£65k				-£65k	
SCCCG	Other	Meds Management	Diabetes	-£170k		-£170k			
SCCCG	Other	Aspirational	LTP Meds Stretch Balance	-£477k					-£477k
Subtotal				-£2,658k	-£1,420k	-£345k	£0k	-£416k	-£477k
SCCCG	Other	Running Costs	Running costs SCCG	-£1,089k		-£1,089k			
Subtotal				-£1,089k	£0k	-£1,089k	£0k	£0k	£0k
				-£15,361k	-£1,512k	-£7,811k	£0k	-£2,403k	-£3,635k

Appendix B

Shropshire CCG

Summary of 2020/21 Budgets

	2020/21		
	Recurrent Budget	Non Recurrent Budget	Annual Budget
	£000	£000	£000
RESOURCES			
Programme Allocation	433,934		433,934
Deficit Brought Forward		(123,988)	(123,988)
Co-Commissioning Allocation	46,299		46,299
Running Costs Allocation	5,835		5,835
Total resource limit	486,068	(123,988)	362,080
EXPENDITURE			
Acute Services			
Shrewsbury and Telford Hospitals NHS Trust	166,631		166,631
Robert Jones and Agnes Hunt FT	34,282		34,282
West Midlands Ambulance Service Contract	15,146		15,146
Other Acute Contracts	33,896		33,896
Acute NCA's	4,858		4,858
Acute Special Placements	13		13
Winter Resilience	2,030		2,030
Future Fit	101		101
STP	350		350
Acute services - Other	112		112
High Cost Drugs	513		513
Acute Services Team	602		602
Acute Reserves	0		0
Acute Services Total	258,534	0	258,534
Community Health Services			
Shropshire Community Trust	42,215		42,215
Other Community Services	6,965		6,965
Palliative Care	2,302		2,302
Care closer to home reserve	2,755		2,755
Community Health Services Total	54,237	0	54,237
Individual Commissioning			
Complex Care	36,606		36,606
Funded Nursing Care	7,195		7,195
Complex Care Team	970		970
Continuing Care Reserves	0		0
Individual Commissioning Total	44,771	0	44,771
Mental Health Services			
Midland Partnership FT	34,411		34,411
Other NHS Mental Health Contracts	(535)		(535)
Mental Health NCA's	1,093		1,093
Mental Health - Other	3,672		3,672
Mental Health - TCP	56		56
S117 Placements	9,721		9,721
Mental Health Reserves	0		0
Mental Health Services Total	48,418	0	48,418


Primary Care Services		
Prescribing	51,457	51,457
Central Drugs	1,690	1,690
Oxygen	572	572
Enhanced Services	2,777	2,777
Out Of Hours	3,245	3,245
Primary Care Commissioning Schemes (Dermatolo	56	56
Hospice Drugs	78	78
Prescribing Incentives	238	238
Care Home Advanced Scheme	206	206
Primary Care Team	2,008	2,008
Primary Care IT	1,271	1,271
Primary Care Services Total	63,598	0
Other		
Patient Transport	3,937	3,937
NHS 111	1,262	1,262
Referral Assessment Service Team	393	393
Community & Care Co-ordinators	381	381
NHS Property Services	225	225
Better Care Fund	8,310	8,310
Reablement	581	581
Cost of Change	0	0
Other	67	67
Other Total	15,156	0
Reserves		
Commissioning Reserve	173	173
Reserves Total	173	0
Running Costs		
Corporate Costs	3,312	3,312
Service Planning	860	860
Commissioning & Contracting	1,033	1,033
Strategy & Service Redesign	413	413
Finance	769	769
Governance	203	203
Nursing & Quality	135	135
Running Cost Total	6,725	0
Co-Commissioning	47,340	47,340
Co Commissioning Total	47,340	0
Total Expenditure	536,197	0
Budget (Surplus)/Deficit	50,129	124,012
		174,141



Title of the report:	Governing Body Board Assurance Framework (GBAF)
Responsible Director:	Alison Smith - Director of Corporate Affairs
Author of the report:	Alison Smith - Director of Corporate Affairs
Presenter:	Alison Smith - Director of Corporate Affairs
<p>Purpose of the report:</p> <p>To update Governing Body on the latest iteration of the GBAF and ask that the Governing Body reviews the detail of the risks set out in the document.</p>	
<p>Key issues or points to note:</p> <p>The GBAF was previously presented at the Governing Body meeting in January 2020. The GBAF has since been reviewed and updated by Directors.</p> <p>The Governing Body is asked to note the actions taken to mitigate risks as set out in the actions column of the Framework and to give consideration to the risks outlined on the GBAF as it considers its business throughout the Governing Body meeting.</p> <p>The Governing Body is asked to note the new risks 12 and 13 added; for Covid 19 response management and for the risk around not seizing the opportunity of the beneficial changes in working practices resulting from Covid 19. There are also 3 new issues added to the issues log.</p>	
<p>Actions required by Governing Body Members:</p> <p>The Governing Body is asked to:</p> <ul style="list-style-type: none"> • Review the detail of the GBAF risks and highlight any updates required • Consider the risks highlighted in the GBAF as it conducts its business 	



Monitoring form
Agenda Item: GB-2020-05.057

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





Shropshire CCG Governing Body Assurance Framework Version 19.0

Risk ID	Opened by/ when	Map to key Principle	Summary title of risk and fuller description of risk	Key Controls Summary of existing controls / systems in place to manage the risk	Source of Assurance Summary of existing assurances that provide confidence that the existing controls relied upon are operating effectively and that action plans to address weaknesses are implemented.	Gaps in Controls/Assurances Summary of gaps in existing controls or assurances at the time the risk is identified or subsequently updated.	Assessment of risk level - Low / Medium / High / Extreme Risk / Movement of risk rating	Action / Lead Name / Timescale Identify what actions can be taken to fill gaps in controls and assurances and to also assist in achieving the residual target risk rating by the end of the financial year.	post mitigation Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Owner	Amend/ Review: name and date
<p>Key Principle 1 - Deliver a continually improving Healthcare and Patient Experience Key Principle 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation) Key Principle 3 - Achieve Financial sustainability for future investment Key Principle 4 - Visible leadership of the local health economy through behaviour and action Key Principle 5 - Grow the leaders for tomorrow (Business Continuity)</p>											
/1/18	CS	Key Principle 3	<p>4-Finance There is a risk that the CCG fails to deliver its plan for 2019/20 and that the underlying position going forward will deteriorate rather than improve. 1. Underlying Financial Position There is a risk that the CCG fails to deliver its financial plan for 2020/21 and that the underlying position going forward will significantly deteriorate. This is now further impacted by the uncertainty to the financial position due to the impact of the COVID-19 pandemic.</p>	<p>Robust financial model with sufficient detail to model growth, inflation and QIPP sensitivities</p> <p>Comprehensive QIPP Programme in place; overseen by Finance and Performance Committee</p> <p>Joint QIPP Programme Board (meets monthly): QIPP PMO in place.</p> <p>Business case challenge/due diligence on schemes</p> <p>Constitution, Standing Orders, Prime Financial Policies and Scheme of Reservation and Delegation</p> <p>Suite of financial policies and procedures (supported by AGC 27.6.18)</p> <p>Robust contract challenge mechanisms with major providers. <u>Signed Contracts for 19/20</u></p> <p>Finance and contract reports to Finance and Performance Committee and Governing Body, highlighting risks and mitigating actions</p> <p>Regular GB consideration of the finance position and oversight of management actions</p> <p>Disinvestment Process</p>	<p>Lead Committee - Finance and Performance Committee</p> <p>Regular reporting of Finance, QIPP, Contracting and Performance position to Finance and Performance Committee and Governing Body</p> <p>Completion of internal audit recommendations; outstanding audit actions reviewed at Audit Committee. Assurance gained through seeing improving internal audit ratings for finance and QIPP</p> <p>Action Trackers for Contract Management</p> <p>Meetings with Providers and escalation where required through exec level Strategic Commissioning meetings</p> <p>NHSE escalation meetings in place</p> <p>Budget Manager handbook and training programme in place</p>	<p>Gaps in controls (GC):- GC1:- Budget manager training and refresh of support materials and policies now complete. GC2:- gaps in contract management process identified. GC3:- CHC process issues remain. GC4:- Development of robust Financial Recovery Plan</p> <p>GC1: Development of robust financial recovery plan GC2: Absence of formal signed off 2020/21 plan with NHSEI due to pause in planning due to COVID-19 GC3: Absence of signed contracts due to pause in planning and contracting due to COVID-19 GC4: Impact of COVID-19 on financial position currently uncertain GC5: CHC process issues remain</p>	<p>Extreme Likelihood 5 x Impact 5 = 25</p> 	<p>GC2:- Action plan in place: owned and regularly reviewed by CFO and DoG. Actions to be delivered through Q2 and 3-19/20. Update on progress given to August Audit Committee.</p> <p>GC3:- Joint working across CHC and finance teams with a focus on sharing good practice and harmonising procedures. Financial forecasting methodology bedded in finance focus is on robust information to support forecasting and QIPP delivery. Weekly CHC team meetings (with finance in attendance) held which incorporate review of QIPP activities. Impact will be tested through monthly review of the finance position.</p> <p>GC4:- Financial Recovery plan developed and will be submitted to NHSEI as part of the application to amend the forecast at Q3. This includes enhanced governance and increased grip and control but further plans to curb expenditure are currently only holding the position rather than improving it due to the deteriorating position in both emergency and individual commissioning expenditure. Executive team to continue to develop actions to reduce expenditure for remainder of the year and accelerate delivery of 20/21 QIPP.</p> <p>GC1: Financial Recovery plan in development and being discussed with NHSEI on a regular basis. Draft plan submitted as part of application to become a Single Strategic Commissioning organisation. Plan to continue to be refined and aligned with Clinical Commissioning strategy. However, awaiting NHSEI instruction/guidance on the impact of COVID-19. Financial recovery processes implemented including enhanced governance and increased grip and control. Executive team to continue to develop actions to reduce expenditure. Current QIPP plans are hindered by the impact on provider capacity due to COVID-19.</p> <p>GC2: Regular discussion with NHSEI on next steps in agreeing a plan/revising plan for impact of COVID-19. Awaiting further guidance/instruction from NHSEI. Finance team currently working up Month 1-4 forecast snapshot based on the known impact of COVID-19. To be presented to PPQ in May 2020.</p> <p>GC3 - The contract and planning round has been paused. The CCG was in final stages of negotiation with providers for 2020/21 contracts and therefore final contract values have not been agreed. In the meantime we have secured agreement that all parties still wish to operate block contracts once we resume usual activities.</p> <p>GC4: Organisations have stepped away from their original operating plans in order to support our response to COVID-19 and we are awaiting guidance on what is expected of systems with regard to financial modelling and targets for the rest of this financial year. A snapshot of the potential implications on the financial position for Months 1-4 is currently being worked up to be presented to Finance and Performance Committee in May.</p> <p>GC5: Joint working across CHC and finance teams with a focus on sharing good practice and harmonising procedures. Financial forecasting methodology bedded in; finance focus is on robust information to support forecasting and QIPP delivery. Weekly CHC team meetings (with finance in attendance) held which incorporate review of QIPP activities. Impact will be tested through monthly review of the finance position.</p> <p>New Executive Director now in post. Director of Finance to meet with them and review elements of current CHC action plan related to finance process and governance areas (to include process for payments to the LA).</p>	<p>Likelihood 4 x Impact 4 = 16</p>	<p>Claire Skidmore</p>	<p>6.1.20 5.5.20</p>



Risk ID	Opened by/ when	Map to key Principle	Summary title of risk and fuller description of risk	Key Controls Summary of existing controls / systems in place to manage the risk	Source of Assurance Summary of existing assurances that provide confidence that the existing controls relied upon are operating effectively and that action plans to address weaknesses are implemented.	Gaps in Controls/Assurances Summary of gaps in existing controls or assurances at the time the risk is identified or subsequently updated.	Assessment of risk level - Low / Medium / High / Extreme Risk / Movement of risk rating	Action / Lead Name / Timescale Identify what actions can be taken to fill gaps in controls and assurances and to also assist in achieving the residual target risk rating by the end of the financial year	post mitigation Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Owner	Amend/ Review: name and date
72/16	AS 20/09/16 NEW	Key Principle 1	2. Quality and Safety There is a risk that the CCG fails to commission safe, quality services for its population	<p>CORM meetings with providers Quality and Safety visits Triangulation of information and exception and escalation reporting to Quality Committee Healthwatch CQC QSG NHSE Joint Commissioning Serious Incident Panel Quality Strategy and Delivery Plan including achievable milestones included.</p> <p>SaTH: • The CQC has taken urgent enforcement action where deemed necessary and this remains subject to legal process. • Weekly Regulation 31 audit submissions to CQC received by CCG • 'Safe today' calls continue with Trust Executive Clinicians • Daily and monthly quality indicators and outcomes work continues- Trusts IMT remains a barrier • Unannounced site visits undertaken</p> <p>Quality controls other providers: Restructure of quality team priorities to ensure alignment of new leads against other competing priorities QIPP Quality impact assessments, procurement and contracting requirements etc. Workforce lead in place</p> <p>Delivery Plan will be monitored bi-monthly at Quality Committee</p> <p>New SI policy and process to be shared with Quality Committee</p>	<p>Lead Committee - Quality Committee CORM meetings with providers which feed into the Quality Committee.</p> <p>Minutes of QC meeting and Chairs report presented monthly to QC. Public Governing body Executive team meetings, reports, escalation Clinical Commissioning Meeting</p> <p>WMQRS Formative Review of Quality, Patient Safety and Experience Function, Structure, systems & process and assurance report received June 2019.</p> <p>WMQRS review of Quality, Patient Safety and Experience Structure, systems & process and assurance February 2019. Quality strategy and operational delivery plan signed off at September's Quality Committee</p> <p>WMQR Review of Critically Ill and Injured Children at SaTH with action plan in place NHSE&I chaired Safety Oversight and Assurance membership to monitor the SATH quality improvement plan delivery.</p> <p>Senior CCG lead for strategic system working group now in place along with Chief Nurse on LWAB</p>	<p>Gaps in Controls (GC): GC1: Workforce issues in health and social care economy increasing and increased quality risks in system mean that capacity in team to effectively monitor and manage the escalating risks is compromised. This is compounded by need to ensure the increased number of QIPPs, reprocurement and contracting requirements are met.</p> <p>Existing system wide workforce groups not impacting as quickly as the service provision requires it to manage risk</p> <p>Gaps in Assurance (GA): GA1: Sufficient business intelligence support to provide up to date quality data and benchmarking information from which to highlight and focus on concerns.</p> <p>GA2: Reporting to the Quality Committee requires a review on level of detail provided to provide correct level of assurance to the governing body, refer to WMQR of SCCG Quality committee as apt of wider review</p> <p>GA3: Limited assurance on management of SI process as detailed by internal Audit report. Revised policy and process in place and signed off at September Quality Committee and Audit Committee</p>	Likely x Major = 16 	<p>GC1: Workforce oversight of providers via CORMs, STP Strategic Workforce Group and LWAB continues Sytemwide People Plan in development to align with NHSE People Plan.</p> <p>GA3: Procurement for serious incidents and mortality review complete. Review to be timetabled to commence and be completed by late 2020</p> <p>GA3: Action plan to address the limited assurance in place. New SI policy and process to be shared with Quality Committee in September 2019. Revised Quality Strategy produced awaiting sign off from NHEI</p>	Possible x Moderate = High 12	Zena Young	6.1.20
73/16	AS 20/09/16 NEW	Key Principle 1	3. NHS Constitution There is a risk that the CCG fails to meet its NHS Constitution targets either fully or sustainably	<p>Planned Care Working Groups for Cancer and Referral to Treatment Times (RTT) in place</p>	<p>Lead Committee: Finance and Performance Committee</p> <p>Provider Remedial Actions report via the Monthly Contract meetings .</p> <p>Updates from A&E Delivery Group & Board included in the monthly performance reports to Finance & Performance Committee and bi-monthly to Governing Body.</p> <p>Monthly contractual performance data</p>	<p>Gaps in Assurance (GA): GA1: Lack of SaTH medical /surgical representation at the PCW/G</p>	Likely x Major = Extreme 16 	<p>GC1: A&E Delivery Group now includes clinical input (both SaTH and CCG) and focuses on actions to improve ED systems and processes, Same Day Emergency Care (SDEC), Frailty, Ambulance Demand and for the back door Home First. - Pathway Zero and Integrated discharge teams. The two latter schemes are to ensure the system remains one of the best in the region for DTOC which remains <2%. MFFD is varying from 50-75 due to the rate at which patients are made ready during the week. Now A&E Delivery Group focusing on demand management with emphasis on avoiding admissions (Shrewsbury pilot and working with WMAS on providing alternative clinical advice for Care Homes)</p> <p>GC2: SaTH have committed to a significant investment in both nursing and medical staffing for ED to improve performance and improvements are being seen in middle grades and nursing but will not have a significant impact this winter. System wide demand and capacity planning remains a key enabler. The in-hospital element has been refreshed to include the short stay capacity requirements but this now needs refining to take into account the impact of adopting the Same Day Emergency Care principles as part of the NHS long term plan. Further work on the system wide demand and capacity has been delayed due to no system owner being identified despite escalation to the A&E Delivery Board. For RTT this is impacted by SATH being permanently escalated into both DSUs. The system is working to better manage demand to achieve this + SATH have invested in additional Vanguard capacity to maintain a level of clinically urgent elective activity throughout the winter.</p> <p>GC4: Cancer performance has improved in Q3 and breast symptoms and 2wk are now achieving. 62 day cannot be delivered until wider capacity issues resolved for Urology. Progress has been made in this area with SaTH agreeing a formal partnership arrangement with UHNM which will see increased access to robotic surgery from February 2020.</p> <p>GC3: The gaps in controls and assurance have been escalated with SATH via the System Urgent Care Director. GA1 - clinical representation for planned care now through the Elective Transformation Board</p>	Possible x Moderate = High 9	Julie Davies	6.1.20


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

[illegible]

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61/15	Accountable Officer / Chair	Key principle 1, 2,3 and 4	8. Stakeholder and Patient support and trust Failure to maintain stakeholder (including membership) and Patient/Public trust and support leading to negative organisational reputation because of the following reasons:- - Financial performance challenges - Leadership challenges - Organisational culture challenges - NHSE CCG Assurance - 'needs improvement'	Annual Stakeholder 360 degree survey Patient engagement programmes associated with key workstreams Quality Impact Assessments Equality Impact Assessments Patient Insight service Patient Experience service Participation in STP workstreams Better Care Fund Communications and Engagement Plan in relation to transition to a Single Strategic Commissioning Organisation Programme of Line Manager Training in place	Lead Committee - Governing Body Results of 360 degree stakeholder survey Patient Insight reporting Patient Experience reporting Communications and Engagement Plan Communications and engagement planning for each work programme Joint Executive Team	Gaps in controls (GC): GC1: capacity within the organisation and the Communications and Engagement team to meet the communications and engagement requirements GC2: Gaps in staff training opportunities Gaps in assurances (GA):	Like x catastrophic = Extreme 20 	GC1: The volume of transformation work being undertaken by the CCG is significant and capacity remains an issue. Current demands are enhanced due to supporting major programmes of transformation and redesign and forthcoming consultations in relation to MLU and Care Closer to Home, as well as an increased level of public and press interest regarding the CCG interventions regarding maternity and A&E services at SaTH. Work plans and priorities are kept under continuous review and adjustments made where necessary to maximise capacity and responsiveness. Working arrangements with T&WCCG have been reviewed and a joint interim structure is now in place to ensure capacity is maximised and duplication reduced, along with work to maximise communication and engagement capacity and expertise in the Future Fit/ STP team GC2: Staff training opportunities being continuously monitored. Mental Health Awareness training planned for staff	Possible x Major = High 9	Alison Smith	30.04.20
71/16	GB 8.2.17	Key Principles 1, 3	9. Impact of Social Care Funding Challenges Risk of individuals escalating into acute hospital care or not being able to be discharged from acute hospital care thus impacting adversely on the capacity and capability of health services	BCF plan and development of associated Partnership Agreement Joint Commissioning Board ToR Sustainability and Transformation Plan approved by NHS England Performance data DTCOC performance reported monthly BCF Partnership Agreement and Joint Commissioning Board ToR to be completed	Lead Committee - Clinical Commissioning Committee Clinical Commissioning Committee Health and Wellbeing Board Regular reporting regarding hospital and community service performance DTCOC data	Gaps in controls (GC): GC1: Full implementation of Care Closer to Home Programme GC2: Lack of impact assessments in relation to cessation of services by Local Authority Gaps in Assurances (GA) : GA1: Fully formed STP governance structure	Almost certain x Major - Extreme 20 	GC1: Delivering care Closer to Home to reduce demand failure in the acute setting. Demonstrator site procurement for admission avoidance in Shrewsbury area in progress. GC2: On going dialogue with Shropshire Council regarding service cessation impacts GA1: The STP governance structure has been agreed and a Shadow ICS Board is being put in place from February 2020	Possible x Major = High 9	David Evans	6.1.20
78/16	GB 10.10.18	Key Principle 1	10. Management of 0-25 Health & Wellbeing Service. Risk of lack of assurance of quality and safety of current service, in particular for a number of legacy patients	Additional capacity in SCCG through MH Programme Director System Action Plan System Communication plan Contractual levers where required NHSE oversight	Lead Committee CORM T & F Group H&W Board overview NHSE executive assurance process	Gaps in controls (GC): GC1: Workforce plan in delivery; poor data sources remain a concern; Gaps in Assurances (GA): GA1: Lack of pace in improvements has been resolved with the delivery of the recovery action plan more effective than the previous RAP	Major x Possible = High 12 	GC/GA1: Concerns raised by visit of the Intensive Support Team, a comprehensive action, communication and governance plan was developed by the contract lead provider and has now been delivered. The CYP LTP group continues to meet quarterly. The original workforce development plan has been delivered and the remaining issue related to skilled capacity for ASD diagnostic assessments is being resolved by commissioning additional capacity. The providers are on trajectory to reduce these long waiters and continues to be managed through the MPFT Strategic Commissioning Board. A new model of care has been agreed and now implemented to deliver this service in the future within appropriate waiting times.	Possible x Major = High 9	Julie Davies	6.1.20
23/03/20 AS	Key Principle 1	11. Single Strategic Commissioner Failure to create a single strategic commissioner by April 2021	Change Management Policy already in existence PMO support via CSU in place from 01/07/19 HR support via CSU in place from 01/07/19 OD partner support in place from 08/08/19 Joint Project created with joint SRO in place Governance for project in place - workstreams and oversight group Deliverables and programme plan Communications and Engagement Project Plan in place New application deadline agreed with NHSE of 30 April 2020 Action plan for addressing panel application feedback submitted Nov 2019 to NHSE Further work undertaken on scoping operating model to help inform director's design of staffing structures Membership agreement to new interim constitution to allow jointly appointed governing body members on both CCG Boards. Consultation with existing governing body members completed.. Clearer operating model developed at high level which is informing design of staff structure. Application submitted 30 April 2020 Clearer alignment of ICS development with Single Strategic Commissioner timeline	Informal and formal Board discussions and update papers Board paper to March meeting. Board paper and agreement at May Board meeting Briefing papers presented at JHOSC and HWBBs for both local authorities during June 2019 Project reporting weekly to Joint Executive Group Weekly teleconference update on project status with both Accountable Officers and Chairs of both CCGs Weekly progress reports to Joint Executive Group acting as project oversight group	Gaps in controls (GC): No agreement on final form to date to describe operating model and eventual release 20% savings on administration costs Finance plan and commissioning strategy missing key information that will be produced from further modelling and discussions at a system level Gaps in Assurances (GA): Successful application submission to NHSE/I	Possible x Major = High 12 	Further detailed clarity on Operating Model particularly at place level is being worked through staff management of change/staffing design. DE/ST Sep 2020 New Directors to design new staffing structure in preparation for staff management of change which will clarify operating model. Sep 2020 (AS) Proposal being developed to set out process for developing further information to be added to the Commissioning Strategy post application May/June 2020 ST/AP Timeline for additional modelling to inform Finance plan agreed with NHSE/I post application Sep - Dec 2020 CS Submission of application completed and work continues on prep for panel presentation to NHSE/I on 3 June 2020 AS June 2020	Unlikely x major = moderate 8	Alison Smith	30.04.20	

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	23/03/20 AS NEW	Key Principle 1	12. Covid 19 response Failure to manage with partners the local health system response to Covid 19 pandemic	EPRR processes in place and tested National and regional daily Covid 19 calls involving SRO and AO Business Continuity plans in place and have been enacted Critical services identified, non critical scaled down CCG SRO dedicated to leading CCG response – internal and external, with partners in local authority Redeployment of clinical staff to front line NHS services enacted Most staff apart from critical services that must be on site working from home. Financial accounting of Covid 19 additional cost incurred. Staff in on site critical services are complinat with government guidance on safe distances.	Briefings to Board members and Executive team National guidance continues to be issued which is being enacted by CCG Gold Command Risk Register in place	<div>Gaps in controls (GC): Training and redeployment of staff to critical services ongoing</div> <div>Gaps in Assurances (GA): Governance Board and Committee meetings will be scaled back, so regular informal briefing of Board members required. Impact on population currently unknown therefore CCG response may be inadequate.</div>	Almost Certain x Catastrophic = 25 Extreme	<div>Training and redeployment of staff to critical services ongoing</div> <div>Governance Board and Committee meetings will be scaled back, so regular informal briefing of Board members required.</div>	Likely x Catastrophic = 20 Extreme	Sam Tilley	29.03.20 AS
	06/05/20 TJ NEW	Key Principle 1	13. Opportunity to lock in beneficial chnages resulting form Covid 19 response Failure to capture and act upon learning from local system responses to Covid 19 poses a risk to longer term system recovery. Opportunity to 'lock in' beneficial changes that we have collectively brought about in recent weeks. This includes backing local initiatives and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate and rapid scaling of new technology enabled service delivery options such as digital consultations.	Current LHRP to address immediate response to Covid		<div>Gaps in controls: Insufficient synergy between STP PMO , CCG PMO and Provider PMO</div> <div>Gaps in Assurances: No one consistent programme approach to changes in the system Absence of complete and consistent data sources across system Potential for immediate service/ response needs to detract from medium to longer term system planning and to impact on cross system working</div>	<div>Possible and Major=12 High</div> <div></div>	<div>Implementation of whole system governance established as part of COVID 19 response will be further developed to governance structure post Covid (ST May 2020)</div> <div>LHRP subgroups structure to be transformed into the mechanism to co-ordinate and capture learning going forward (ST May 2020)</div> <div>Cross system working to be the focus of methodology of addressing restore and recover as per Simon Stevens letter 29 April (ST May - June 2020)</div> <div>Increased Clinical leadership visable in response work will be being utilised in Restore and Recover ST (May 2020)</div> <div>Programme of work to be co-ordinated around learning from both qualitative and quantitative data sets . (ST TJ/ LC April-June) 2020)</div> <div>Implementation of a transformation oversight group (ST May 2020)</div> <div>Development of a refreshed System LTP (To be co-ordinated by STP Lead date TBC)</div>	Possible x moderate = moderate 9	Steve Trenchard	Added STH 5/05/20

Governing Body Issues Log July 2020						
Issue ID	Date	Description	RAG	Management Response	RAG status after action	Owner
7.19	6.1.0	Financial Position At month 6 the CCG's expenditure run rate exceeds plan and recovery of the forecast position is unlikely		The CB, executive team and budget managers are briefed on this position and the consequences of spend continuing to accrue at current levels. Escalation meetings are taking place regularly with NHSE/I colleagues. The Governing Body and Finance Committee have discussed submitting a formal amendment to the CCG forecast financial position at Month 9/Q3. The Governing Body and Executive Committee have been involved in the development of a financial recovery plan including enhanced governance and grip and control.		CS
	5.5.20	QIPP Delivery Capacity for delivery of QIPP transformational schemes is an issue both external and internal to the CCG. Concern that system cluster groups are not progressing to the delivery of target savings plans quickly enough is now further impacted by the impact of COVID-19 on provider capacity to implement transformational change.		High Level Plans on a page have been requested from the STP PMO Team by Programme Leads. CCG PMO are working closely with the System PMO Team to ensure updates are fed into CCG Plans. The CCG PMO team continue to build upon local level QIPP plans. The CCG to be kept regularly informed on the impact of Covid-19 and the impact this has on staff members and the general public. Exec Leads to agree on alternative ways to deliver schemes.		CS
	5.5.20	IG Compliance - There are 4 key risks currently impacting on CCG IG compliance Records Management - There is a risk that poor records management in the CCG leads to loss of corporate memory, failure to identify information assets and therefore risks around information governance. Data Handling - There is a risk that data is handled incorrectly due to Covid		Executive team have oversight of records management improvement progress across the CCG and continue to push this with the IG team. As part of creation of a single commissioning organisation an overall induction pack for new staff will be developed to include IG. CSU IG team working closely with high risk teams to address data handling issues		CS
	5.5.20	Counter Fraud The highest risks of fraud within the ccg are associated with bank mandates, individual commissioning payments and cyber fraud. There is now also heightened risk during the COVID-19 pandemic		Counter fraud work plan in place that is a risk based assessment of areas to target for review and support throughout the year. Fraud awareness sessions to be held at staff briefings		CS
2.18	01-Apr-18	Quality & Safety Triangulation of intelligence from a range of sources has highlighted a range of Quality issues for ongoing management		Working with providers to ensure patient safety. Ongoing monitoring arrangements in place. Quality Strategy and delivery plan developed to focus action where needed. Utilising NHS quality escalation framework in addition to our own reporting mechanisms to identify and manage concerns SaTH actions and monitoring • The CQC has taken urgent enforcement action where deemed necessary and this remains subject to legal process. • Weekly Regulation 31 audit submissions to CQC received by CCG • 'Safe today' calls continue with Trust Executive Clinicians • Daily and monthly quality indicators and outcomes work continues- Trusts IMT remains a barrier • CCG seeking to commission a review mortality data and learning from deaths • Unannounced site visits undertaken • WMQ Review of Critically Ill and Injured Children at SaTH with action plan in place - daily oversight of service provision in EDs via safe today process. • NHSE&I Chaired SATH Safety and Oversight Assurance meeting and Maternity Oversight meeting in place attended by Chief Nurse and Medical Director. Review of Maternity Care underway as commissioned the Secretary of State for Health is in progress. Media coverage is on national platforms which impacts on staff within SATH and confidence in maternity services for the population		ZY

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

Risk Matrix

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

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

		Low risk
		Moderate risk
		High risk
15 - 25		Extreme risk

Agenda item: GB-2020-05.058
Shropshire CCG Governing Body meeting: 13.05.20

Title of the report:	Single Strategic Commissioner for Shropshire & Telford & Wrekin – Update Report
Responsible Director:	David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG
Author of the report:	Alison Smith, Director of Corporate Affairs, NHS Shropshire CCG and NHS Telford and Wrekin CCG
Presenter:	David Evans, Accountable Officer, Telford & Wrekin CCG
Purpose of the report: The purpose of this report is to provide: 1) an update on the application process for creating a single strategic commissioner across Shropshire and Telford and Wrekin; and	
Key issues or points to note: To note that the application for dissolution of the two existing CCGs and proposal to create a single CCG from April 2021 was made on 30 th April 2020.	
Actions required by Governing Body Members: The Governing Body is asked to: <ul style="list-style-type: none"> Note the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin; 	

Monitoring form
Agenda Item: GB-2020-05.058

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications <i>Future working arrangements will impact on future resources required by the CCG's</i>	Yes
2	Health inequalities <i>If yes, please provide details of the effect upon health inequalities</i>	No
3	Human Rights, equality and diversity requirements <i>The CCGs have commissioned Equality Impact Assessments on both the workforce of both CCGs and of the populations the CCGs serve.</i>	Yes
4	Clinical engagement <i>Clinical engagement will be key in moving forward with and shaping future working arrangements</i>	Yes
5	Patient and public engagement <i>Public engagement forms part of the Communications and Engagement Plan for the programme.</i>	Yes
6	Risk to financial and clinical sustainability <i>Future working arrangements are a key consideration in the financial and clinical sustainability of the CCG's going forwards</i>	Yes

NHS Shropshire CCG Governing Body Meeting 13th May 2020

Single Strategic Commissioner for Shropshire & Telford & Wrekin – Update Report

**David Evans, Accountable Officer,
NHS Shropshire CCG and NHS Telford and Wrekin CCG**

1. Introduction

1.1 At its meeting held on 14th May 2019, the Governing Body agreed to support the dissolution of both CCGs and the formation of a single strategic commissioning organisation for the Shropshire, Telford & Wrekin footprint. It also supported recruitment of a single Accountable Officer across both CCGs and the establishment of a single management team, whether an early application to NHS England for establishment of a single CCG was accepted or not.

1.2 On September 17th both CCG memberships supported this proposal and an application was formally made to NHS England/NHS Improvement on 30th September to dissolve the two existing CCGs with a view to creating a single CCG from April 2020.

1.3 An NHS England panel meeting was convened by the regional team to consider the application in more detail on 11th October 2019 with the outcome that the application was unsuccessful, mainly due to lack of time to develop some of the key evidence to a sufficient level, to satisfy the criteria used to judge the application by NHS England.

1.4 Since October 2019 the CCGs have undertaken significant work on developing the proposal to create a single CCG culminating in the Governing Body's support to make another application on 30 April 2020, with a view to a single CCG being created in April 2021. This report seeks to provide the Governing Body with a further update on progress in moving towards becoming a single strategic commissioner with NHS Telford and Wrekin CCG and in making a re-application to NHS England/Improvement on 30th April 2020.

2. Report on progress of the programme

2.1 The NHS England/NHS Improvement have supported the CCGs to make a further application earlier than the normal deadline of September 2020, as they believe our application can be enhanced to meet the 10 application criteria in full, if we continue to work at pace. We have agreed with NHS England the following new timescale for re-application and the programme timelines have been amended accordingly:

- Final submission of revised application evidence - 30th April 2020
- Regional NHS England/NHS Improvement panel – early June 2020
- National NHS England/NHS Improvement Committee – July 2020
- Creation of a new single CCG – April 2021

2.2 As part of NHS England's commitment to supporting both CCGs through this process and acknowledging their feedback from the panel process, two national merger leads on Organisational Development/HR and Strategy had been asked by NHS England/NHS Improvement to provide support to the programme in relation to the next steps required on Organisational Development and further support on developing the Commissioning Strategy. The involvement of these national leads has now ended but has resulted in the Commissioning Strategy being further enhanced with more detail on the approach the single CCG will take to utilising population health management, refining our proposed operating model and being clearer about what we will commission in the future and in what way. The Organisational Development Plan has also been enhanced with a series of actions agreed to scope further pieces of work on clinical leadership, a Board Development programme, and a talent management process now included in the plan.

2.3 Public engagement on the proposal to create one single CCG across Shropshire, Telford and Wrekin was undertaken from late January to February 2020 with a public engagement launch event taking place on 24th January in Shrewsbury. In addition this was supplemented with a hard copy and online survey and pop ups at Oswestry Library, Darwin Shopping Centre Shrewsbury, Ludlow Library, Park Lane Centre Telford, Telford Shopping Centre and Tesco Supermarket Wellington. Feedback from the launch event has been shared with participants and all engagement feedback, whether through face to face discussions or via the survey has been collated in a draft Engagement Report which forms part of the application submission. The draft Engagement Report has been shared with Healthwatch for their comment, prior to being published on both CCGs websites and distributed to those that participated in the engagement exercise and expressed an interest in receiving the engagement output. There were 71 survey responses received together with feedback from the Engagement Workshop and pop-ups. Generally those that responded from both Shropshire and Telford and Wrekin were in support of the proposal. The key headline feedback of concerns received can be summarised around five areas:

- Local voice, is lost by the creation of a bigger CCG
- Fear that particular population needs will become invisible in a larger geography i.e. deprivation in Telford and Wrekin and rurality in Shropshire.
- Fear that local delivery and local partnerships will be abandoned/lost within a geographically larger CCG
- Fear that the benefits hoped for will not materialise
- Fear that talented staff will be lost in the transition

2.4 The management of change process to create one single staffing structure for senior managers and staff had started with Directors appointed in December 2019.

However, due to the Covid 19 response both CCGs have placed the staff management of change process, which had begun on hold, until earliest September 2020.

2.5 The highest risks to the programme are currently; developing a financial plan that will meet the NHS England criteria for the application process, the continuing impact of Covid 19 and the delay in proceeding with the planned staff management of change process.

2.6 Work has continued to develop the financial plan for the new single CCG, however this has been challenging as much of the content and modelling continues to be dependent on the parallel work to develop a sustainable financial plan to support the local Long Term Plan, which has not yet be approved by NHS England/Improvement. Discussions have taken place with NHS England/Improvement on a way forward which has enabled a finance plan to be submitted.

2.7 Following the Governing Body meeting in January, drafting of a new Constitution for the CCG that will align with a similarly drafted Constitution for Telford and Wrekin, has been completed and agreed by both memberships for adoption. This has been followed by completion of a management of change process for existing Governing Body members during April. We have now embarked on the election process of shared Governing Body members in May, which will be followed by recruitment of other jointly appointed Governing body members in June and July 2020, with a view to having newly appointed Governing bodies for both CCGs by the end of July.

3. Recommendations

The Governing Body is asked to:

- Note the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin

Agenda item: GB-2020-05.059
Shropshire CCG Governing Body meeting: 13.05.20

Title of the report:	Governance Arrangements in Response to Covid 19
Responsible Director:	David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG
Author of the report:	Alison Smith, Director of Corporate Affairs, NHS Shropshire CCG and NHS Telford and Wrekin CCG
Presenter:	David Evans, Accountable Officer, Telford & Wrekin CCG
Purpose of the report: The purpose of this report is to outline alternative Governance arrangements during Covid 19 for adoption by the CCG.	
Key issues or points to note: Amending Governance processes as outlined in this report will align to and support the CCG's response to the pandemic and to ensure that the CCG maintains timely and effective decision making.	
Actions required by Governing Body Members: The Governing Body is asked to approve the proposed temporary arrangements to the CCG's Governance processes up to and including 31 st July 2020, noting that these arrangements will be reviewed further in the July 2020 Governing Body meeting.	

Monitoring form
Agenda Item: GB-2020-05.059

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

NHS Shropshire CCG Governing Body Meeting 12th May 2020

Governance Arrangements in Response to Covid 19

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

1.Introduction

It is important during the emergency response to Covid 19 that the CCG reviews its internal Governance arrangements to ensure they are aligned with the nature of the crisis we are facing. In a letter from Amanda Pritchard, Chief Operating Officer, NHS England/Improvement dated 28 March entitled “Reducing the burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic” the high level guidance was outlined for Trust and CCG governance and meetings, those directly relating to the CCG are shown below:

Governance and meetings

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

2. Proposal to adopt alternative governance processes

Board and Committee meetings

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

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

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

<p>Performance and Chair to meet to discuss issues arising in between formal meetings.</p> <p>Reduced agenda to be proposed by CFO and Director of Performance and then approved by Chair</p>	<p>and the Director of Performance and Chair to meet to discuss issues arising in between formal meetings.</p> <p>Reduced agenda standing items to be proposed by CFO, Exec Directors of Quality and Transformation and Director of Performance and then approved by Chair</p>
<p><u>Quality Committee</u></p> <p>Remains but regularity reduced to bi-monthly meetings – May/July/September via Microsoft Teams</p> <p>Exec Director and Chair to meet to discuss issues arising in between formal meetings.</p> <p>Reduced agenda standing items to be proposed by ED of Quality and then approved by Chair</p>	
<p><u>Clinical Commissioning Committee (CCC)</u></p> <p>Remains but regularity reduced to bi-monthly meetings – May/July/September via Microsoft Teams</p> <p>Exec Director for Transformation and Chair to meet to discuss issues arising in between formal meetings.</p> <p>Reduced agenda standing items to be proposed by ED of Transformation and then approved by Chair</p>	
<p><u>Primary Care Commissioning Committee (PCC)</u></p> <p>To be stood down and convened only as required.</p>	<p><u>Primary Care Commissioning committee (PCC)</u></p> <p>To be stood down and convened only as required.</p>
<p><u>Audit Committee</u></p> <p>Immediate meetings in April and June required for sign off of accounts and annual report taking into account</p>	<p><u>Audit Committee</u></p> <p>Immediate meetings in April and June required for sign off of accounts and annual report taking into account</p>

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

Decision making

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

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

NHS Shropshire CCG:	NHS Telford and Wrekin CCG:
<i>Constitution, Standing Orders Section 3.8 – Emergency Powers and Urgent Decisions:</i>	<i>Constitution, Standing Orders Section 3.9 – Emergency Powers and Urgent Decisions:</i>
<i>‘Emergency powers and urgent decisions</i>	<i>‘The powers which the group have</i>

<p><i>are covered in the scheme of delegation – Approve any urgent decisions taken by the Chairperson of the CCG and Accountable Officer for ratification by the CCG in public session.’</i></p>	<p><i>delegated to the CCG Governance Board within these standing orders may in emergency or for an urgent decision be exercised by the Chair of the CCG Governance Board and Accountable Officer, after having consulted at least one other member of the CCG Governance Board where there is not sufficient time to hold a meeting of the CCG Governance Board which will be quorate.</i></p> <p><i>The exercise of such powers by the Chair and Accountable Officer shall be reported to the next formal meeting of the CCG Governance Board in public session for formal ratification.’</i></p>
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In order to maintain a level of transparency to decision making, given that meetings of the Board or the Primary Care Commissioning Committee cannot be held in public due to social distancing we will:

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

In order to facilitate rapid decision making The Local Health Resilience Partnership is managing the Covid 19 response for the health system for Shropshire, Telford and Wrekin

by instigating Bronze, Silver and Gold Command, with decisions being made at Gold Command level. A record of these decisions is being routinely kept and will be shared on a regular basis with a virtual joint group of CCG Chairs and Committee Chairs from both CCGs, to provide a level of assurance on what and how these decisions are being made.

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

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

Risk management

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

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

3. Recommendations

- The Governing Body is asked to approve the proposed temporary arrangements to the CCG's Governance processes up to and including 31st July 2020, noting that these arrangements will be reviewed further in July 2020 Governing Body meeting.

Agenda item: GB-2020-05.060
Shropshire CCG Governing Body meeting: 13.05.2020

Title of the report:	Temporary Changes to Commissioning and Contracts to support COVID-19
Responsible Director:	Steve Trenchard, Executive Director for Transformation
Author of the report:	Angie Parkes Deputy Director for Planning and Commissioning Tracey Jones Deputy Executive Integrated Care
Presenter:	Steve Trenchard, Executive Director for Transformation
Purpose of the report: To improve commissioning of effective, safe and sustainable services which deliver the best possible outcomes, based upon best available evidence To increase life expectancy and reduce health inequalities To encourage healthier lifestyles To support vulnerable people In meeting the objectives above, to exercise CCG functions effectively, efficiently and economically, and in accordance with generally accepted principles of good governance and as an employer of choice.	
Key issues or points to note: On the 30 January 2020 the NHS declared a Level 4 National Incident in relation to Covid-19. On the 17 March Simon Stevens wrote to all NHS organisations outlining the steps in responding to Covid-19. The six key areas to focus on were: <ol style="list-style-type: none"> 1. Free up maximum possible inpatient and critical care capacity 2. Prepare for, and respond to, large numbers of inpatients requiring respiratory support 3. Support our staff and maximise staff availability 4. Support the wider population measures announced by the Government 5. Stress test operational readiness 6. Remove routine burdens The CCG are following national guidelines in relation to contract changes. Some members of commissioning have been clinically redeployed resulting in reduced capacity within the team.	

Much of business as usual is on hold and the majority of transformation is reactive to national guidance rather than proactive to identified needs and gaps in services. However, some transformation has occurred directly linked to the planned transformation e.g. non face to face appointments as well as acceleration of the previous transformation work in relation to a whole system approach to Anticipatory Care Planning.

As part of the CCG's agile response to Covid-19 in line with Government directives, the usual commissioning routes for service change have been by paused. Whilst this is appropriate for an immediate response in relation to Pandemic there will be a requirement to address governance processes for any proposed service changes to be considered as permanent including the need to address fully the CCG duties in relation to public involvement and consultation.

The pandemic has given the system the opportunity to remove barriers to transformation. It is imperative that the system does not lose this good practice.

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

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

Consideration should be given to developing new processes for agreeing and implementing service changes across the system, including how the learning from COVID can be used at a system level for accelerated progress towards a Single Strategic Commissioning organisation operating within an ICS framework.

Actions required by Governing Body Members:

That the board:

- Receives and discusses the report.

Monitoring form **Agenda Item: GB-2020-05.060**

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications <i>If yes, please provide details of additional resources required</i> <i>Possible impact on QIPP and need to collate Covid allocated spend</i>	Yes
2	Health inequalities <i>If yes, please provide details of the effect upon health inequalities</i>	No
3	Human Rights, equality and diversity requirements <i>If yes, please provide details of the effect upon these requirements</i>	No
4	Clinical engagement <i>If yes, please provide details of the clinical engagement</i>	No
5	Patient and public engagement <i>If yes, please provide details of the patient and public engagement</i>	No
6	Risk to financial and clinical sustainability <i>If yes how will this be mitigated</i>	No

1 Temporary Changes to Commissioning Intentions and Contract to support COVID-19

2 Background

On the 30 January 2020 the NHS declared a Level 4 National Incident in relation to Covid-19. On the 17 March Simon Stevens wrote to all NHS organisations outlining the steps in responding to Covid-19. The six key areas to focus on were:

1. Free up maximum possible inpatient and critical care capacity
2. Prepare for, and respond to, large numbers of inpatients requiring respiratory support
3. Support our staff and maximise staff availability
4. Support the wider population measures announced by the Government
5. Stress test operational readiness
6. Remove routine burdens

The actions that required CCG commissioning resource to support included:

- Postpone all non-urgent elective operations
- Urgently discharge all hospital patients who are medically fit to leave
- Local implementation of nationally procured block purchase in independent hospitals
- Free up community and intermediate care beds so they could be used more flexibly
- Segregate all patients with respiratory problems and cohort positive cases in bays or wards
- Mental Health, LD and autism providers to plan for Covid-19 patients in all inpatient settings.
- Case by case review of all MH, LD and autism patients who are unable to follow advice on containment and isolation
- MH, LD and autism staff should undergo refresher training on physical healthcare, vital signs and the deteriorating patient so they are clear about triggers for transfer to acute inpatient care
- Make adjustments for staff members at increased risk
- Move registered nurses, midwives and AHPs in non-patient facing roles to support direct clinical practice
- Support older and vulnerable people who are shielded
- Rollout remote consultations using video, telephone, email and text message services for all routine activity. Face to face appointments should only take place where absolutely necessary
- Social distancing to protect staff and patients
- Move to block contract payments

3 Contracting Changes

NHSEI guidelines were issued in relation to dealing with contracts during the Covid-19 pandemic. The CCGs are following the national guidelines and the changes to contracts are detailed below.

NHS Trusts and Foundation Trusts

Contracts with Shrewsbury and Telford Hospital Trust (SaTH), Robert Jones and Agnes Hunt (RJA), Shropshire Community Trust (SCT) and Midlands Partnership Foundation Trust have implied contracts based on 2020/21 service and general conditions as outlined by NHSEI. A contract will be agreed and signed at some point but there are likely to be significant differences to has or has not been agreed to date as we work to reset, restore and recover as appropriate. The payment mechanism is via a fixed monthly payment as directed by NHSEI for the period April – July 2020. Further guidance is awaited for the remainder of the contract year 2020/21.

These changes also apply to NHS Trusts and Foundation Trusts where the CCGs were an associate to a contract in 2019/20.

Independent Hospitals

NHSEI have commissioned capacity from Independent Hospitals and the CCGs are not required to sign a contract until NHSEI give the approval to proceed. It is expected that contracts for the remainder of 2020/21 will be along the same lines as those agreed in 2019/20 unless notice to terminate the contract, or service lines within it, was given prior to March 2020.

Other Smaller Providers

Depending on the service provider contracts have been agreed that are based on one of the following options:

- 1) A fixed monthly sum for the first four months to, at a minimum, cover proportionate costs with an open book approach to reconciliation
- 2) An activity basis for Any Qualified Provider, zero value contracts and contracts where activity can in the main continue virtually.

4 Commissioning Changes

Workforce

There have been some workforce implications in relation to the Covid-19 pandemic. Two members of the commissioning team who are qualified, registered clinicians have been redeployed to support the local health providers in responding to the pandemic. This has resulted in a reduced resource to deal with commissioning work.

A large proportion of the remaining workforce resource available within the commissioning team has been dedicated to responding to the Covid-19 pandemic and its impact on services, providers and patients. Examples of the range of work undertaken include:

- a) Commissioners to become part of the Local Health resilience Partnership (LHRP) response, leading and supporting rapid service redesign as subgroup chairs and members
- b) Commissioners developing and Implementing workstreams to capture baseline position month 11 and changes to services as a response to Covid 19
- c) Commissioners supporting providers in demand and capacity modelling, facilitating cross system working

"Business as Usual"

A proportion of the previous business as usual has been stood down during the pandemic in relation to commissioning work. Most meetings are no longer taking place or are taking place virtually which, in most cases, makes the meetings quicker. There are less contractual conversations that require commissioner input taking place due to the changes in contracting during this period. The work in relation to addressing commissioning intentions for this year has stopped due to the health economy focus on dealing with the current crisis.

The proactive transformation that was planned for this period has, for the most part, stalled. However, there has been continuation of the Health and Social Care Rapid Response Team and work to accelerate the telehealth plot in relation to management of patients within the community to enhance support to patients.

Reactive transformation to deal with the pandemic has replaced this work for the commissioning team. Some of this reactive transformation dovetails with the planned transformation and some is outside of this. Examples of the transformation that meet CCG objectives include:

- Increased use of telephone appointments

- Implementation of Attend Anywhere for outpatient appointments within community services and secondary care
- Use of video consultation in primary care and mental health services
- Development of 24/7 mental health access line
- Initiatives aimed at improving self-care and self-help
- Strengthening clinical leadership in service design and delivery
- Implementation of ReSPECT forms

5 Future Impact on Commissioning

Decision Making

As part of the CCGs agile response to Covid-19 in line with Government directives, the usual governance routes for service change have been paused. Whilst this is appropriate for an immediate response in relation to the pandemic there will be a requirement to address governance processes for any proposed service changes to be considered for permanent implementation.

Decisions have been made using Gold Command model and have therefore bypassed the usual CCG and provider governance processes. Any decisions that have been made and have the opportunity to be permanently implemented following the pandemic will need to be retrospectively agreed. It may be beneficial for the system to agree a single process for retrospectively approving changes without having to return to previous governance heavy practices.

The CCG has duties in relation to public involvement and consultation during decision making. Due to the reactive nature of the current situation this has not been possible during this time and will need to be retrospectively managed. The system should consider liaising with Healthwatch and the Joint Health Overview and Scrutiny Board to develop a streamlined process for engaging patients in relation to these changes.

Develop a “new normal”

On 29 April a letter was sent to by Simon Stevens relating to the second phase of NHS response to Covid-19. The commissioning resource will be utilised in the coming weeks to understand the actions required and work with the local health and social care system to deliver them.

The commissioners will work with the system to identify the changes that have occurred, review them and determine where services/changes should:

- a) Revert to previous position
- b) Maintain current levels
- c) Expand to further areas

The pandemic has given the health system the opportunity to remove barriers to transformation and consideration should be given to developing new processes for agreeing and implementing service changes across the system, including how the learning from COVID can be used at a system level for accelerated progress towards a Single Strategic Commissioning organisation operating within an ICS framework.

Commissioners are required to report changes made to NHSEI for region wide logging and future assurance. The system is required to collaboratively develop a recovery-plan in line with Simon Steven’s letter (29th April 2019) that enables the safe return to business as usual. This guidance states that LHRP should remain for the next 6 weeks.

Agenda item: GB-2020-05.061
Shropshire CCG Governing Body meeting: 13 May 2020

Title of the report:	Report from Audit Committee 29 April 2020
Responsible Director:	Alison Smith, Director of Corporate Affairs Claire Skidmore, Executive Director of Finance
Author of the report:	Keith Timmis, Lay Member – Governance & Audit
Presenter:	Keith Timmis, Lay Member – Governance & Audit
<p>Purpose of the report: To highlight to the Governing Body key issues arising from the 29 April 2020 Audit Committee meeting and to agree any actions that result.</p>	
<p>Key issues or points to note:</p> <ol style="list-style-type: none"> 1. We noted a series of national returns were submitted well in advance of their deadlines. Despite having the option of later timings staff ensured we even beat the original deadlines. This will allow us to focus on the priorities we face in the new operational year. This is highly commendable. 2. We are still not able to give you the Mental Health Investment Standard report, pending a national decision on the release of the results of the work. 3. Internal audit have concluded that our arrangements provide “Moderate assurance” overall. 4. The Committee discussed the progress for the preparation and audit of the CCG annual report and accounts. We are further ahead this year and the Committee were pleased with the progress. The final accounts audit has started. 5. Counter Fraud reported on the completion of the final provider self-assessment tool. We have submitted the CCG self-assessment tool. There were no issues of concern. 	
<p>Actions required by Governing Body Members:</p> <ul style="list-style-type: none"> • Note the content of the report. 	

Monitoring form
Agenda Item: GB-2020-05.061

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

NHS Shropshire CCG Audit Committee Report 29 April 2020
Keith Timmis: Lay Member – Governance & Audit

Matters arising

- 1 The Committee met to discuss a slightly restricted agenda on 29 April. While we are dealing with the impact of the Covid pandemic we will deal with only urgent or nationally mandated work. We anticipate returning to normal meetings from the autumn and intend to catch up with outstanding work where possible. Planned work will be reevaluated throughout the year to ensure we maintain appropriate oversight of governance, while minimising the impact on the organisation.

Governing Body Assurance Framework

- 2 We discussed the current version of the GBAF including a new risk for the Covid pandemic. We agreed to add a second Covid risk to include the issues associated with the recovery from the pandemic and the potential for consequences from the emergency actions the CCG has taken. Overall, the Committee is happy the GBAF covers the key risks and actions.

Annual Report

- 3 Members of the Audit Committee have reviewed the draft annual report at a number of stages during its preparation. The Committee praised the work of those involved in the drafting and collating of the report. External audit will be reviewing the report as part of their work on our annual accounts.

Annual accounts

- 4 The national accounts timetable has been delayed and accounts now have to be completed by 25 June. The senior finance team and Audit Committee Chair met to review the draft accounts before submission. We submitted our draft accounts on 24 April, well in advance of the deadline for that stage. The Committee was happy with the progress so far and confirmed that the May extraordinary meeting to receive the results of the external audit was now cancelled until June. We believe we would have been ready for a final submission in May but need to follow the national timing.

Internal audit

- 5 Internal audit have updated their plan for 2020/21 to take account of the comments we made at the February Audit Committee. They also took the opportunity to include coverage to reflect the potential issues caused by Covid, particularly the need to ensure we maintain good financial governance.
- 6 The Internal Audit report on our Board Assurance Framework concluded that we reached “level A”. We noted the previous decision of the Governing Body to revisit our “principles” noted on the GBAF as we move to the new CCG. This will give us the chance to ensure they are up to date and more clearly written to drive our work on assurance. The Director of Corporate Affairs will also look at how we word “sources of assurance” and “gaps in assurance”, probably after providing update training to those who complete the GBAF. The Committee agreed this work is important but not urgent and should wait for quieter times. We expect all the work to be completed ready for the start of the new CCG in April 2021.
- 7 The Annual Internal Audit Report and Head of Internal Audit Opinion concluded that they can give the CCG “Moderate assurance”. They included a useful summary of the reports from the year and the comparison with earlier years. I have included this as an appendix to this report. The Committee confirmed the aim we expressed in 2018/19 that we wanted to see “Significant assurance” as our target for all reviews. Within that overall target

we particularly want to see progress in financial management and financial reporting.

External audit

- 8 We are still waiting for approval from NHSEI to release the results of the special review of mental health expenditure. We are not expecting to have any issues of significance to report to the Governing Body. This has been the situation for about six months and we do not expect to have permission for some months yet.
- 9 The external auditors have completed their interim review and concluded there were no significant issues to report to us. The process was much smoother this year and they noted how responsive staff had been, despite the difficult circumstances. Their work is further ahead than this stage last year. The final accounts' work is underway and will look closely at the costs and supporting information for complex care in particular.
- 10 We considered an addendum to the external audit plan. This outlined concerns from external audit about the increased risks because of the Covid pandemic. For example, national changes to information on prescription costs and the agreement of balances exercise may require additional disclosures to the accounts, or extra work to gain sufficient audit evidence to form their opinion.
- 11 They will also focus on our arrangements for the quality of local services and our partnership working as part of their VFM Conclusion. This Conclusion has been qualified in recent years and we do not expect that to change this year.

Counter Fraud

- 12 The final fraud self-assessment tool from one of our providers has been received. The CCG has also completed its own return and submitted this well in advance of the national deadline. There are no issues we need to report to the Governing Body.

Other matters

- 13 The Executive Director of Finance outlined the approach we are taking to ensure our processes provide sufficient "grip and control", even when we have to respond rapidly to changing situations and priorities. She will present a formal report at our next meeting.
- 14 The Information Governance toolkit has been completed. Again, this was done well in advance of the national deadline. All the actions that were outstanding at the time of our last meeting had been completed. Future work on this will have a strong focus on records management.

Next meeting

- 15 The next Audit Committee is scheduled for 24 June 2020.

Appendix

Area of Review	Level of Assurance				
	2019/20	2018/19	2017/18	2016/17	2015/16
Financial Management/ Budget Setting inc QIPP	Moderate	Moderate*	Moderate	Limited	Moderate
Financial Reporting/ Delivery inc QIPP	Moderate	Moderate*	Moderate	Moderate	Limited
QIPP Schemes	~	Significant**	~	~	~
Treasury Management	~	~	Limited	Limited	Moderate
Financial Ledger	Significant	Significant	Limited	Limited	Moderate
Payroll	Significant	Significant	Limited	Limited	Moderate
Creditors	Moderate	Moderate	Limited	Limited	Significant
Income and Debtors	Significant	Moderate	Limited	Limited	Significant
Assurance Framework- Interim	N/a	Level A	Level A	Level B	N/a
Assurance Framework- year end	Level A	Level A	Level A	Level A	Level A
CHC- Healthcheck/ Broadcare Processes	N/a	Moderate	Moderate	Limited	Follow up- Action Required
Information Governance Toolkit	N/a	N/a	Level 2	Level 2	Level 2
Data Protection Toolkit Compliance	Action required	Action required	N/a	N/a	N/a
GDPR Readiness Assessment	~	Action required	N/a	N/a	N/a
Conflicts of Interest	Full	Significant	Significant	Moderate	~
Primary Care Commissioning	ongoing	~	Moderate	Limited	~
Provider Serious Incidents	Follow Up	~	Limited	~	~
Better Care Fund	~	~	Limited	~	Significant
Safeguarding Children	~	~	~	~	Moderate
Contract Monitoring	Significant	Moderate	~	Moderate	~

Non- GMS Payments	~	Moderate	~	~	~
Area of Review	Level of Assurance				
	2019/20	2018/19	2017/19	2016/17	2015/16
Workforce Controls	~	Moderate	~	~	~
Future Fit Programme- Governance Healthcheck	~	~	~	Moderate	~
Enablement Beds- Spot Commissioning	~	~	~	~	Significant
Looked After Children	Significant	~	~	~	~
Overall Head of Internal Audit Opinion	Moderate	Moderate	Limited	Limited	Limited

*- QIPP element excluded in 2018/19 due a separate review of QIPP Schemes completed.

** QIPP The control objective in relation to realistic and achievable plans received Moderate Assurance

Agenda item: GB-2020-05.062
Shropshire CCG Governing Body meeting: 13.05.20

Title of the report:	New Constitution and Governance Handbook – For Information Only
Responsible Director:	David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG
Author of the report:	Alison Smith, Director of Corporate Affairs, NHS Shropshire CCG and NHS Telford and Wrekin CCG
Presenter:	David Evans, Accountable Officer, Telford & Wrekin CCG
<p>Purpose of the report:</p> <p>The purpose of this report is to provide for information only the final version of the new Constitution and Governance Handbook that has been adopted by both Shropshire CCG membership and Telford and Wrekin CCG membership.</p> <p>The Constitution and Governance Handbook are attached to this report for information only.</p>	
<p>Key issues or points to note:</p> <ul style="list-style-type: none"> • Both CCG memberships voted on 7th April 2020 by a majority to adopt the proposed new Constitution and Governance Handbook. • The Constitution and Governance Handbook will enable both CCGs to appoint joint Governing Body members whilst still maintaining two separate CCGs in the interim period between August 2020 and March 2021. • A new Constitution and Governance Handbook will still need to be produced for a single CCG in preparation for its creation in April 2021, but it is anticipated that this version will provide the foundation upon which only small amendments would need to be made. 	
<p>Actions required by Governing Body Members:</p> <p>The Governing Body is asked to:</p> <ul style="list-style-type: none"> • note the outcome of the membership vote on adopting the new Constitution and Governance Handbook; and • note the content of the new Constitution and Governance Handbook attached. 	

Monitoring form
Agenda Item: GB-2020-05.062

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications	No
	<i>None specifically identified</i>	
2	Health inequalities	No
	<i>None specifically identified</i>	
3	Human Rights, equality and diversity requirements	No
	<i>None specifically identified</i>	
4	Clinical engagement	No
	<i>None specifically identified</i>	
5	Patient and public engagement	No
	<i>None specifically identified</i>	
6	Risk to financial and clinical sustainability	No
	<i>None specifically identified</i>	

NHS Shropshire CCG Governing Body Meeting 13th May 2020

New Constitution and Governance Handbook – For Information Only

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

1.Introduction

Following the Board meeting in January, a new Constitution and Governance Handbook for the CCG that will align with a similarly drafted Constitution for Telford and Wrekin was drafted. A detailed timeline showing the stages of developing and approving a new Constitution, was shared with the Governing Body in the Single Strategic Commissioner Update report in March.

This report seeks to update the Governing body on the outcome of that process and to note the output.

2. Report

2.1 The Constitution and Governance handbook were drafted for 9th March 2020 and a period of consultation was undertaken with the Board members of both CCGs and with the practices from both memberships for their feedback from 9th March to 27th March 2020. Feedback was received from individuals on both Boards which were incorporated as amendments where required. No feedback was received from practices.

2.2 The Constitution and Governance Handbook were then sent to practices within both memberships on 30th March with guidance on electronically voting for adoption or not of the Constitution and Governance Handbook that were shared with them.

2.3 The electronic vote by the two memberships was completed on 7th April with the following outcome:

Telford and Wrekin CCG

majority of 7 for and 3 abstentions - 10 out of 13 (quorum = required 9 practices to vote)

Shropshire CCG

majority of 29 for and 2 abstentions – 31 out of 40 (just needed simple majority no quorum required).

On this basis the Constitution and Governance Handbook were approved for submission to NHS England/Improvement for ratification.

3. Recommendations

The Governing Body is asked to:

- note the outcome of the membership vote on adopting the new Constitution and Governance Handbook; and
- note the content of the new Constitution and Governance Handbook attached.

NHS SHROPSHIRE CLINICAL COMMISSIONING GROUP

NHS TELFORD AND WREKIN CLINICAL COMMISSIONING GROUP

CONSTITUTION

NHS Shropshire Clinical Commissioning Group Constitution
NHS Telford and Wrekin Clinical Commissioning Group Constitution

Version	Effective Date	Changes
V11.2	1 st August 2020	Standard model
V18.2	1 st August 2020	Standard model

Key to document highlights:

Red text - shows the content for NHS Shropshire CCG where different to NHS Telford and Wrekin CCG

Blue text – shows the content for NHS Telford and Wrekin CCG where different to NHS Shropshire CCG

CONTENTS

1	Introduction	5
1.1	Name.....	5
1.2	Statutory Framework	5
1.3	Status of this Constitution	6
1.4	Amendment and Variation of this Constitution.....	6
1.5	Related documents.....	7
1.6	Accountability and transparency.....	7
1.7	Liability and Indemnity	9
2	Area Covered by the CCG	10
3	Membership Matters	11
3.1	Membership of the Clinical Commissioning Group	11
3.2	Nature of Membership and Relationship with CCG	14
3.3	Speaking, Writing or Acting in the Name of the CCG	14
3.4	Members' Rights.....	14
3.5	Members' Meetings	15
3.6	Practice Representatives.....	17
4	Arrangements for the Exercise of our Functions.....	17
4.1	Good Governance	17
4.2	General.....	17
4.3	Authority to Act: the CCG	18
4.4	Authority to Act: the Governing Body.....	18
5	Procedures for Making Decisions	18
5.1	Scheme of Reservation and Delegation	18
5.2	Standing Orders	19
5.3	Standing Financial Instructions (SFIs)	19
5.4	The Governing Body: Its Role and Functions	20
5.5	Composition of the Governing Body	20
5.6	Additional Attendees at the Governing Body Meetings.....	22
5.7	Appointments to the Governing Body	23
5.8	Committees and Sub-Committees.....	23

5.9 Committees of the Governing Body.....	23
5.10 Collaborative Commissioning Arrangements	24
5.11 Joint Commissioning Arrangements with Local Authority Partners	26
5.12 Joint Commissioning Arrangements – Other CCGs.....	27
5.13 Joint Commissioning Arrangements with NHS England/Improvement.....	29
6 Provisions for Conflict of Interest Management and Standards of Business Conduct.....	32
6.1 Conflicts of Interest.....	32
6.2 Declaring and Registering Interests.....	32
6.3 Training in Relation to Conflicts of Interest.....	33
6.4 Standards of Business Conduct	33
Appendix 1: Definitions of Terms Used in This Constitution	36
Appendix 2: Committee Terms of Reference	3940
Audit Committee	40
Remuneration Committee.....	48Error! Bookmark not defined.
Primary Care Commissioning Committee	Error! Bookmark not defined.
Appendix 3: Standing Orders.....	84

1 Introduction

1.1 Name

The name of this clinical commissioning group is

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

("the CCG").

1.2 Statutory Framework

1.2.1 CCGs are established under the NHS Act 2006 ("the 2006 Act"), as amended by the Health and Social Care Act 2012. The CCG is a statutory body with the function of commissioning health services in England and is treated as an NHS body for the purposes of the 2006 Act. The powers and duties of the CCG to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to CCGs, as well as by regulations and directions (including, but not limited to, those issued under the 2006 Act).

1.2.2 When exercising its commissioning role, the CCG must act in a way that is consistent with its statutory functions. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to CCGs, including the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to CCGs take the form of statutory duties, which the CCG must comply with when exercising its functions. These duties include things like:

- a) Acting in a way that promotes the NHS Constitution (section 14P of the 2006 Act);
- b) Exercising its functions effectively, efficiently and economically (section 14Q of the 2006 Act);
- c) Financial duties (under sections 223G-K of the 2006 Act);
- d) Child safeguarding (under the Children Acts 2004, 1989);
- e) Equality, including the public-sector equality duty (under the Equality Act 2010); and
- f) Information law, (for instance under data protection laws, such as the EU General Data Protection Regulation 2016/679, and the Freedom of Information Act 2000).

1.2.3 Our status as a CCG is determined by NHS England/Improvement. All CCGs are required to have a constitution and to publish it.

1.2.4 The CCG is subject to an annual assessment of its performance by NHS England/Improvement which has powers to provide support or to intervene where it is satisfied that a CCG is failing, or has failed, to discharge any of our functions or that there is a significant risk that it will fail to do so.

1.2.5 CCGs are clinically-led membership organisations made up of general practices. The Members of the CCG are responsible for determining the governing arrangements for the CCG, including arrangements for clinical leadership, which are set out in this Constitution.

1.3 Status of this Constitution

1.3.1 This CCG was first authorised on 1st April 2013.

1.3.2 Changes to this constitution are effective from the date of approval by NHS England/Improvement.

1.3.3 The constitution is published on the CCG website at

www.shropshireccg.nhs.uk

www.telfordandwrekinccg.nhs.uk

1.4 Amendment and Variation of this Constitution

1.4.1 This constitution can only be varied in two circumstances.

- a) where the CCG applies to NHS England/Improvement and that application is granted; and
- b) where in the circumstances set out in legislation NHS England/Improvement varies the constitution other than on application by the CCG.

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

- a) changes are thought to have a material impact;
- b) changes proposed to the reserved powers of the members;
- c) at least half (50%) of the Governing Body Members formally request that the amendments be put before the membership for approval.

1.4.3 Where material and non material amendments to the Constitution are required in response to a declared national emergency and the respective quorum for either the membership as a whole or the Governing Body cannot be maintained to approve these changes, then these can be

approved prior to ratification by NHS England under emergency decision making described in standing orders.

1.5 Related documents

1.5.1 This Constitution is also informed by a number of documents which provide further details on how the CCG will operate. With the exception of the Standing Orders, the Standing Financial Instructions and the Statutory Committees' terms of reference which are included in the Constitution, these documents do not form part of the Constitution for the purposes of 1.4 above. They are the CCG's:

a) Statutory Committees' Terms of Reference (Audit Committee, Remuneration Committee and Primary Care Commissioning Committee), appendix 2

b) Standing Orders – which set out the arrangements for meetings and the selection and appointment processes for the CCG's Committees and the CCG Governing Body (including committees), appendix 3

c) Standing Financial Instructions – which set out the delegated limits for financial commitments on behalf of the CCG, appendix 4

d) Governance Handbook (add in weblink here) – which includes:

- The Scheme of Reservation and Delegation – sets out those decisions that are reserved for the membership as a whole and those decisions that have been delegated by the CCG or the Governing Body
- Prime financial policies – which set out the arrangements for managing the CCG's financial affairs.
- Non statutory Committee terms of reference; and
- Governance Structure

e) Conflicts of Interest Policy (add in weblink here)

1.6 Accountability and transparency

1.6.1 The CCG will demonstrate its accountability to its members, local people, stakeholders and NHS England/Improvement in a number of ways, including by being transparent. We will meet our statutory requirements to:

a) publish our constitution and other key documents including

- Governance Handbook;

- Key corporate strategies and plans;
- b) appoint independent lay members and non-GP clinicians to our Governing Body;
- c) manage actual or potential conflicts of interest in line with NHS England/Improvement's statutory guidance *Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017* and expected standards of good practice (see also part 6 of this constitution);
- d) hold Governing Body meetings in public (except where we believe that it would not be in the public interest in relation to all or part of a meeting);
- e) publish an annual commissioning strategy that takes account of priorities in the health and wellbeing strategy;
- f) procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers and publish a Procurement Strategy;
- g) involve the public, in accordance with its duties under section 14Z2 of the 2006 Act, and as set out in more detail in the CCG's Communications and Engagement Strategy.
- h) when discharging its duties under section 14Z2, the CCG will ensure that it has due regard of the principles of
 - openness;
 - early and active involvement; and
 - fairness and non-discrimination;
- i) comply with local authority health overview and scrutiny requirements;
- j) meet annually in public to present an annual report which is then published;
- k) produce annual accounts in respect of each financial year which are externally audited;
- l) publish a clear complaints process;

m) comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the CCG;

n) provide information to NHS England/Improvement as required; and

o) be an active member of the local Health and Wellbeing Board.

1.6.2 In addition to these statutory requirements, the CCG will demonstrate its accountability by:

- a) Publishing its principal commissioning policies;
- b) Publishing its principal operational policies;
- c) Annual report and Governance Statement;
- d) Minutes of meetings held in public of the Governing Body;
- e) Expenditure over £25,000;
- f) Register of Interests;
- g) Gifts, Hospitality and Sponsorship register; and
- h) Register of procurement decisions.

1.7 Liability and Indemnity

1.7.1 The CCG is a body corporate established and existing under the 2006 Act. All financial or legal liability for decisions or actions of the CCG resides with the CCG as a public statutory body and not with its Member practices.

1.7.2 No Member or former Member, nor any person who is at any time a proprietor, officer or employee of any Member or former Member, shall be liable (whether as a Member or as an individual) for the debts, liabilities, acts or omissions, howsoever caused by the CCG in discharging its statutory functions.

1.7.3 No Member or former Member, nor any person who is at any time a proprietor, officer or employee of any Member or former Member, shall be liable on any winding-up or dissolution of the CCG to contribute to the assets of the CCG, whether for the payment of its debts and liabilities or the expenses of its winding-up or otherwise.

1.7.4 The CCG may indemnify any Member practice representative or other officer or individual exercising powers or duties on behalf of the CCG in respect of any civil liability incurred in the exercise of the CCGs' business, provided that

the person indemnified shall not have acted recklessly or with gross negligence.

2 Area Covered by the CCG

2.1.1

2.1.1 The area covered by the CCG is coterminous with the area covered by Shropshire Council.

2.1.1 The area covered by the CCG is coterminous with area covered by The Borough of Telford and Wrekin.

3 Membership Matters

3.1 Membership of the Clinical Commissioning Group

3.1.1 The CCG is a membership organisation.

3.1.2 All practices who provide primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract in our area are eligible for membership of this CCG.

3.1.3 The practices which make up the membership of the CCG are listed below.

Practice Name	Address
Albrighton Medical Practice	Shaw Lane, Albrighton, Wolverhampton, WV7 3DT
Alveley Medical Practice	Village Road, Alveley, Bridgnorth, WV15 6NG
The Beeches Medical Practice	1 Beeches Road, Bayston Hill, Shrewsbury, SY3 0PF
Belvidere Medical Practice	23 Belvidere Road, Shrewsbury, SY2 5LS
Bishop's Castle Medical Practice	Schoolhouse Lane, Bishop's Castle, SY9 5BP
Bridgnorth Medical Practice	Northgate Health Centre, Northgate, Bridgnorth, WV16 4EN
Broseley Medical Centre	Bridgnorth Road, Broseley, TF12 5EL
Brown Clee Medical Practice	Ditton Priors, Bridgnorth, WV16 6SS
Cambrian Surgery	Oswestry Health Centre, Thomas Savin Road, Oswestry, SY11 1GA
The Caxton Surgery	Oswald Road, Oswestry, SY11 1RD
Churchmere Medical Group	Trimpley Street, Ellesmere, SY12 0DB
Church Stretton Medical Practice	Easthope Road, Church Stretton, SY6 6BL
Claremont Bank Surgery	Claremont Bank, Shrewsbury, SY1 1RL
Cleobury Mortimer Medical Centre	Vaughan Road, Cleobury Mortimer, Kidderminster, Worcestershire, DY14 8DB
Clive Surgery	20 High Street, Clive, Shrewsbury, SY4 5PS

Craven Arms Medical Practice	20 Shrewsbury Rd, Craven Arms, SY7 9PY
Dodington Surgery	29 Dodington, Whitchurch, SY13 1EN
Highley Medical Centre	Bridgnorth Road, Highley, Bridgnorth, WV16 6HG
Hodnet Medical Centre	18 Drayton Road, Hodnet, Market Drayton, TF9 3NF
Knockin Medical Centre	Knockin, Oswestry, SY10 8HL
Marden Medical Practice	25 Sutton Road, Shrewsbury, SY2 6DL
Market Drayton Medical Practice	Market Drayton Primary Care Centre, Maer Lane, Market Drayton, TF9 3AL
Marysville Medical Practice	Brook Street, Belle Vue, Shrewsbury, SY3 7QR
The Meadows Medical Practice (Clun and Knighton)	Penybont Road, Knighton, Powys, LD7 1HB
Much Wenlock & Cressage Medical Practice	Kingsway Lodge, Much Wenlock, TF13 6BL
Mytton Oak Surgery	Racecourse Lane, Shrewsbury, SY3 5LZ
Plas Ffynnon Medical Centre	Middleton Road, Oswestry, SY11 2RB
Pontesbury Medical Practice	Hall Bank, Pontesbury, Shrewsbury, SY5 0RF
Portcullis Surgery	Portcullis Road, Ludlow, SY8 1GT
Prescott Surgery	Baschurch, Shrewsbury, SY4 2DR
Radbrook Green Surgery	Bank Farm Road, Shrewsbury, SY3 6DU
Riverside Medical Practice	Roushill, Shrewsbury, SY1 1PQ
Severn Fields Medical Practice	Severn Fields Health Village, Sundorne Road, Shrewsbury SY1 4RQ
Shawbury Medical Practice	Poynton Road, Shawbury, SY4 4JS
Shifnal & Priorslee Medical Practice	Shrewsbury Road, Shifnal, TF11 8AJ
South Hermitage Surgery	South Hermitage, Belle Vue, Shrewsbury, SY3 7JS
Station Drive Surgery	Station Drive, Ludlow, SY8 2AB
Wem & Prees Medical Practice (Wem Site)	New Street, Wem, Shrewsbury, SY4 5AF

Westbury Medical Centre	Westbury, Shrewsbury, SY5 9QX
Worthen Medical Practice	Village Hall, Worthen, Shrewsbury, SY5 9HT

Practice Name	Address
Charlton Medical Centre	Lion Street, Oakengates , Telford, TF2 6AQ
Court Street Medical Practice	Court Street Medical Centre, Court Street, Madeley, Telford, TF7 5DZ
Dawley Medical Practice	Webb House, King Street, Dawley, Telford, TF4 2AA
Donnington Medical Practice	Wrekin Drive, Donnington, Telford, TF2 8EA
Hollinswood and Priorslee Medical Practice	Downmeade, Hollinswood, Telford, TF3 2EW
Ironbridge Medical Practice	Trinity Hall, Dale Road, Coalbrookdale, Telford, TF8 7DT
Linden Hall	Station Road, Newport, Nr Telford, Shropshire, TF10 7EN
Shawburch Medical Practice	5 Acorn Way, Shawburch, Telford, TF5 0LW
Stirchley Medical Practice	Sandino Road, Stirchley , Telford, TF3 1FB
Teldoc	Malinslee Surgery, Church Road, Malinslee, Telford, TF3 2JZ
The Surgery	Wellington Road, Newport, Nr Telford, Shropshire, TF10 7HG
Wellington Medical Practice	The Health Centre, Victoria Avenue, Wellington, Telford, TF1 1PZ
Woodside Medical Practice	Woodside Health Centre, Wensley Green, Woodside, Telford, TF7 5NR

3.2 Nature of Membership and Relationship with CCG

3.2.1 The CCG's Members are integral to the functioning of the CCG. Those exercising delegated functions on behalf of the Membership, including the Membership Forum, Governing Body and its committees/sub-committees, and the Primary Care Commissioning Committee, remain accountable to the Membership.

3.3 Speaking, Writing or Acting in the Name of the CCG

3.3.1 Members are not restricted from giving personal views on any matter. However, Members should make it clear that personal views are not necessarily the view of the CCG.

3.3.2 Nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the CCG, any member of its Governing Body, any member of any of its Committees or Sub-Committees or the Committees or Sub-Committees of its Governing Body, or any employee of the CCG or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

3.4 Members' Rights

3.4.1 Members' rights and decision making powers are set out in the Standing Orders and the CCG's Scheme of Reservation and Delegation respectively and include:

- a) Calling and/or attending a general meeting of the Members;
- b) Nominating a Practice Representative to represent the practice on the Membership Forum and **Locality Forums**.
- c) Submitting and/or approving a proposal for material amendment of the Constitution.
- c) Putting themselves forward for election to the Governing Body and to the role of Chair.
- d) Electing the GP/Primary Care Health Professional members of the Governing Body.

e) Approving appointment of a Chair to the Membership Forum

3.5 Members' Meetings

3.5.1 To ensure the effective involvement and participation of each of its Members, the CCG has established:

a) The Membership Forum which comprises a Practice representative from each member practice which must be a health professional, and which will ensure:

i) there is accountability between the CCG Governing Body and the Groups Member practices, and to make decisions and exercise powers reserved to the membership, as listed in the Scheme of Reservation and Delegation.

ii) to ensure the effective involvement and participation of each of Its Members.

b) The Chair of the CCG will meet regularly with the Chair of the Membership Forum to provide a mechanism for feedback to the Governing Body by the Member Practices.

3.5.1 To ensure the effective involvement and participation of each of its Members, the CCG has established:

a) The Membership Forum which comprises a Practice Representative from each member practice which will ensure that there is accountability between the CCG Governing Body and the Groups Member practices, and to make decisions and exercise powers reserved to the membership, as listed in the Scheme of Reservation and Delegation.

b) The Locality Forums which are local geographical groupings ("Localities") of Practice Members which comprise the respective Practice Representatives of the practices within each locality to provide a forum for discussion and involvement with member practices. The CCG has constituted three localities: North Shropshire, Shrewsbury and Atcham and South Shropshire.

c) The Chair of the CCG will meet regularly with the Chairs of the Locality Forums to provide a mechanism for feedback to the Governing Body by the Member Practices.

3.5.2 Meetings of the Membership Forum will take place as and when required to transact decisions and undertake discussions, either face to face or by virtual or electronic means in accordance with the procedure set out in Standing Orders and will be chaired by a practice representative elected by and from the practice representatives of each member practice.

- 3.5.2 Meetings of the Membership Forum will take place as and when required to transact decisions and undertake discussions, either face to face or by virtual or electronic means in accordance with the procedure set out in Standing Orders and will be chaired by the CCG Chair.
- 3.5.3 Meetings of the Locality Forums will take place at least 4 times a year, either face to face or by virtual or electronic means in accordance with the procedure set out in standing orders and will be chaired by a GP/Primary Healthcare Professional from a member practice, elected by the practice representatives of each member practice of the respective Locality Forum and in accordance with Standing Orders.
- 3.5.4 Decisions made by the Membership Forum may be undertaken by a show of hands or virtually using technology to allow Practice Representatives to cast a vote remotely by an electronic or online ballot.
- 3.5.5 Each member of the Group will nominate one practice representative to represent the practice in all matters, and vote on behalf of the practice at CCG Membership Forum meetings.

Each member may also nominate a Practice manager attendee to the Membership Forum.

Each member may also nominate a Practice Manager attendee to the Locality Forum meetings.

- 3.5.6 Each Member authorises their member Practice Representative to:
- a) receive notice of, attend and vote at any meetings of the Membership Forum and Locality Forum (whether by a show of hands or by electronic poll, or sign any written resolution) on behalf of that member).
 - b) receive distributions on behalf of the member practice; and
 - c) deal with and give directions as to; resources, securities, benefits, documents, notices or other communications in whatever form arising by right of, or received in connection with, the member's membership of the Group.
- 3.5.7 The CCG Membership Forum delegates all decision making to the CCG Governing Body with these exceptions:
- a) approval to change the Group's constitution where;
 - i) amendments with have a material impact; or
 - ii) amendments are changing reserved powers of the membership; or
 - iii) 50% of all Governing body membership have requested it is put before the membership for approval.
 - b) approval to appoint a Chair to the Membership Forum.

3.6 Practice Representatives

- 3.6.1** Each Member practice has a nominated lead healthcare professional who represents the practice in its dealings with the CCG.
- 3.6.2** The Standing orders attached to this Constitution in appendix 3, set out the role of Practice Representatives and the ways in which this role is expected to be fulfilled.

4 Arrangements for the Exercise of our Functions.

4.1 Good Governance

- 4.1.2** The CCG will, at all times, observe generally accepted principles of good governance in the way that it conducts its business. These include:

- a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conducts of its business.
- b) the Good Governance Standard for Public Services;
- c) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the Nolan principles;
- d) the seven key principles of the NHS Constitution;
- e) the Equality Act 2010;
- f) the Standards for Members of NHS Boards and Governing Bodies in England; and
- g) adoption of standards and procedures that facilitate speaking out and raising of concerns including a Freedom to Speak up Guardian.

4.2 General

- 4.2.1** The CCG will:
- a) comply with all relevant laws, including regulations;
 - b) comply with directions issued by the Secretary of State for Health or NHS England/Improvement;
 - c) have regard to statutory guidance including that issued by NHS England/Improvement; and
 - d) take account, as appropriate, of other documents, advice and guidance.

- 4.2.2** The CCG will develop and implement the necessary systems and processes to comply with (a)-(d) above, documenting them as necessary in this constitution, its scheme of reservation and delegation and other relevant policies and procedures as appropriate.

4.3 Authority to Act: the CCG

- 4.3.1** The CCG is accountable for exercising its statutory functions. It may grant authority to act on its behalf to:

- a) any of its members;
- b) its Governing Body;
- c) employees; and
- d) a Committee or Sub-Committee of the Group.

- 4.3.2** The extent of the authority to act by the respective bodies' and individuals', depends on the powers delegated to them by the Group and is expressed through:

- a) The CCG's Scheme of Reservation and Delegation; and
- b) Committees' terms of reference

4.4 Authority to Act: the Governing Body

- 4.4.1** The Governing Body may grant authority to act on its behalf to:

- a) any Member of the Governing Body;
- b) a Committee or Sub-Committee of the Governing Body;
- c) a Member of the CCG who is an individual (but not a Member of the Governing Body); and
- d) any other individual who may be from outside the organisation and who can provide assistance to the CCG in delivering its functions.

- 4.4.2** The extent of the authority to act by the respective bodies' and individuals', depends on the powers delegated to them by the Governing Body and is expressed through:

- a) The CCG's Scheme of Reservation and Delegation; and
- b) Committees' terms of reference

5 Procedures for Making Decisions

5.1 Scheme of Reservation and Delegation

- 5.1.1** The CCG has agreed a scheme of reservation and delegation (SoRD) which is published in full within the CCG's Governance Handbook.

ADD IN WEBPAGE LINK HERE TO THE GOVERNANCE HANDBOOK

- 5.1.2** The CCG's SoRD sets out:

- a) those decisions that are reserved for the membership as a whole;
- b) those decisions that have been delegated by the CCG, the Governing Body or other individuals.

- 5.1.3** The CCG remains accountable for all of its functions, including those that it has delegated. All those with delegated authority, including the Governing Body, are accountable to the Members for the exercise of their delegated functions.

- 5.1.4** The Accountable Officer may periodically propose amendments to the SoRD, which shall be considered and approved by the Governing Body unless:

- a) Changes are proposed to the reserved powers; or
- b) At least half (50%) of all Governing Body member practice representatives (including the Chair) formally request that the amendments be put before the membership for approval.

5.2 Standing Orders

- 5.2.1** The CCG has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the CCG;
- the appointments to key roles including Governing Body members;
- the procedures to be followed during meetings; and
- the process to delegate powers.

- 5.2.2** A full copy of the standing orders is included in appendix 3. The standing orders form part of this constitution.

5.3 Standing Financial Instructions (SFIs)

- 5.3.1** The CCG has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

- 5.3.2** A copy of the SFIs is included at Appendix 4 and form part of this constitution.

5.4 The Governing Body: Its Role and Functions

5.4.1 The Governing Body has statutory responsibility for:

- a) ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance (its main function); and for
- b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme established.

5.4.2 The CCG has also delegated the following additional functions to the Governing Body which are also set out in the SoRD. Any delegated functions must be exercised within the procedural framework established by the CCG and primarily set out in the Standing Orders and SFIs:

- a) approving any functions of the Group that are specified in regulations;
- b) leading and setting of vision and strategy;
- c) preparing the annual commissioning plan;
- d) approving the annual budget;
- e) overseeing and monitoring quality improvement;
- f) overseeing and monitoring performance;
- g) overseeing risk assessment and securing assurance actions to mitigate identified strategic risks;
- h) promoting a culture of strong engagement with patients, their carers, Members, the public and other stakeholders about the activity and progress of the CCG;
- i) ensuring good governance and leading a culture of good governance throughout the CCG.

The detailed procedures for the Governing Body, including voting arrangements, are set out in the standing orders.

5.5 Composition of the Governing Body

5.5.1 This part of the constitution describes the make-up of the Governing Body roles. Further information about the individuals who fulfil these roles can be found on our website.

ADD IN WEBLINK HERE

5.5.2 The National Health Service (Clinical Commissioning Groups) Regulations 2012 set out a minimum membership requirement of the Governing Body of:

- a) The Chair, who is a GP or Primary Healthcare Professional elected from and by the individuals described in 5.5.3 (b) below and will undertake the role of clinical leader for the CCG
- b) The Accountable Officer
- c) The Executive Director of Finance (Chief Finance Officer)
- d) one Secondary Care Specialist;
- e) one registered nurse
- f) Two lay members:
 - one to lead on audit, conflicts of interest and to undertake the role of Conflicts of Interest Guardian and Freedom to Speak Up Guardian; and
 - one with knowledge about the CCG area enabling them to lead on patient and public involvement matters.

5.5.3 The CCG has agreed the following additional members:

- a) A third lay member who leads on primary care commissioning matters.
- b) 6 GPs or Primary Healthcare Professionals; with three elected by Shropshire Clinical Commissioning Group membership and three elected by Telford and Wrekin Clinical Commissioning Group membership and from which will be elected a Chair set out in 5.5.2 (a) above.
- c) The Executive Director of Transformation;
- d) The Executive Director of Quality; and
- e) Any additional and temporary member or members who may be appointed in the circumstances set out in section 6.5.4.

5.5.4 Where more than one person is appointed jointly from the same or different member practices to the role described in 5.5.3 (b) above through an election process, those persons shall become or be appointed to a CCG Governing body members role jointly, and shall count for the

purposes of the composition of the Governing Body as one person and shall have one vote.

5.5.5 A deputy Chair of the CCG Governing Body will be appointed from amongst the Governing body Lay Members.

5.5.6 A Deputy Clinical Chair of the CCG will be appointed from amongst the Governing Body GP or Primary Healthcare Professionals.

5.6 Additional Attendees at the Governing Body Meetings

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

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

- a) The Director of Corporate Affairs;
- b) The Director of Partnerships;
- c) The Director of Performance;
- d) The Director of Planning;
- e) Director Public Health for Shropshire;
- f) Director of Public Health for Telford and Wrekin;
- g) Representative of Shropshire Healthwatch; and
- h) Representative of Telford and Wrekin Healthwatch.

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

- a) The Director of Corporate Affairs;
- b) The Director of Partnerships;
- c) The Director of Performance;
- d) The Director of Planning;

5.7 Appointments to the Governing Body

- 5.7.1** The process of appointing GPs to the Governing Body, the selection of the Chair, and the appointment procedures for other Governing Body Members are set out in the standing orders.
- 5.7.2** Also set out in standing orders are the details regarding the tenure of office for each role and the procedures for resignation and removal from office.

5.8 Committees and Sub-Committees

- 5.8.1** The CCG may establish Committees and Sub-Committees of the CCG.
- 5.8.2** The Governing Body may establish Committees and Sub-Committees.
- 5.8.3** Each Committee and Sub-Committee established by either the CCG or the Governing Body operates under terms of reference and membership agreed by the CCG or Governing Body as relevant. Appropriate reporting and assurance mechanisms must be developed as part of agreeing terms of reference for Committees and Sub-Committees.
- 5.8.4** With the exception of the Remuneration Committee, any Committee or Sub-Committee established in accordance with clause 5.8 may consist of or include persons other than Members or employees of the CCG.
- 5.8.5** All members of the Remuneration Committee will be members of the CCG Governing Body.
- 5.8.6** The CCG has established three Locality Forums as Committees of the Group based upon geographical areas: North Shropshire, Shrewsbury and Atcham and South Shropshire. These forums act as the mechanism for involving the CCG membership.

5.9 Committees of the Governing Body

- 5.9.1** The Governing Body will maintain the following statutory or mandated Committees:
- 5.9.2** **Audit Committee:** This Committee is accountable to the Governing Body and provides the Governing Body with an independent and objective view of the CCG's compliance with its statutory responsibilities. The Committee is responsible for arranging appropriate internal and external audit.
- 5.9.3** The Audit Committee will be chaired by a Lay Member who has qualifications, expertise or experience to enable them to lead on finance and audit matters and members of the Audit Committee may include

people who are not Governing Body members.

- 5.9.4 Remuneration Committee:** This Committee is accountable to the Governing Body and makes recommendations to the Governing Body about the remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the CCG.
- 5.9.5** The Remuneration Committee will be chaired by a lay member other than the audit chair and only members of the Governing Body may be members of the Remuneration Committee.
- 5.9.6 Primary Care Commissioning Committeeⁱ** This committee is required by the terms of the delegation from NHS England/Improvement in relation to primary care commissioning functions. The Primary Care Commissioning Committee reports to the Governing Body and to NHS England/Improvement. Membership of the Committee is determined in accordance with the requirements of *Managing Conflicts of Interest: Revised statutory Guidance for CCGs 2017*. This includes the requirement for a lay member Chair and a lay Vice Chair.
- 5.9.7** None of the above Committees may operate on a joint committee basis with another CCG(s). However, they are able to form Committees in Common.
- 5.9.8** The terms of reference for each of the above committees are included in Appendix 2 to this constitution and form part of the constitution.
- 5.9.9** The Governing Body has also established a number of other Committees to assist it with the discharge of its functions. These Committees are set out in the SoRD and further information about these Committees, including terms of reference, are published in: the CCG's Governance Handbook which does not form part of this Constitution.

5.10 Collaborative Commissioning Arrangements

- 5.10.1** The CCG wishes to work collaboratively with its partner organisations in order to assist it with meeting its statutory duties, particularly those relating to integration. The following provisions set out the framework that will apply to such arrangements.
- 5.10.2** In addition to the formal joint working mechanisms envisaged below, the Governing Body may enter into strategic or other transformation discussions with its partner organisations, on behalf of the CCG.

5.10.3 The Governing Body must ensure that appropriate reporting and assurance mechanisms are developed as part of any partnership or other collaborative arrangements. This will include:

- a) reporting arrangements to the Governing Body, at appropriate intervals;
- b) engagement events or other review sessions to consider the aims, objectives, strategy and progress of the arrangements; and
- c) progress reporting against identified objectives.

5.10.4 When delegated responsibilities are being discharged collaboratively, the collaborative arrangements, whether formal joint working or informal collaboration, must:

- a) identify the roles and responsibilities of those CCGs or other partner organisations that have agreed to work together and, if formal joint working is being used, the legal basis for such arrangements;
- b) specify how performance will be monitored and assurance provided to the Governing Body on the discharge of responsibilities, so as to enable the Governing Body to have appropriate oversight as to how system integration and strategic intentions are being implemented;
- c) set out any financial arrangements that have been agreed in relation to the collaborative arrangements, including identifying any pooled budgets and how these will be managed and reported in annual accounts;
- d) specify under which of the CCG's supporting policies the collaborative working arrangements will operate;
- e) specify how the risks associated with the collaborative working arrangement will be managed and apportioned between the respective parties;
- f) set out how contributions from the parties, including details around assets, employees and equipment to be used, will be agreed and managed;
- g) identify how disputes will be resolved and the steps required to safely terminate the working arrangements;
- h) specify how decisions are communicated to the collaborative partners.

5.11 Joint Commissioning Arrangements with Local Authority Partners

5.11.1 The CCG will work in partnership with its Local Authority partners to reduce health and social inequalities and to promote greater integration of health and social care.

5.11.2 Partnership working between the CCG and its Local Authority partners might include collaborative commissioning arrangements, including joint commissioning under section 75 of the 2006 Act, where permitted by law. In this instance, and to the extent permitted by law, the CCG delegates to the Governing Body the ability to enter into arrangements with one or more relevant Local Authority in respect of:

- a) Delegating specified commissioning functions to the Local Authority;
- b) Exercising specified commissioning functions jointly with the Local Authority;
- c) Exercising any specified health -related functions on behalf of the Local Authority.

5.11.3 For purposes of the arrangements described in 5.11.2, the Governing Body may:

- a) agree formal and legal arrangements to make payments to, or receive payments from, the Local Authority, or pool funds for the purpose of joint commissioning;
- b) make the services of its employees or any other resources available to the Local Authority; and
- c) receive the services of the employees or the resources from the Local Authority.
- d) where the Governing Body makes an agreement with one or more Local Authority as described above, the agreement will set out the arrangements for joint working, including details of:
 - how the parties will work together to carry out their commissioning functions;
 - the duties and responsibilities of the parties, and the legal basis for such arrangements;
 - how risk will be managed and apportioned between the parties;

- financial arrangements, including payments towards a pooled fund and management of that fund;
- contributions from each party, including details of any assets, employees and equipment to be used under the joint working arrangements; and
- the liability of the CCG to carry out its functions, notwithstanding any joint arrangements entered into.

5.11.4 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.11.2 above.

5.12 Joint Commissioning Arrangements – Other CCGs

5.12.1 The CCG may work together with other CCGs in the exercise of its Commissioning Functions.

5.12.2 The CCG delegates its powers and duties under 5.12 to the Governing Body and all references in this part to the CCG should be read as the Governing Body, except to the extent that they relate to the continuing liability of the CCG under any joint arrangements.

5.12.3 The CCG may make arrangements with one or more other CCGs in respect of:

- a) delegating any of the CCG's commissioning functions to another CCG;
- b) exercising any of the Commissioning Functions of another CCG; or
- c) exercising jointly the Commissioning Functions of the CCG and another CCG.

5.12.4 For the purposes of the arrangements described at 5.12.3, the CCG may:

- a) make payments to another CCG;
- b) receive payments from another CCG; or
- c) make the services of its employees or any other resources available to another CCG; or
- d) receive the services of the employees or the resources available to another CCG.

- 5.12.5** Where the CCG makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.
- 5.12.6** For the purposes of the arrangements described above, the CCG may establish and maintain a pooled fund made up of contributions by all of the CCGs working together jointly pursuant to paragraph 5.12.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.
- 5.12.7** Where the CCG makes arrangements with another CCG as described at paragraph 5.12.3 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working including details of:
- a) how the parties will work together to carry out their commissioning functions;
 - b) the duties and responsibilities of the parties, and the legal basis for such arrangements;
 - c) how risk will be managed and apportioned between the parties;
 - d) financial arrangements, including payments towards a pooled fund and management of that fund;
 - e) contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.
- 5.12.8** The responsibility of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 0 above.
- 5.12.9** The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.12.1 above.
- 5.12.10** Only arrangements that are safe and in the interests of patients registered with Member practices will be approved by the Governing Body.
- 5.12.11** The Governing Body shall require, in all joint commissioning arrangements, that the lead Governing Body Member for the joint arrangements:
- a) make a quarterly written report to the Governing Body;

- b) hold at least one annual engagement event to review the aims, objectives, strategy and progress of the joint commissioning arrangements; and
- c) publish an annual report on progress made against objectives.

5.12.12 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give six months' notice to partners to allow for credible alternative arrangements to be put in place, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period. .

5.13 Joint Commissioning Arrangements with NHS England/Improvement

5.13.1 The CCG may work together with NHS England/Improvement. This can take the form of joint working in relation to the CCG's functions or in relation to NHS England/Improvement's functions.

5.13.2 The CCG delegates its powers and duties under 5.13 to the Governing Body and all references in this part to the CCG should be read as the Governing Body, except to the extent that they relate to the continuing liability of the CCG under any joint arrangements.

5.13.3 In terms of either the CCG's functions or NHS England/Improvement's functions, the CCG and NHS England/Improvement may make arrangements to exercise any of their specified commissioning functions jointly.

5.13.4 The arrangements referred to in paragraph 5.13.3 above may include other CCGs, a combined authority or a local authority.

5.13.5 Where joint commissioning arrangements pursuant to 5.13.3 above are entered into, the parties may establish a Joint Committee to exercise the commissioning functions in question. For the avoidance of doubt, this provision does not apply to any functions fully delegated to the CCG by NHS England/Improvement, including but not limited to those relating to primary care commissioning.

5.13.6 Arrangements made pursuant to 5.13.3 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England/Improvement and the CCG.

5.13.7 Where the CCG makes arrangements with NHS England/Improvement (and another CCG if relevant) as described at paragraph 5.13.3 above,

the CCG shall develop and agree with NHS England/Improvement a framework setting out the arrangements for joint working, including details of:

- a) how the parties will work together to carry out their commissioning functions;
- b) the duties and responsibilities of the parties, and the legal basis for such arrangements;
- c) how risk will be managed and apportioned between the parties;
- d) financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
- e) contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

5.13.8 Where any joint arrangements entered into relate to the CCG's functions, the liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.13.3 above. Similarly, where the arrangements relate to NHS England/Improvement's functions, the liability of NHS England/Improvement to carry out its functions will not be affected where it and the CCG enter into joint arrangements pursuant to 5.13.

5.13.9 The CCG will act in accordance with any further guidance issued by NHS England/Improvement on co-commissioning.

5.13.10 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.

5.13.11 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the lead Governing Body Member for the joint arrangements make;

- a) make a quarterly written report to the Governing Body;
- b) hold at least one annual engagement event to review the aims, objectives, strategy and progress of the joint commissioning arrangements; and
- c) publish an annual report on progress made against objectives.

5.13.12 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement

but has to give six months' notice to partners to allow for credible alternative arrangements to be put in place, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

6 Provisions for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

- 6.1.1** As required by section 14O of the 2006 Act, the CCG has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the CCG will be taken and seen to be taken without being unduly influenced by external or private interest.
- 6.1.2** The CCG has agreed policies and procedures for the identification and management of conflicts of interest.
- 6.1.3** Employees, Members, Committee and Sub-Committee members of the CCG and members of the Governing Body (and its Committees, Sub-Committees, Joint Committees) will comply with the CCG policy on conflicts of interest. Where an individual, including any individual directly involved with the business or decision-making of the CCG and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CCG considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution and the Standards of Business Conduct Policy.
- 6.1.4** The CCG has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the CCG's governance lead, their role is to:
- a) Act as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest;
 - b) Be a safe point of contact for employees or workers of the CCG to raise any concerns in relation to conflicts of interest;
 - c) Support the rigorous application of conflict of interest principles and policies;
 - d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
 - e) Provide advice on minimising the risks of conflicts of interest.

6.2 Declaring and Registering Interests

- 6.2.1** The CCG will maintain registers of the interests of those individuals listed in the CCG's policy.

- 6.2.2** The CCG will, as a minimum, publish the registers of conflicts of interest and gifts and hospitality of decision making staff at least annually on the CCG website and make them available at our headquarters upon request.
- 6.2.3** All relevant persons for the purposes of NHS England/Improvement's statutory guidance *Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017* must declare any interests. Declarations should be made as soon as reasonably practicable and by law within 28 days after the interest arises. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.
- 6.2.4** The CCG will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually. All persons required to, must declare any interests as soon as reasonable practicable and by law within 28 days after the interest arises.
- 6.2.5** Interests (including gifts and hospitality) of decision making staff will remain on the public register for a minimum of six months. In addition, the CCG will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The CCG's published register of interests states that historic interests are retained by the CCG for the specified timeframe and details of whom to contact to submit a request for this information.
- 6.2.6** Activities funded in whole or in part by third parties who may have an interest in CCG business such as sponsored events, posts and research will be managed in accordance with the CCG policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.3 Training in Relation to Conflicts of Interestⁱⁱ

- 6.3.1** The CCG ensures that relevant staff and all Governing Body members receive training on the identification and management of conflicts of interest and that relevant staff undertake the NHS England/Improvement Mandatory training.

6.4 Standards of Business Conduct

- 6.4.1** Employees, Members, Committee and Sub-Committee members of the CCG and members of the Governing Body (and its Committees, Sub-Committees, Joint Committees) will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
- a) act in good faith and in the interests of the CCG;

- b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
- c) comply with the standards set out in the Professional Standards Authority guidance - *Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England*; and
- d) comply with the CCG's requirements set out in the policy for managing conflicts of interest which is available on the CCG's website and will be made available on request.

6.4.2 Individuals contracted to work on behalf of the CCG or otherwise providing services or facilities to the CCG will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the CCG's managing conflicts of interest policy.

6.5 Managing Conflicts of Interest

6.5.1 Individual members of the Group, committees or sub-committees of the Group the CCG Governing Body, the committees or sub-committees of the CCG Governing Body and employees will comply with the arrangements determined by the Group for managing conflicts or potential conflicts of interest.

6.5.2 Where more than 50% of the members of a meeting or a percentage that is below the quorum stipulated for the meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.

6.5.3 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the Group's standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the Accountable Officer on the action to be taken.

6.5.4 In these circumstances the CCG may adopt one of the following actions:

- a) requiring another of the Group's committees or sub-committees, the Group's CCG Governing Body or the CCG Governing Body's committees or sub-

committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible,

- b) where the initial responsibility for the decision does not rest with the Governing Body, refer the decision to the Governing Body and exclude all GPs or other practice representatives with an interest from the decision making process.
- c) Subject to the provisions of clause 6.5.5, inviting on a temporary basis one or more of the following individuals who shall act as members for the duration of the relevant meeting, in order to make up the quorum (where these are permitted members of the CCG Governing Body or committee / sub-committee in question) so that the Group can progress the item of business:
 - (i) a member of the CCG who is an individual;
 - (ii) an individual appointed by a member to act on its behalf in the dealings between it and the CCG;
 - (iii) a member of a relevant Health and Wellbeing Board;
 - (iv) a member of a governing body of another CCG or an individual appointed by a member of another CCG to act on its behalf in another CCG.
 - (v) A member of one of the CCG's other committees or sub-committees or, where appropriate, the CCG Governing Body's committees or sub-committees.
 - (vi) An individual who is a GP partner or salaried GP of a member practice of another CCG.
 - (vii) A member of the CCG's Governing Body.

These arrangements must be recorded in the minutes.

6.5.5 In choosing which of the seven categories of individual to invite as outlined in 6.5.4(c) above, the Chair and Accountable Officer will consider the need for the relevant individual to have either clinical knowledge, patient experience knowledge, and/or locality knowledge and the independence that the proposed individual may bring, in the circumstances and in relation to the item which is to be subject to discussion and decision making at the meeting.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006
Accountable Officer (AO)	<p>an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act, appointed by NHS England/Improvement, with responsibility for ensuring the Group:</p> <p>complies with its obligations under:</p> <p>sections 14Q and 14R of the 2006 Act,</p> <p>sections 223H to 223J of the 2006 Act,</p> <p>paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006, and</p> <p>any other provision of the 2006 Act specified in a document published by the Board for that purpose;</p> <p>exercises its functions in a way which provides good value for money.</p>
Area	The geographical area that the CCG has responsibility for, as defined in part 2 of this constitution
Chair of the CCG Governing Body	The individual appointed by the CCG to act as chair of the Governing Body and who is usually either a GP member or a lay member of the Governing Body.
Chief Finance Officer (CFO)	A qualified accountant employed by the Group with responsibility for financial strategy, financial management and financial governance and who is a member of the Governing Body.
Clinical Commissioning Groups (CCG)	A body corporate established by NHS England/Improvement in accordance with Chapter A2 of Part 2 of the 2006 Act.
Committee	A Committee created and appointed by the membership of the CCG or the Governing Body.
Sub-Committee	A Committee created by and reporting to a Committee.
Governing Body	The body appointed under section 14L of the NHS Act 2006, with the main function of ensuring that a Clinical

	Commissioning Group has made appropriate arrangements for ensuring that it complies with its obligations under section 14Q under the NHS Act 2006, and such generally accepted principles of good governance as are relevant to it.
Governing Body Member	Any individual appointed to the Governing Body of the CCG
Healthcare Professional	<p>A Member of a profession that is regulated by one of the following bodies:</p> <p>the General Medical Council (GMC)</p> <p>the General Dental Council (GDC)</p> <p>the General Optical Council;</p> <p>the General Osteopathic Council</p> <p>the General Chiropractic Council</p> <p>the General Pharmaceutical Council</p> <p>the Pharmaceutical Society of Northern Ireland</p> <p>the Nursing and Midwifery Council</p> <p>the Health and Care Professions Council</p> <p>any other regulatory body established by an Order in Council under Section 60 of the Health Act 1999</p>
Lay Member	A lay Member of the CCG Governing Body, appointed by the CCG. A lay Member is an individual who is not a Member of the CCG or a healthcare professional (as defined above) or as otherwise defined in law.
Membership Forum	The mechanism for the CCG membership to meet, discuss and approve decisions where necessary, either face to face or by virtual or electronic means via practice representatives.
Practice Representative	Each Member practice nominates a lead healthcare professional who represents the practice in its dealings with the CCG.
Primary Care Commissioning	A Committee required by the terms of the delegation from NHS England/Improvement in relation to primary care

Committee	commissioning functions. The Primary Care Commissioning Committee reports to NHS England/Improvement and the Governing Body
Professional Standards Authority	An independent body accountable to the UK Parliament which help Parliament monitor and improve the protection of the public. Published <i>Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England</i> in 2013
Member/ Member Practice	A provider of primary medical services to a registered patient list, who is a Member of this CCG.
Member practice representative	Member practices appoint a healthcare professional to act as their practice representative in dealings between it and the CCG, under regulations made under section 89 or 94 of the 2006 Act or directions under section 98A of the 2006 Act.
NHS England/Improvement	The operational name for the National Health Service Commissioning Board.
Registers of interests	Registers a Group is required to maintain and make publicly available under section 14O of the 2006 Act and the statutory guidance issues by NHS England/Improvement, of the interests of: the Members of the Group; the Members of its CCG Governing Body; the Members of its Committees or Sub-Committees and Committees or Sub-Committees of its CCG Governing Body; and Its employees.
Joint Committee	Committees from two or more organisations that work together with delegated authority from both organisations to enable joint decision-making

Appendix 2: Committee Terms of Reference

- **Audit Committee**
- **Remuneration Committee**
- **Primary Care Commissioning Committee**

Audit Committee

Terms of Reference

1. Introduction

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

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

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

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

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

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

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

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

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

2. Membership

2.1 The membership of the Committee will be as follows:

- Governing Body lay members for Governance, PPI and Primary Care; and

Deputies:

- Independent Governing Body member who is clinically qualified

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

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

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

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

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

3. Chairing Arrangements

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

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

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

4. Secretary

The secretarial support will be provided by CCG Corporate PA team. The Director of Corporate Affairs will be responsible for supporting the chair in the management of the committee's business and for drawing the committee's attention to best practice, national guidance and other relevant documents, as appropriate.

5. Quorum

5.1 The committee's quorum will be 2 of the voting members listed in section 2 above. In the event of a tied vote, the Chair has a casting vote.

5.2 To ensure that the quorum can be maintained, Committee members are able to nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained.

5.3 If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

5.4 If the committee is not quorate, the meeting may;

- proceed if those attending agree, but no decisions may be taken; or
- in accordance with clause 6.5.4 invite an additional and temporary member or members to attend; or
- may be postponed at the discretion of the Chair.

5.5 The committee will endeavour to make decisions by reaching a consensus. Where a consensus cannot be reached, the Chair will escalate the committee's views on the issue for consideration by the Governing Body.

5.6 For all Governing Board committees, the details of the process for decision making and holding a vote will be the same as set out in standing orders.

5.7 In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 6.5.4 of the Constitution and in order to

ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

6.Frequency and notice of meetings

6.1 The committee will meet as required, but at least 4 times per year and a schedule of meetings will be agreed upon by the committee at the start of each year. The chair may call a meeting in cases of urgency and should be available electronically, giving at least 5 working days notice.

6.2 Agendas will be sent out at least 5 working days before the meeting, papers should be sent out with the agenda unless in cases of urgency, but these should be agreed with the chair in advance.

6.3 Draft minutes will be produced by the minute taker within 7 working days of the meeting and circulated to the Chair of the committee for comment and to assist in preparation of the Audit Chair's report to the Governing Body.

6.4 Full minutes of the committee meeting will be circulated with the agenda for the following meeting, and agreed by the membership at the meeting and signed by the Chair.

6.5 The external auditors or head of internal audit may request a meeting if they consider that one is necessary.

6.6 At least once a year the committee will meet privately with the external and internal auditors.

6.7 The Accountable Officer will be invited to attend and discuss, at least annually, with the committee the process for assurance that supports the annual governance statement. He or she will normally attend when the committee considers the draft internal audit plan and annual accounts.

7.Remit and responsibilities of the committee

The key duties of an audit committee are as follows:

7.1.Integrated governance, risk management and internal control

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities that support the achievement of the CCG's objectives.

Its work will dovetail with that of other Committees, which the CCG has established, to seek assurance that robust clinical quality is in place.

In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (i.e. the Annual report, and the annual governance statement), together with any appropriate independent assurances prior to endorsement by the CCG.
- The underlying assurance processes that indicate the degree of achievement of CCG objectives (i.e. performance/quality reporting processes and outcomes of internal audits), the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Service.
- The policies and procedures for all work related to security management.
- The policies and procedures in place for ensuring economy, efficiency and effectiveness in the use of resources.

7.1.2 Approve on behalf of the CCG Governing Body:

- Detailed financial policies
- HR policies and procedures
- Approve the Group's counter fraud and security management arrangements including supporting plans, policies and procedures.
- Approve the Group's risk management policies and procedures
- Approve the Group's arrangements, including supporting plans, policies and procedures for business continuity and emergency planning
- Approve the arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping of confidentiality of records and for storage, management and transfer of information and data.
- Approve arrangements including supporting policies and procedures for handling Freedom of Information requests.

7.1.3 In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.1.4 This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

7.2 Internal audit

The committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards (PSIAS) and provides appropriate independent assurance to the audit committee, accountable officer and CCG. This will be achieved by:

- Consideration by the Committee of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the internal audit strategy, annual operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the CCG.
- An annual review of the effectiveness of internal audit.

7.3 External audit

The committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

7.4 Other assurance functions

The audit committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the CCG.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

7.5 Counter fraud

The committee shall satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the anti fraud work plan and any material changes to it during the year.

Management

The committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The committee may also request specific reports from individual functions within the CCG as they may be appropriate to the overall arrangements.

7.6 Financial reporting

The audit committee shall monitor the integrity of the financial statements of the CCG and any formal reports relating to the CCG's financial performance.

The committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG and to the CCG's Finance Committee.

The audit committee shall review the annual report and financial statements before submission to the governing body and the CCG, focusing particularly on:

- The wording in the governance statement and other disclosures relevant to the terms of reference of the committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

8. Relationship with the Governing Body

The chair of the committee will prepare a report following every meeting that will be presented at the CCG Governing Body which will provide assurance and identify to the Governing Body any items requiring particular attention.

9. Policy and best practice

The committee will apply best practice in the decision making processes it will follow, seeking independent advice where required and ensuring that decisions are based upon clear and transparent criteria.

The committee has full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

10. Conduct of the committee

The committee is expected to conduct its business in accordance with any national guidance and relevant codes of conduct/good governance practice, including the latest edition of the HFMA NHS Audit Committee Handbook.

Members of the committee are expected to declare conflicts of interest as set out in the constitution.

Annually the committee will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference should be approved by the CCG Governing Body.

11. Decision Making

For all other Group's committees and sub-committees, including the Clinical Commissioning Group Governing Body's committees and sub-committees, the details of the process for decision making and holding a vote will be the same as set out in standing order 3.8.

Date to be reviewed: April annually

Remuneration Committee

Terms of Reference

1. Introduction

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

2. Membership

The committee shall be appointed by the CCG from amongst its Governing Body members.

The following are members of the committee:

- Chair of the CCG
- 3 lay members; Governance, PPI and Primary Care

Only members of the committee have the right to attend committee meetings. Other individuals such as the accountable officer, any HR lead and external advisers may be invited to attend for all or part of any meeting as and when appropriate, however, should not be in attendance for discussions about their own remuneration and terms of service.

3. Chairing Arrangements

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

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

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

4. Secretary

4.1 Secretarial support for the panel will be provided by the lead human resources officer. Their role will be to support the chair in the management of remuneration business and for drawing the committee's attention to best practice, national guidance and other relevant documents, as appropriate.

5. Quorum

5.1 The committee's quorum will include 2 of the members listed in section 2 above.

5.3 If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

5.4 If the committee is not quorate, the meeting may;

- proceed if those attending agree, but no decisions may be taken; or
- in accordance with clause 6.5.4 invite an additional and temporary member or members to attend; or
- may be postponed at the discretion of the Chair.

5.5 The committee will endeavour to make decisions by reaching a consensus. Where a consensus cannot be reached, the Chair will escalate the committee's views on the issue for consideration by the Governing Body.

5.6 For all Governing Board committees, the details of the process for decision making and holding a vote will be the same as set out in standing orders.

5.7 In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 6.5.4 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

6. Frequency and notice of meetings

6.1 The committee will meet as required, but at least once per year and meetings will be called by the chair of the CCG giving at least 5 working days notice.

6.2 Draft minutes will be produced by the minute taker within 7 days of the meeting and circulated to members of the committee for comment within 5 days. The chair will then sign them within 5 days.

6.3 Full minutes of the Remuneration Committee will be sent in confidence to members and those in attendance at the Committee.

7. Remit and responsibilities of the committee

7.1 The committee shall make recommendations to the CCG Governing Body on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

7.2 In addition the following have also been delegated to the committee by the CCG Governing Body:

- recommends to the CCG Governing Body the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms excluding ill health and normal retirement for all employees.
- recommends to the CCG Governing Body business cases for staff who wish to retire and then return to employment by the CCG that have been considered and recommended by the Executive team.
- recommends to the CCG Governing Body the remuneration and conditions of service of the senior team;
- reviewing the performance of the Accountable Officer and other senior team members and recommending annual salary awards, if appropriate;
- the committee will recommend to the CCG Governing Body, the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms excluding ill health and normal retirement for all employees;
- it will consider the severance payments of the Accountable Officer and other senior staff, and recommend seeking HM Treasury approval as appropriate in accordance with the guidance “Managing Public Money” (HM Treasury.gov.uk);

8. Relationship with the Governing Body

8.1 The lead human resource officer will prepare reports from the Remuneration Committee which will be presented to the Governing Body annually. The reports will include the main items discussed and decisions made by the Committee. The Reports **will not** include specific detail relating to individuals or the deliberations of the Committee.

9. Policy and best practice

9.1 The committee will apply best practice in the decision making processes it will follow, seeking independent advice where required and ensuring that decisions are based upon clear and transparent criteria.

10. Conduct of the committee

10.1 The committee is expected to conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice.

10.2 Members of the committee are expected to declare conflicts of interest as set out in the constitution.

10.3 Annually the committee will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference should be approved by the CCG Governing Body.

11. Decision Making

11.1 For all other Group's committees and sub-committees, including the Clinical Commissioning Group Governing Body's committees and sub-committees, the details of the process for decision making and holding a vote will be the same as set out in standing order 3.8.

Date to be reviewed: April annually

Primary Care Commissioning Committee (PCC)

Terms of Reference

1. Introduction

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

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

NHS Shropshire CCG

NHS Telford and Wrekin CCG.

The delegation is set out in Schedule 1.

1.3 The CCG has established the

NHS Shropshire CCG Primary Care Commissioning Committee

NHS Telford and Wrekin CCG Primary Care Commissioning Committee

(PCC) ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

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

- NHS Shropshire CCG
- NHS Telford and Wrekin CCG

2 Statutory Framework

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

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

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

- a) Management of conflicts of interest (section 14O);
- b) Duty to promote the NHS Constitution (section 14P);
- c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- d) Duty as to improvement in quality of services (section 14R);
- e) Duty in relation to quality of primary medical services (section 14S);
- f) Duties as to reducing inequalities (section 14T);
- g) Duty to promote the involvement of each patient (section 14U);
- h) Duty as to patient choice (section 14V);
- i) Duty as to promoting integration (section 14Z1);
- j) Public involvement and consultation (section 14Z2).

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

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

2.5 The Committee is established as a committee of the

NHS Telford and Wrekin CCG

Governing Body in accordance with Schedule 1A of the “NHS Act”.

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

3 Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in

Shropshire

Telford and Wrekin,

under delegated authority from NHS England/Improvement.

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

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

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

3.5 This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

3.6 The CCG will also carry out the following activities:

- a) To plan, including needs assessment, primary care services in **Shropshire Telford and Wrekin**;
- b) To undertake reviews of primary care services in **Shropshire Telford and Wrekin**;
- c) To co-ordinate a common approach to the commissioning of primary care services generally;
- d) To manage the budget for commissioning of primary care services in **Shropshire Telford and Wrekin**.

4 Geographical Coverage

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

5 Membership

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

Voting members:

5.2 1 Lay Member:

- Lay Member for Patient and Public Involvement

5.3 The CCG has agreed the following additional members:

- A second lay member (who is the chair of the Primary Care Commissioning Committee)
- Independent GP Representative
- Accountable Officer
- Executive Director of Finance (Chief Finance Officer) (or deputy)

- Executive Director of Transformation (or deputy)
- Executive Director of Quality (or deputy)
- Director Of Partnerships (or Deputy)

Non-voting members:

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

Key regular attendees with a standing invite to attend Committee meetings will be:

- **Shropshire Telford and Wrekin** Healthwatch representative
- **Shropshire Telford and Wrekin** Council Health and Wellbeing Board representative

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

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

5.4 In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 6.5.4 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

6 Meetings and Voting

6.1 The Committee will operate in accordance with the CCG's Standing Orders as set out in Standing Order 3.8. The Secretarial support to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

6.2 Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

7 Quorum

7.1 The Committee's quorum will include 4 of the voting members outlined in section 5.1 above, one of which must be a lay member and one an Executive member.

5.3 If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

5.4 If the committee is not quorate, the meeting may;

- proceed if those attending agree, but no decisions may be taken; or
- in accordance with clause 6.5.4 invite an additional and temporary member or members to attend; or
- may be postponed at the discretion of the Chair.

5.5 The committee will endeavour to make decisions by reaching a consensus. Where a consensus cannot be reached, the Chair will escalate the committee's views on the issue for consideration by the Governing Body.

5.6 For all Governing Board committees, the details of the process for decision making and holding a vote will be the same as set out in standing orders.

5.7 In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 6.5.4 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

8. Frequency and notice of meetings

8.1 The Committee will meet as required, but at least 4 times per year and a schedule of meetings will be agreed upon by the Committee at the start of each year.

8.2 meetings of the Committee shall:

- a) be held in public, subject to the application of 23(b);

- b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

8.2 Draft minutes will be produced by the minute taker within 7 days of the meeting and circulated to the Chair of the committee for comment within 5 days. They will be presented to the next meeting for committee for approval and the chair will then sign them within 5 days.

8.4 The agenda and supporting papers will be circulated to all members at least five working days before the date of the meeting, unless there are exceptional circumstances for individual papers agreed in advance with the Chair.

8.5 Extraordinary meetings may be held at the discretion of the Chair. A minimum of seven working days' notice should be given when calling an extraordinary meeting.

8.6 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.

9 Conduct of the Committee

9.1 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

9.2 The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest..

9.3 The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

9.4 Members of the Committee shall respect confidentiality requirements and codes of conduct as set out in the CCG's Constitution

9.5 The CCG will also comply with any reporting requirements set out in its constitution.

9.6 It is envisaged that these Terms of Reference will be reviewed annually, reflecting experience of the Committee in fulfilling its functions. NHS England/Improvement may also issue revised model terms of reference from time to time.

10 Accountability of the Committee

10.1 The budget and resource accountability arrangements and the decision-making scope of the Committee will be agreed pursuant to the delegation and delegation agreement with NHS England/Improvement.

10.2 For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the delegation will prevail.

10.3 The Committee will make allowance for consultation with members of the public and other CCGs.

11 Procurement of Agreed Services

11.1 The detailed arrangements regarding procurement of primary care services will be set out in the delegation agreement entered into between the Group and NHS England/Improvement.

12 Decisions

12.1 The Committee will make decisions within the bounds of its remit.

12.2 The decisions of the Committee shall be binding on NHS England/Improvement and NHS Telford and Wrekin CCG.

12.3 The Committee will produce an executive summary report which will be presented to Local Team of NHS England/Improvement and the NHS Telford and Wrekin CCG Governing Body following each meeting for information.

Date to be reviewed: April annually

Schedule 1 – Delegated Functions

a) decisions in relation to the commissioning, procurement and management of Primary Medical services Contracts, including but not limited to the following activities:

- I. decisions in relation to Enhanced Services;
- II. decisions in relation to Local Incentive Schemes (including the design of such schemes);
- III. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
- IV. decisions about 'discretionary' payments;
- V. decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

- b) the approval of practice mergers;
- c) planning primary medical services in the Area, including carrying out needs assessments;
- d) undertaking reviews of primary medical care services in the Area;
- e) decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
- f) management of the Delegated Funds in the Area;
- g) Premises Costs Directions functions;
- h) co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
- i) such other ancillary activities as are necessary in order to exercise the Delegated Functions.

Schedule 2 – Reserved Functions

- a) management of national performers list;
- b) management of the revalidation and appraisal process;
- c) administration of payments in circumstances where a performer is suspended and related performers list management activities;
- d) Capital Expenditure functions;
- e) section 7A functions under the NHS Act;
- f) functions in relation to complaints management;
- g) decisions in relation to the Prime Minister's Challenge Fund; and
- h) such other ancillary activities that are necessary in order to exercise the Reserved Functions.

Appendix 3: Standing Orders

1. STATUTORY FRAMEWORK AND STATUS

1.1 Introduction

1.1.1 These Standing Orders (SOs) have been drawn up to regulate the proceedings of the **NHS Shropshire CCG NHS Telford and Wrekin CCG** so that Group can fulfil its obligations, as set out in the National Health Services Act 2006, as amended by the Health and Social Care Act 2012 (the Act) and related regulations. They are effective from the date the Group is established.

1.1.2 The standing orders, together with the Group's scheme of reservation and delegation, Standing Financial Instructions (SFIs) and the Group's prime financial policies, provide a procedural framework within which the Group discharges its business. They set out:

- a) the arrangements for conducting the business of the Group;
- b) the appointment of member practice representatives;
- c) procedure to be followed at meetings of the Group, CCG Governing Body and any committees or sub-committees of the Group or CCG Governing Body;
- d) the process to delegate powers; and
- e) the declaration of interests and standards of conduct.

1.1.3 These arrangements must comply, and must be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate of any relevant guidance.

1.1.4 The standing orders and SFIs have effect as if incorporated into the Group's constitution. The Scheme of Reservation and Delegation and Prime Financial Policies are contained in the CCG's Governance Handbook and do not form part of this constitution. Group members, employees, members of the CCG Governing Body, members of the CCG Governing Body's committees and sub-committees and persons working on behalf of the Group should be aware of the existence of all of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation, SFIs and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

1.2 Schedule of matters reserved to the CCG and the scheme of reservation and delegation

- 1.2.1 The 2006 Act (as amended by the 2012 Act) provides the Group with powers to delegate the Group's functions and those of the CCG Governing Body to certain bodies (such as committees) and certain persons. The Group has decided that certain decisions may only be exercised by the Group in formal session. These decisions and also those delegated are contained in the Group's scheme of reservation and delegation which is part of the CCG's Governance Handbook.

2. THE CCG: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESS

2.1 Composition of membership

- 2.1.1 Chapter 3 of the Group's constitution provides details of the membership of the Group.
- 2.1.2 Chapter 5 of the Group's constitution provides details of the governing structure used in the Group's decision-making processes, whilst section 2.2.2 of these standing orders outlines certain key roles and responsibilities within the Group and its CCG Governing Body, including the role of practice representatives.

2.2 Key Roles and appointment process

- 2.2.1 These standing orders set out the responsibilities of the key roles on the CCG Membership Forum, Locality Forum and CCG Governing Body and how the Group appoints individuals to these roles.
- 2.2.2 **The practice representative** represent their practice's views and act on behalf of the practice in matters relating to the Group. The role of each practice representative is to:
- a) to routinely attend monthly CCG Practice Forum meetings;
 - b) to attend CCG Practice Forum annual general meeting and extraordinary meetings if called;
 - c) to represent the views of the member practice at the CCG Membership Forum and vote on the member practice's behalf;
 - d) to act as a communication conduit between the member practice and the CCG

Membership Forum and Locality Forums

Membership Forum

and CCG Governing Body;

- e) to provide a forum for consultation by the CCG Governing Body of the Group's membership;
- f) to consult with colleagues; GPs, nurses, other practice staff to enable them to feed the practice's views into clinical commissioning decisions;
- g) to proactively engage with the CCG Governing Body on issues of service redesign, commissioning decisions and other operational issues;
- h) to comment on the commissioning plan and monitor delivery against the plan by the CCG Governing Body;
- i) to discuss and debate the views and wishes of the members.
- j) to elect a Chair of the CCG **Locality Membership** Forum from one of their own number.

2.2.3 Practice Representatives are subject to the following appointment process:

- a) Each member practice will be required to nominate one representative who is a healthcare professional which includes but is not limited to; a General Practitioner or other Healthcare Professional who is a partner of that practice, or a salaried or locum GP or another healthcare professional, to the CCG **Membership and Locality Membership** Forum. The name of this representative must be submitted in writing to the CCG Governing Body. That representative will have one vote.
- b) If a member representative is unable to attend a CCG **Membership and Locality Membership** Forum meeting, the practice member may allocate another member of the practice to take their vote.
- c) **The practice representatives from each practice will be collectively known as the CCG Membership Forum.**
- c) **The practice representatives from each practice will be collectively known as the CCG Membership Forum when meeting to make decisions and exercise powers reserved to the membership, as listed in the Scheme of Reservation and Delegation.**
- d) **The practice representatives from each practice meeting from within a designated locality will be collectively known as the CCG Locality Forum.**

- e) Each member may remove and replace their member representative at any time and from time to time, by notice in writing to the CCG Governing Body.
- f) The CCG Governing Body shall be entitled to treat any member representative as having the continuing authority given to him or her under clause (a) until it is notified of the removal of that member representative in accordance with clause (d).
- g) A member representative shall cease to be a member's representative if he or she:
 - i) ceases to be a GP partner or salaried GP of a member practice;
 - ii) ceases to be on the National Performers list;
 - iii) is a member of a practice that ceases to be, for whatever reason, a member of the Group;
 - iv) is struck off the professional register by order of the GMC or is under suspension;
 - v) is expelled by a resolution passed by a majority of the CCG Governing Body for conduct prejudicial to the Group.

2.2.4 The Chair of a the CCG Locality Membership Forum is responsible for:

- a) leading the CCG Locality Membership Forum, ensuring it remains continuously able to discharge its duties and responsibilities, as set out in this constitution; and
- b) ensuring that the CCG Membership Forum effectively holds the Clinical Commissioning Group Board to account for discharging the statutory duties delegated to it by the CCG.

2.2.5 The Chair of the CCG Locality Membership Forum, is subject to the following appointment process:

- a) The Chair must be a GP, who has been appointed by their practice to fulfil the role outlined in 2.2.2 above and 3.6 in the Group's constitution as a Membership Forum representative.
- a) The Chair must be a GP, Primary Healthcare Professional or Practice Manager working in a membership practice.
- b) Nominations will be sought from the GPs, Healthcare Professional or Practice Manager who meet the criteria stated in (a) above. Nominees must provide evidence of their practice's support of the nomination. The nominees meeting the role criteria, will then go forward for selection through an electoral process, by an electorate formed by respective Locality Membership Forum representatives.

- c) The appointment of this role will be by the CCG **Locality Membership** Forum ratifying the first candidate with the highest number of valid votes received. Where more than one candidate receives the same number of valid votes, a further voting process will commence for those candidates receiving the same number of votes. Where only one person stands for election, they will be appointed without the need for an election process, subject to ratification by the **Locality Membership** Forum.
- d) The term of office of the Chair of the CCG **Locality Membership** Forum will be 3 years.
- e) Currently a serving Chair will be eligible for re-election.
- f) The grounds for removal from office for the CCG **Locality Membership** Forum Chair are as follows:
 - (i) ceases to be a GP partner or salaried GP of a member practice;
 - (ii) ceases to be on the National performers list;
 - (iii) is a partner or employee of a practice that ceases to be, for whatever reason, a member of the Group;
 - (iv) is struck off by the relevant professional body or is under suspension;
 - (v) is expelled by a resolution passed by a majority of the CCG Governing Body for conduct prejudicial to the Group.
- g) The period of notice for the chair will be 3 months in writing to the Accountable Officer.

2.2.6 The Chair of the CCG Governing Body as listed in 5.5.2 in the Group's constitution, is responsible for:

- a) leading the CCG Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities, as set out in this constitution;
- b) building and developing the Group's CCG Governing Body and its individual members;
- c) ensuring that the Group has proper constitutional and governance arrangements in place;
- d) ensuring that, through the appropriate support, information and evidence, the CCG Governing Body is able to discharge its duties;
- e) supporting the Accountable Officer in discharging the responsibilities of the organisation;

- f) contributing to building a shared vision of the aims, values and culture of the organisation;
- g) leading and influencing to achieve clinical and organisational change to enable the Group to deliver its commissioning responsibilities;
- h) overseeing governance and particularly ensuring that the CCG Governing Body and the wider Group behaves with the utmost transparency and responsiveness at all times;
- i) ensuring that public and patients views are heard and their expectations understood and, where appropriate as far as possible, met;
- j) ensuring that the organisation is able to account to its local patients, stakeholders and the NHS England/Improvement;
- k) ensuring that the Group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority.
- l) undertaking the role of clinical lead of the CCG.
- k) acting as the Clinical Lead for the CCG and take a lead in interactions with stakeholders, including with NHS England/Improvement.

2.2.7 The Chair of the CCG Governing Body is subject to the following appointment process:

- a) The Chair must be a GP who has been elected as a GP/other primary Care Health Professional on the CCG Governing Body of both; NHS Shropshire CCG and NHS Telford and Wrekin CCG. Those appointed jointly to a GP/other Primary Care Health Professional role on the CCG Governing Body as set out in section 5.5.4 of the Constitution, are exempt from standing for the role of Chair.
- b) Nominations will be sought from the Governing Body GP/Primary Care Health Professionals who meet the criteria stated in (a) above. Nominees must provide evidence of their practice's support of the nomination.
- c) The appointment of this role will be through an electoral process, by an electorate formed from the GP/Primary Care Health Professional Governing Body members, ratifying the first candidate with the highest number of valid votes received. Where more than one candidate receives the same number of valid votes, a further voting process will commence for those candidates receiving the same number of votes.

- d) The term of office of the Chair will be four years.
- e) Currently serving Chair will be eligible for re-election.
- f) The grounds for removal from office for the GP Chair are as follows:
 - (i) ceases to be a GP partner, salaried GP or GP contractor of a member practice of either NHS Shropshire CCG or NHS Telford and Wrekin CCG;
 - (ii) ceases to be on the performers list of Shropshire or Telford and Wrekin;
 - (iii) is a partner or employee of a practice that ceases to be, for whatever reason, a member of the either Group;
 - (iv) is struck off by the relevant professional body or is under suspension;
 - (iv) is expelled by a resolution passed by a 67% majority of the CCG Governing Body for conduct prejudicial to the Group.
- g) The period of notice for the chair will be 3 months in writing to the Accountable Officer.

2.2.8 The Deputy Chair of the CCG Governing Body, as listed in paragraph 5.5.5 in the Group's constitution, deputises for the Chair of the CCG Governing Body where he or she has a conflict of interest, or is otherwise unable to act at a governing Body meeting

2.2.9 The Deputy Chair of the CCG Governing Body is subject to the following appointment process:

- a) The Deputy Chair must be one of the lay members of the CCG Governing Body.
- b) Appointment of the Deputy Chair is by election by the members of the CCG Governing Body on a show of hands in a public meeting. The candidate receiving the most votes will become the Deputy Chair.
- c) The term of office of the Deputy Chair will be four years.
- d) Currently serving Deputy Chair will be eligible for re-election.
- e) The grounds for removal from office for the Deputy Chair is as follows:

- (i) is no longer eligible to remain on the CCG Governing Body in their capacity as a Board member.
 - (ii) performance does not meet the role description or person specification.
 - (ii) Conduct prejudicial to the Group
- f) The period of notice for the Deputy Chair will be one month in writing to the Accountable Officer.

2.2.10 The Deputy Clinical Chair of the CCG, as listed in paragraph 5.5.6 in the Group's Constitution, deputises for the Chair of the Governing Body in the absence of the Chair to undertake his or her duties other than chairing the Governing Body and is able to act within the authority of the Chair role as outlined within the Constitution and CCG Scheme of Reservation and Delegation.

2.2.11 **The Deputy Clinical Chair of the CCG** is subject to the following appointment process:

- a) The Deputy Clinical Chair must be one of the GP/Primary Healthcare Professionals elected to the Governing Body.
- b) Appointment of the Deputy Clinical Chair is by election by the members of the CCG Governing Body on a show of hands in a public meeting. The candidate receiving the most votes will become the Deputy Clinical Chair.
- c) The term of office of the Deputy Clinical Chair will be four years.
- d) Currently serving Deputy Clinical Chair will be eligible for re-election provided they remain a GP/Primary Healthcare Professional on the Governing Body.
- e) The grounds for removal from office for the Deputy Clinical Chair are as follows:
 - (i) is no longer eligible to remain on the CCG Governing Body in their capacity as a Board member.
 - (ii) performance does not meet the role description.
 - (ii) Conduct prejudicial to the Group

2.2.12 **The Accountable Officer**, as listed in paragraph 5.5.2(b) in the Group's constitution, role is to:

- a) be responsible for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically, thus ensuring improvement in the quality of services and the health of the local population, whilst maintaining value for money;

- b) at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the National Audit Office) is embodied, and that safeguarding of funds is ensured through effective financial and management systems.
- c) working closely with the chair of the CCG Governing Body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the CCG Governing Body) of the organisation's on-going capability and capacity to meet its duties and responsibilities. This will include arrangements for the on-going developments of its members and staff.

2.2.13 The Accountable Officer is subject to the following appointment process:

- a) The Accountable Officer for the CCG will be appointed by NHS England/Improvement and then automatically appointed to the Governing Body.
- b) The term of office on the Governing Body is the same as their respective employment contract.
- d) They can be eligible for reappointment only if they are re-recruited to their respective roles by the CCG as their employer.
- e) The grounds for removal from office would be if their employment contract with their employer for their respective role is terminated, whether by they themselves or their employer.
- f) The notice period they would need to give would correspond to their contracted notice period with their employer, unless varied by their employer.

2.2.14 The Chief Finance Officer as listed in paragraph 5.5.2(c) in the Group's constitution, role is to:

- a) be responsible for providing financial advice to the CCG and for supervising financial control and accounting systems.
- b) being the CCG Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
- b) making appropriate arrangements to support and monitor the Group's finances;

- c) overseeing robust audit and governance arrangements leading to propriety in the use of the Group's resources;
- d) being able to advise the CCG Governing Body on the effective, efficient and economic use of the Group's allocation, to remain within that allocation, and deliver required financial targets and duties; and
- e) producing the financial statements for audit and publication, in accordance with statutory requirements to demonstrate effective stewardship of public money and accountability to the NHS England/Improvement;

2.2.15 The Chief Finance Officer, is subject to the following appointment process:

- a) Will be automatically appointed to the Governing Body following a recruitment process and appointment by the CCG as their employer to their respective role.
- c)_ The term of office on the Governing Body is the same as their respective employment contract.
- d) They can be eligible for reappointment only if they are re-recruited to their respective roles by the CCG as their employer.
- e) The grounds for removal from office would be if their employment contract with their employer for their respective role is terminated, whether by they themselves or their employer.
- f) The notice period they would need to give would correspond to their contracted notice period with their employer, unless varied by their employer.

2.2.16 The GP/other primary care health professional, as listed in paragraphs 5.5.3(b) have been identified by the Group from member practices to support the work of the Group and /or represent the Group rather than represent their own individual practices. **NHS Shropshire CCG** **NHS Telford and Wrekin CCG** will have six GP/primary care health professionals (including the Chair) on the Group's CCG Governing Body. As members of the Group's CCG Governing Body, they bring their unique understanding of the Group's member practices to the discussion and decision making of the CCG Governing Body. These GPs and primary health professionals undertake the following roles on behalf of the Group:

- a) To share responsibility with the other members of the CCG Governing Body for all aspects of the Group's CCG Governing Body business, including making decisions on behalf of the Group.

- b) Bring an understanding of the issues of general practice, to the discussion and decision making process of the CCG Governing Body.
- c) To provide an unbiased, strategic clinical view on all aspects of the Group's business
- d) To provide an in depth understanding of the health inequalities of the area, and to take a balanced view of the clinical and management agenda.
- e) To provide clinical leadership on priority areas of work, Group's objectives and strategic developments.
- f) Liaise with key stakeholders to ensure that NHS commissioning is aligned.
- g) Facilitate discussions to encourage all members to participate in clinical commissioning matters.

2.2.17 The GP/other primary health professional, is subject to the following appointment process:

- a) The GP/other primary care health professional must be either a member of the Group or of **NHS Shropshire CCG NHS Telford and Wrekin CCG**, a partner of a partnership that is a member of these Groups or a shareholder, employee or GP contractor of a member of these Groups, and for the avoidance of doubt may be, but need not be, a representative of a member of the Group.
- b) Nominations will be sought for any GP/other primary care health professional practising within the Group's area or **NHS Shropshire CCG NHS Telford and Wrekin CCG** who meets the criteria stated in (a) above. Nominees must provide evidence of their practice's support of the nomination. The nominees meeting the role criteria, will then go forward for selection through an electoral process, by an electorate formed by the respective practice representatives of the member practices of NHS Shropshire CCG and NHS Telford and Wrekin CCG.
- c) The appointment of these roles will be by the CCG Governing Body ratifying the first three candidates with the highest number of valid votes received from NHS Shropshire CCG membership and the first three candidates with the highest number of valid votes received from NHS Telford and Wrekin CCG membership. Where more than one candidate receives the same number of valid votes, a further voting process will commence for those candidates receiving the same number of votes. Where only one candidate or joint candidates stand for one or each vacancy, then providing that candidate or joint candidates meet the criteria stated in (a) above they will be appointed to the vacancy without an

election process taking place, subject to ratification at the CCG's Governing Body.

- d) The term of office of the GP/other primary care health professional will be three years.
- e) Currently serving GP/other primary care health professional will be eligible for re-election.
- f) The grounds for removal from office for the GP/other primary care health professional are as follows:
 - (i) ceases to be a GP partner, shareholder, employee or GP contractor of a member of the Group or **NHS Shropshire CCG NHS Telford and Wrekin**;
 - (ii) ceases to be on the National Performers List;
 - (iii) is a partner or employee of a practice that ceases to be, for whatever reason, a member of the Group;
 - (iv) is struck off by the relevant professional body or is under suspension;
 - (v) is expelled by a resolution passed by a 67% majority of the CCG Governing Body for conduct prejudicial to the Group.
- g) The period of notice for a GP/other primary care health professional will be 3 months in writing to the Chair of the CCG Governing Body.

2.2.18 The lay members of the CCG Governing Body, as listed in 5.5.2(f) and 5.5.3 (a) of the Group's constitution, role is to:

- a) share responsibility with the other members of the CCG Governing Body for all aspects of the Group's CCG Governing Body business including making decisions on behalf of the Group;
- b) to focus on the strategic and impartial, providing an external view of the work of the CCG that is removed from the day to day running of the organisation.

2.2.19 The lay members of the CCG Governing Body are subject to the following appointment process:

- a) The lay members will be appointed through a selection process open to the general public, that will include submission of an application and interview process using a role description and person specification.
- b) The term of office of lay members will be four years.

- c) Currently serving lay members may be reappointed based upon a favourable performance review by the chair of the CCG Governing Body.
- d) The grounds for removal from office for the lay members are as follows:
 - (i) performance does not meet the role description or person specification.
 - (ii) Conduct prejudicial to the Group
- e) The period of notice for lay members is three months in writing to the chair of the CCG Governing Body.

2.2.20 The registered nurse of the CCG Governing Body, as listed in 5.5.2(e) of the Group's constitution, role is:

- a) to share responsibility with the other members of the CCG Governing Body for all aspects of the Group's CCG Governing Body business including making decisions on behalf of the Group.
- b) to bring a broader view on health and care issues to underpin the work of the CCG from a nursing perspective. In particular, they will bring to the governing body an understanding of the contribution of nursing to patient care

2.2.21 The registered nurse of the CCG Governing Body is subject to the following appointment process:

- a) The registered nurse must be a nurse who does not practice within a main provider to the Group.
- b) The registered nurse will be appointed through a selection process open to registered nurses meeting criteria (a) above, that will include submission of an application and interview process using a role description and person specification.
- c) The term of office of the registered nurse will be four years.
- d) Currently serving registered nurse may be reappointed based upon a favourable performance review by the chair of the Clinical Commissioning Group Governance Board.
- e) The grounds for removal from office for the registered nurse are as follows:

- (i) performance does not meet the role description or person specification;
 - (ii) conduct prejudicial to the Group;
 - (iii) is struck off by the relevant professional body or is under suspension;
 - (iv) is employed by one of the Group's main provider of services.
- f) The period of notice for the registered nurse is three months in writing to the chair of the Clinical Commissioning Group Governance Board.

2.2.22 The secondary care specialist doctor of the CCG Governing Body, as listed in 5.5.2(d) of the Group's constitution, role is to:

- a) To share responsibility with the other members of the CCG Governing Body for all aspects of the Group's CCG Governing Body business including making decisions on behalf of the Group.
- b) to bring a broader view on health and care issues to underpin the work of the CCG from a secondary care perspective. In particular, they will bring to the governing body an understanding of patient care in the secondary care setting.

2.2.23 The secondary care specialist doctor is subject to the following appointment process:

- a) The secondary care specialist doctor must be a doctor who does not practice within the Group's area.
- b) The secondary care specialist doctor will be appointed through a selection process open to secondary specialist doctors meeting criteria (a) above, that will include submission of an application and interview process using a role description and person specification
- c) The term of office of the secondary care specialist doctor will be four years.
- d) Currently serving secondary care specialist doctor may be reappointed based upon a favourable performance review by the chair of the CCG Governing Body.

- e) The grounds for removal from office for the secondary care specialist are as follows:
- (i) performance does not meet the role description or person specification.
 - (ii) conduct prejudicial to the Group
 - (iii) is struck off by the relevant professional body or is under suspension;
 - (iv) is employed by one of the Group's main provider of services.
- f) The period of notice for the secondary care specialist clinician is three months in writing to the chair of the CCG Governing Body.

3. MEETINGS OF THE CCG

3.1 Calling meetings of the Group

- 3.1.1 Ordinary meetings of the Group constituted as the Membership Forum, shall be held at regular intervals at such times and places as the Group may determine.
- 3.1.2 The CCG Governing Body or one third of the member representatives can call an ordinary meeting of the CCG Membership Forum at any time by giving all members at least 21 days notice.

3.2 Calling Annual General Meeting (AGM)

- 3.2.1 The Governing Body shall hold an Annual General Meeting (AGM) on behalf of the Group:
- once in each year provided that not more than 15 months shall elapse between the date of one Annual General Meeting and that of the next;
 - on a business day; and
 - that AGM shall be held at such a time and place as the CCG Governing Body shall determine no later than September 30th of any year and in a publically accessible premises within the CCG 's area.
- 3.2.2 The matters to be discussed at the AGM shall be set out in a notice and shall include consideration, and if necessary approval of:
- the Group's annual accounts;
 - the Group's annual report.

- 3.2.3 The Group's AGM will be held in public wherever possible and minutes of the meeting will be a matter of public record.

3.3 Calling meetings of the CCG Governing Body

- 3.3.1 The CCG Governing Body shall meet in public wherever possible on a regular basis no less than 5 times per year, and at such times and places as the CCG Governing Body determines.
- 3.3.2 Any member of the CCG Governing Body or one third of the member representatives of the CCG Practice Forum can call a meeting of the CCG Governing Body at any time by giving all members at least 21 days notice.

3.4 Agenda, supporting papers and business to be transacted

- 3.4.1 Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the chair of the meeting at least 14 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least 10 working days before the meeting takes place. The agenda will be circulated to all members of a meeting 5 days before the date the meeting will take place, save in emergency. Supporting papers will accompany the agenda wherever possible, but these will be circulated at least 3 days before the date of the meeting save in emergency.
- 3.4.2 The Chairs of the **CCG Locality Forums** **Membership Forum** and CCG Governing Body will draw up the agendas.
- 3.4.3 Agenda and certain papers for the Group's CCG Governing Body and Primary Care Commissioning committee, including details about meeting dates, times and venues, will be published on the Group's website at

ADD WEBLINK HERE

or made available on application by post to

ADD ADDRESS HERE

3.5 Petitions

- 3.5.1 Where a petition has been received by the Group the Chair of the CCG Governing Body shall include the petition as an item for the agenda of the next meeting of the CCG Governing Body.

3.6 Chair of meeting

- 3.6.1 At any meeting of the CCG Membership Forum, **Locality Forum** CCG Governing Body or of a committee or sub-committee, the Chair, if any and if

present, shall preside. If the Chair is absent from the meeting, the Deputy Chair if any and if present, shall preside.

- 3.6.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If both the Chair and Deputy Chair are absent, or are disqualified from participating, or there is neither a chair nor deputy, a member of the Group, CCG Membership Forum, **Locality Forum**, CCG Governing Body, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

3.7 Chair's ruling

- 3.7.1 The decision of the Chair on questions of order, relevancy and regularity and their interpretation of the Constitution, Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies and terms of reference at the meeting, shall be final.

3.8 Quorum

- 3.7.1 The quorum of the CCG Governing Body shall be one third of the members, with at least two of those members in attendance being clinicians, one of which must be a GP/Primary Healthcare Professional.
- 3.7.2 The quorum of the CCG **Locality and** Membership Forum shall be at least half (50%) of the practice representatives.
- 3.7.3 An employee of the Group, who is in attendance on behalf of a voting member of the CCG Governing Body, but without formal acting up status, may not count towards the quorum.
- 3.7.4 If the quorum is lost due to a member or members being disqualified from taking part in a vote or discussion due to a declared interest, then, subject to clauses 6.4.10 that matter may not be discussed further or voted upon that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.
- 3.7.5 For all other of the Group's committees and sub-committees, including the CCG Governing Body's committees and sub-committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference.
- 3.7.6 In rare and exceptional circumstances and where agreed with the Chair prior to the meeting, members of the CCG Governing Body and its committees and sub committees may participate in meetings by telephone, by use of video conferencing facilities and/or webcam where such facilities are available.

Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

3.8 Decision making

3.8.1 Section 5 of the CCG's Constitution, together with the Scheme of Reservation and Delegation, sets out the governing structure for the exercise of the CCG's statutory functions. Generally it is expected that at the CCG meetings decisions will be reached by consensus. Should this not be possible then a vote of its members will be required, the process for which is set out below:

a) Eligibility – only voting members of a meeting/committee (or their named deputy) can be eligible to vote.

b) Majority necessary to confirm a decision – simple majority of those present and who are able to cast a vote is required.

c) Casting vote – in the event of a tie, the Chair of the Committee/meeting has the casting vote. For Governing Body meetings, where the Chair and member practice representatives are unable to cast a vote due to a conflict of interest, the Accountable Officer is able to cast a final deciding vote.

d) Dissenting views – members taking a dissenting view but losing a vote will have their dissent recorded in the minutes.

e) Voting in absence – members eligible to cast a vote may vote in absence by a formal letter to the CCG Chair or through a proxy vote via a nominated deputy.

3.9 Emergency powers and urgent decisions

3.9.1 The powers which the Group has reserved and has delegated to the CCG Governing Body and the Primary Care Commissioning Committee within these standing orders may in emergency or for an urgent decision be exercised by the Chair of the CCG Governing Body and Accountable Officer, after having consulted at least one other member of the CCG Governing Body where there is not sufficient time to hold a meeting of the CCG Membership Forum, Governing Body or Primary Care Commissioning Committee which will be quorate.

3.9.2 The exercise of such powers by the Chair and Accountable Officer shall be reported to the next formal meeting of the CCG Governing Body or Primary Care Commissioning Committee in public session for formal ratification.

3.10 Suspension of Standing Orders

- 3.10.1 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or the NHS England/Improvement, any part of these standing orders may be suspended at any meeting, provided two thirds of those meeting members present are in agreement.
- 3.10.2 A decision to suspend standing orders together with the reasons for doing so shall be recorded in the minutes of the meeting.
- 3.10.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend standing orders.

3.11 Record of Attendance

- 3.11.1 The names and titles of all members of the Group's meetings, present at the meeting shall be recorded in the minutes of the Group's meetings.

3.12 Minutes

- 3.12.1 The minutes will record the names of those attending the meeting. In the case of the CCG Membership Forum and Locality Forum the minutes will record both the member practice represented and the individual representing that practice.
- 3.12.2 The minutes will be drafted by the appointed minute taker within 7 days of the meeting and submitted for agreement as a true record at the next ensuing meeting, where they will be signed by the person presiding as the Chair within 5 days.
- 3.12.3 The minutes will be circulated with the agenda and supporting papers of the next ensuing meeting wherever possible, or at a future meeting and with regard to the CCG Governing Body and Primary Care Commissioning Committee, published on the website at:

ADD IN WEBLINK TO PAGE HERE

3.13 Admission of public and the press

- 3.13.1 Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the CCG Governing Body and the Primary Care Commissioning Committee but shall be required to withdraw upon the CCG Governing Body or the Primary Care Commissioning Committee announcing as follows:

"That representatives of the press, and other members of the public, be excluded from the remainder of this 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).

Guidance should be sought from the Group's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

3.13.2 General disturbances

The Chair (or Deputy Chair if one has been appointed) or the person presiding over the meeting, shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press, such as to ensure that the Group's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the CCG Governing Body to complete its business without the presence of the public" (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

3.13.3 Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Group's CCG Governing Body or Primary Care Commissioning Committee following the exclusion of representatives of the press, and other members of the public, as provided in 3.13.1 and 3.13.2 above, shall be confidential to the members of the CCG Governing Body or Primary Care Commissioning Committee.

Members, any employee of the Group or observers in attendance shall not reveal or disclose the contents of papers marked "In Confidence" or minutes headed "Items Taken in Private" outside of the Group, without the express permission of the Group. This prohibition shall apply equally to the content of any discussion during the CCG Governing Body's meeting or Primary Care Commissioning Committee's meeting or any other committee or sub-committee meeting, which may take place on such reports or papers.

3.13.4 Use of mechanical or electrical equipment for recording or transmission of meetings

Nothing in these standing orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Group or its Committees or

Sub-committees, meetings of the CCG Governing Body held in private pursuant to 3.13.3 above or of the Governing Body's Committees or sub-committees. Such permission shall be granted only upon resolution of the CCG Governing Body.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of committees and sub-committees

- 4.1.1 The Group may appoint committees and sub-committees of the Group, subject to any regulations made by the Secretary of State, and make provision for the appointment of committees and sub-committees of its CCG Governing Body. Where such committees and sub-committees of the Group, or committees and sub-committees of its CCG Governing Body, are appointed they are included in the CCG's Governance Handbook.
- 4.1.2 Other than where there are statutory requirements, such as in relation to the CCG Governing Body's audit committee or remuneration committee, the Group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the Group.
- 4.1.3 The provisions of these standing orders shall apply where relevant to the operation of the CCG Governing Body, the CCG Governing Body's committees and sub-committee and all committees and sub-committees unless stated otherwise in the committee or sub-committee's terms of reference.

4.2 Terms of Reference

- 4.2.1 Terms of reference for the following statutory or mandated CCG Committees will be incorporated into the Constitution:
 - a) Audit Committee
 - b) Remuneration Committee
 - c) Primary Care Commissioning Committee
- 4.2.2 Terms of reference for the non-statutory and non-mandated committees and sub-committees of the CCG and CCG Governing Body are contained in the CCG's Governance Handbook.

4.3 Delegation of Powers by Committees to Sub-committees

- 4.3.1 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Group or CCG Governing Body.

4.4 Approval of Appointments to Committees and Sub-Committees

- 4.4.1 The Group shall approve, via the [Membership Forum](#), [Locality Membership Forums](#) the appointments to each of the committees and sub-committees which it has formally constituted. The CCG Governing Body shall approve the appointments to each of the committees and sub-committees which it has formally constituted including the Governing Body itself.

5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

- 5.1 If for any reason these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the CCG Governing Body for action or ratification. All members of the Group and staff have a duty to disclose any non-compliance with these standing orders to the Accountable Officer as soon as possible.

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1 Group seal

- 6.1.1 The Group may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

- The Accountable Officer
- The Chair of the CCG
- The Executive Director of Finance (Chief Finance Officer)

6.2 Execution of a document by signature

- 6.2.1 The following individuals are authorised to execute a document on behalf of the Group by their signature.

- The Accountable Officer
- The Chair of the CCG Governing Body
- The Executive Director of Finance (Chief Finance Officer)

7. OVERLAP WITH OTHER GROUP POLICY STATEMENTS/PROCEDURES AND REGULATIONS

7.1 Policy statements: general principles

- 7.1.1 The Group will from time to time agree and approve policy statements/ procedures which will apply to all or specific groups of staff employed by NHS

Telford and Wrekin CCG. The decisions to approve such policies and procedures will be recorded in an appropriate Group minute and will be deemed where appropriate to be an integral part of the Group's standing orders.

8. DISPUTE RESOLUTION

- 8.1 If a dispute arises between the Group and a member practice, or between member practices, then all parties are required to adhere to the following process:
- a) Should a practice have any dispute or wish to appeal against any decision made, this should be raised in writing to the Chair of the CCG **respective Locality Forum Membership Forum** initially, who will endeavour to resolve any dispute.
 - b) Should the issue remain unresolved, the Chair of the CCG **Locality Membership** Forum will formally take the matter to the formal CCG Governing Body for resolution.
 - c) Practices will have a right of appeal to NHS England/Improvement

Appendix 4: Standing Financial Instructions (SFIs)

Standing Financial Instructions is the Financial scheme of delegation that sets out the levels of financial authority that are delegated to different levels of staff within the CCG. Staff may only operate within the authority levels delegated to them and any breaches must be reported immediately to the Executive Director of Finance or Deputy Director of Finance. Breaches will also be reported to the Audit Committee.

The Financial Scheme of Delegation is reviewed and amended from time to time. It is the responsibility of the Accountable Officer to communicate current policy to staff.

The Financial Scheme of Delegation must be read in conjunction with other relevant financial and other policies of the CCG, including the CCG's policies in relation to Conflicts of Interest.

Key:

AO - Accountable Officer

EDoF – Executive Director of Finance

DoP - Director of Partnerships

EDoQ – Executive Director of Quality

Other Exec - Executive Director other than AO and CFO

AC - Audit Committee

Equiv – equivalent staff member (who may be fulfilling work of similar nature or at an equivalent level of seniority relevant and appropriate for the authority level, to be determined by a more senior line manager)

Notes:

1. An authorised individual may appoint another to formally deputise (eg during leave). In that case, the deputy has the authority of the individual that has assigned it. Such appointment must be in writing and clear as to the scope and terms of the assignment.

2. Primary Care joint commissioning differs from other commissioning arrangements and involves some degree of authority and involvement of other co-commissioners. Authorities exercised under this Financial Scheme of Delegation must take account of any applicable requirements that may apply to such arrangements.

Approval to Spend				
Ref:	Authorities/duties delegated	Delegated to (Level)	Delegated Approval Limit	Comments/Notes
1	Signing of Healthcare Commissioning Annual Contracts & SLAs and Pooled Budgets	AO, EDoF or EDoQ	No limit	If within budget agreed by Board
2	Variations to healthcare and non-healthcare contracts	AO, EDoF or EDoQ	All contracts.	If within budget agreed by Board
3	Continuing Healthcare - Authorisation of Continuing Healthcare contracts and related cost packages.	AO, EDoF, EDoQ or DoP Head or equiv	No Limit Up to £250,000	If supported by contract/tendering and quotation approval and within budget. Limits relate to anticipated total package costs
4	Approval for payment of Healthcare Invoices where an SLA is in place	AO, EDoF or EDoQ Head or equivalent Budget mgr	No limit £250,000 £10,000	
5	Non-contracted Purchase of Healthcare invoices	AO, EDoF or EDoQ Head or equivalent Budget mgr	No Limit £20,000 £10,000	If national guidance on pre-approval processes have been followed.
6	Non-Pay goods and services outside the NHS (including Grants), whether expenditure is revenue or capital in nature	AO or EDoF and Chair AO and EDoF AO or EDoF Other Exec Head or equiv Budget mgr Resource mgr	No limit £2,000,000 £1,000,000 £250,000 £20,000 £10,000 £1,000	If within budget agreed by Board Limits relate to anticipated total committed expenditure
7	Charitable Funds	AO or EDoF Other exec or head/equiv	£50,000 £25,000	Greater than £50,000 - CCG Board

8	Losses and special payments	Board AO and EDoF EDoF	Above £50,000 £50,000 £1,000 (ex gratia payments to patients & staff for loss of personal effects only)	<i>Losses and Special Payments Policy</i> must be followed All instances to be notified to AC.
9	Tenancy agreement /licences	AO and EDoF	No limit	

Quotation and Tendering Procedures				
Ref:	Authorities/duties delegated	Delegated to (Level)	Delegated Approval Limit	Comments/Notes
10	We are required to confirm value for money in all our expenditure, and should seek to do so in appropriate ways regardless of the levels of expenditure involved.			
	Confirmed best value*	All staff involved, including CSU procurement staff	£25,000	
	2 written quotes		£25,001-£50,000	
	3 written quotes		£50,001-£75,000	
	Tender		Above £75,000	
	Incoming tenders – opening, checking and reading tenders received	Designated procurement manager		
11	Waiving of tenders / quotations	AO or EDoF	No limit	All instances to be notified to AC.

Note*: Staff must have a point of reference that enables them to confirm that the quoted rate is reasonable, and must refer to that in a request for expenditure. Eg an interim rate quoted can be gauged against actual rates for equivalent staff or in some cases a second quote may be necessary.

Personnel & Pay				
Ref:	Authorities/duties delegated			Comments/Notes
12	New starters, leavers, and other staff changes			<i>Establishment Control Policy</i> must be followed
13	Disciplinary and dismissal			In line with HR policies
14	Employee expenses			<i>Employee Expenses Policy</i> must be followed and applicable financial authority levels observed

Other				
Ref:	Authorities/duties delegated	Delegated to (Level)	Delegated Approval Limit	Comments/Notes
15	Virements between budgets	AO, EDoF, other exec or head/equiv	Revenue only	Must be in accordance with <i>Budgetary Control Policy</i>
16	Finalisation of response to complaints	AO or designated deputy	No limit	
17	Banking arrangements	EDoF, and other bank signatories	As specified in bank mandate	In accordance with mandated Government Banking Service arrangements

If there is any doubt about the application of the above, please consult the EDoF or a member of the Finance team.

NHS SHROPSHIRE CLINICAL COMMISSIONING GROUP

NHS TELFORD AND WREKIN CLINICAL COMMISSIONING GROUP

GOVERNANCE HANDBOOK

Version	Approved by CCG Governing Body	Approved by the Membership where applicable
Shropshire 1.0 Telford and Wrekin 3.0		

Contents

Section	Title	Page
1.	Introduction and overview – purpose of the Handbook	3
2.	Scheme of Reservation and Delegation (SoRD)	4
3.	Prime Financial Policies	17
4.	CCG Committees/Sub-committees	31
5.	CCG Committees/Sub-committees Structure and Summary	32
6.	Committee/Sub-committee Terms of Reference	34
	<ul style="list-style-type: none"> • Finance Committee • Quality and Performance Committee • Joint Strategic Commissioning Committee • Joint Individual Funding Committee • Joint Individual Funding Appeal Panel • Assuring Involvement Committee (AIC) • Locality Forums 	

Introduction

NHS Shropshire NHS Telford and Wrekin CCG's Governance Handbook brings together a range of documents which support the Constitution and good governance. It particularly outlines the Scheme of Reservation and Delegation and Prime Financial Policies that the CCG adheres to.

Amendments to the documents that make up the Governance Handbook are approved by the CCG Governing Body with some exceptions set out in the Scheme of Reservation and Delegation which would require approval by the CCG Membership.

Approved changes then need to be shared with NHS England/Improvement within 14 days of approval for review.

Scheme of Reservation and Delegation (SoRD)

1. Schedule of Matters Reserved to the Clinical Commissioning Group and Scheme of Delegation
2. The clinical commissioning Group remains accountable for all of its functions, including those that it has delegated.

Policy Area	Decision	Reserved to the membership	Reserved or delegated to the Clinical Commissioning Group Governing Body	Accountable Officer	Chief Finance Officer	Other
1.Regulation and Control	1.1 Determine the arrangements by which the members of the Group approve those decisions that are reserved for the membership.	Yes				
	1.2 Consideration and approval of applications to NHS England/Improvement on any matter concerning changes to the Group's constitution, arrangements for taking urgent decisions, SFIs, and standing orders and statutory and mandated Committee terms of reference and, where that change: <ul style="list-style-type: none"> • Will have a material impact; or • Is to reserved powers of members; or • Has had at least 50% of all Governing Body Members formally request that amendments be put before the membership for approval. 	Yes				
	1.3 Consideration and approval of changes to the Group's constitution, SFIs, arrangements for taking urgent decisions, standing orders and statutory and mandated Committee terms of reference where that change:		Yes			

	<ul style="list-style-type: none"> • Will have <u>no</u> material impact; or • Is <u>not</u> to reserved powers of members; or • There has been <u>no</u> formal request by at least 50% of Governing Body Members that amendments be put before the membership for approval. 					
	1.4 Consideration and approval of changes to terms of reference for the Group's or CCG Governing Body, non-statutory or non-mandated committees sub-committees, and membership of committees		Yes			
	1.5 Exercise or delegation of those functions of the Group which have not been retained as reserved by the Group, delegated to the Clinical Commissioning Group Governing Body, delegated to a committee or sub-committee of the Group or to one of its members or employees.			Yes		
	1.6 Prepare the Group's overarching scheme of reservation and delegation, which sets out those decisions reserved to the membership and those delegated to the Group's Clinical Commissioning Group Governing Body, committees and sub-committees, individuals or specified persons.			Yes		
	1.7 Approval of the Group's overarching scheme of reservation and delegation where that change: <ul style="list-style-type: none"> • Is proposed to the reserved powers of the membership; or • At least 50% of Governing Body member practice representatives (including the Chair) formally request that amendments be put before the membership for approval. 	Yes				
	1.8 Approval of the Group's overarching scheme of reservation and delegation where that change: <ul style="list-style-type: none"> • Is <u>not</u> proposed to the reserved powers of the membership; or 		Yes			

	<ul style="list-style-type: none"> There has been <u>no</u> request by at least 50% of Governing Body member practice representatives (including the Chair) formally requesting that amendments be put before the membership for approval. 					
	1.9 Prepare the Group's Prime Financial Policies.			Yes		
	1.20 Approval of the Group's Prime Financial Policies.		Yes			
	1.21 Prepare detailed financial policies that underpin the Group's prime financial policies.				Yes	
	1.22 Approve detailed financial policies.					Finance Committee
	1.23 Approve arrangements for managing exceptional funding requests.		Yes			
	1.24 Approve exceptional individual funding requests					Individual Funding Committee
	1.25 Determine whether proper process has been followed by the Individual Funding Committee when considering an individual funding request.					Individual Funding Appeal Panel
	1.26 Set out who can execute a document by signature/use of the seal		Yes			
	1.27 Approval of changes to the provision or delivery of assurance services to the Group					Audit Committee
	1.28 Approval of the Group's banking arrangements		Yes			
	1.29 Approval of the Group's strategies, plans, policies and procedures, unless specified elsewhere in this scheme of reservation and delegation		Yes			
	1.31 Discharge delegated responsibilities from the Governing Body					Audit

	or CCG through Committees in Common by specified Committees.					Committee Remuneration Committee Primary care Commissioning Committee Finance Committee Quality and Performance committee Individual Funding Committee Assuring involvement Committee
2. Practice Member Representatives and Members of the Clinical Commissioning Group Governing Body	2.1 Approve the arrangements for: (i) identifying practice members to represent practices in matters concerning the work of the Group; and (ii) appointing clinical leaders to represent the Group's membership on the Group's Clinical Commissioning Group Governing Body, for example through election (if desired).		Yes			
	2.2 Approve the appointment of Clinical Commissioning Group Governing Body members, the process for recruiting and removing non-elected members to the Clinical Commissioning Group Governing Body (subject to any regulatory requirements) and succession planning.		Yes			
	2.3 Approve arrangements for identifying the Group's proposed Accountable Officer.		Yes			
	2.4 Approval of the arrangements, including policies and procedures for the management of conflicts of interest		Yes			

	2.5 Approval of the dismissal of a Clinical Commissioning Group Governing Body Member		Yes			
	2.6 Approval of the appointment of the Deputy Chair of the Clinical Commissioning Group Governing Body		Yes			
3. Strategy and Planning	3.1 Agree the vision, values and overall strategic direction of the Group.		Yes			
	3.2 Approval of the Group's operating structure.		Yes			
	3.3 Approval of the Group's consultation arrangements for the commissioning plan.		Yes			
	3.4 Approval of the Group's commissioning plan.		Yes			
	3.5 Approval of the Group's corporate budgets that meet the financial duties of the CCG.		Yes			
	3.6 Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure.		Yes			
	3.7 Approval of the Group's Procurement Strategy		Yes			
	3.8 Approval of the local health economy's Long Term Plan (LTP)		Yes			
	3.9 Approval of the total allotments received for the next financial year and their proposed distribution, including any sums held in reserve		Yes			
	3.10 Approval of the release of investment for QIPP schemes recommended by the Joint QIPP Board where this is outside existing budget delegations and contract value and where assurance on affordability and availability has been provided by the Chief Finance Officer for all other services not listed in 3.11.		Yes			
	3.11 Approval of the release of investment for QIPP schemes					Joint Strategic

	recommended by the Joint QIPP Board where this is outside existing budget delegations and contract value and where assurance on affordability and availability has been provided by the Chief Finance Officer for the following services: <ul style="list-style-type: none"> • Acute services • Specialist services • Community services • Maternity Services • Urgent care – 111 services • Emergency and non emergency Transport services • Mental Health services • Prescribing (Strategic) • Equipment services • Services commissioned via a Section 75 agreement • Childrens' Services • Individuals Commissioning • Learning disabilities • Shared grants • Care closer to home • Specialised Commissioning 					Commissioning Committee
	3.12 Approval of QIPP schemes that are within budget delegations and existing contractual values.					Joint Strategic Commissioning committee
	3.13 Approval and monitoring of the Section 75 pooled budget arrangements for Better Care Fund with the local authority					Joint Strategic Commissioning Committee
4. Annual Reports and Accounts	4.1 Approval of the Group's annual report and annual accounts.					Audit Committee
	4.2 Approval of the arrangements for discharging the Group's statutory financial duties		Yes			

5. Human Resources	5.1 Approve the terms and conditions, remuneration and travelling or other allowances for Clinical Commissioning Group Governing Body members, including pensions and gratuities.		Yes			
	5.2 Approve terms and conditions of employment for all employees of the Group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the Group.		Yes			
	5.3 Approve any other terms and conditions of services for the Group's employees.		Yes			
	5.4 Determine the terms and conditions of employment for all employees of the Group.		Yes			
	5.5 Determine pensions, remuneration, fees and allowances payable to governing body members, employees of the CCG (including GPs performing roles within the CCG) and to other persons providing services to the Group		Yes			
	5.6 Approve business cases for staff who wish to retire and return to employment with the CCG.		Yes			
	5.7 Recommend pensions, remuneration, fees and allowances payable to governing body members, employees of the CCG (including GPs performing roles within the CCG) and to other persons providing services to the Group not covered by Agenda for Change.					Remuneration Committee
	5.8 Recommend to the Governing Body the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms, excluding ill health and normal retirement, for all employees					Remuneration Committee

	5.9 Recommend to the Governing Body business cases for staff who wish to retire and then return to employment with the CCG that have been considered and recommended by the Executive team.					Remuneration Committee
	5.10 Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the Group) and for other persons working on behalf of the Group.		Yes			
	5.11 Review disciplinary arrangements where the Accountable Officer is an employee or member of another Group.		Yes			
	5.12 Approval of the arrangements, including supporting policies and procedures for discharging the Group's statutory health and safety duties as an employer.		Yes			
	5.13 Approve HR policies and procedures for employees and for other persons working on behalf of the Group.					Audit Committee
6. Quality and Safety	6.1 Approve arrangements, including supporting strategies and plans, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		Yes			
	6.2 Approve policies and procedures, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.					Quality and Performance Committee
	6.3 Approve arrangements for supporting the NHS England/Improvement/Improvement in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.		Yes			
	6.4 Approval of the Group's Quality Strategy		Yes			

	6.5 Oversees delivery of the Group's Quality Strategy					Quality and Performance committee
	6.6 Oversees the effective reporting and learning from medication safety incidents					Quality and Performance committee
	6.7 Oversees the development of clinical pathways to enable clarity by general practice.					Joint Strategic Commissioning Committee
	6.8 Approves the development of clinical pathways to enable clarity by general practice					Joint Strategic Commissioning Committee
7. Operational and Risk Management	7.1 Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the Group.			Yes		
	7.2 Approve the Group's counter fraud and security management arrangements, including supporting plans, policies and procedures.					Audit Committee
	7.3 Approval of the Group's risk management strategy		Yes			
	7.4 Approval of the Group's risk management policies and procedures.					Audit Committee
	7.5 Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Group's or pooled budget arrangements under section 75 of the NHS Act 2006).					Joint Strategic Commissioning Committee
	7.6 Approval of a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the Group.		Yes			
	7.7 Approve proposals for action on litigation against or on behalf			Yes		

	of the Group.					
	7.8 Approve the Group's arrangements, including supporting plans, policies and procedures for business continuity and emergency planning.					Audit Committee
	7.9 Approve the use of the Group's resources out of hours for exceptional circumstances and limited to situations of necessity					Director on Call
8. Information Governance	8.1 Approve the Group's arrangements, including supporting policies and procedures for handling complaints.					Quality and Performance Committee
	8.2 Approval of the arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.					Audit Committee
9. Tendering and Contracting	9.1 Approval of the Group's contracts for any healthcare services <i>within approved budgets</i> *With the exception of GMS, PMS and APMS – see separate delegation*			Yes	Yes	
	9.2 Approval of the Group's contracts for any commissioning support <i>within approved budgets</i> .			Yes	Yes	
	9.3 Approval of the Group's contracts for corporate support (for example finance provision) <i>within approved budgets</i> .			Yes	Yes	
	9.4 To approve that the CCG proceeds to procurement for the following healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification: <ul style="list-style-type: none"> • Acute services • Specialist services • Community services • Maternity Services 					Joint Strategic Commissioning Committee

	<ul style="list-style-type: none"> • Urgent care – 111 services • Emergency and non emergency Transport services • Mental Health services • Prescribing (Strategic) • Equipment services • Services commissioned via a Section 75 agreement • Childrens' Services • Individuals Commissioning • Learning disabilities • Shared grants • Care closer to home • Specialised Commissioning 					
	9.5 To approve that the CCG proceeds to procurement for all healthcare services not stated in 9.4 above which will include the approval of the timeline for procurement, the proposal for procurement and the service specification.		Yes			
	<p>9.5 To approve the award of healthcare services procurement for the following services:</p> <ul style="list-style-type: none"> • Acute services • Specialist services • Community services • Maternity Services • Urgent care – 111 services • Emergency and non emergency Transport services • Mental Health services • Prescribing (Strategic) • Equipment services • Services commissioned via a Section 75 agreement • Childrens' Services • Individuals Commissioning 					Joint Strategic Commissioning Committee

	<ul style="list-style-type: none"> • Learning disabilities • Shared grants • Care closer to home • Specialised Commissioning 					
	9.6 To approve the award of healthcare services procurement outside the scope of 9.5 above.		Yes			
10. Partnership Working	10.1 To the extent permitted by law, authority to enter into arrangements with one or more relevant Local Authority in respect of: <ul style="list-style-type: none"> • delegating specified commissioning functions to the Local Authority; • exercising specified commissioning functions jointly with the Local Authority; • exercising any specified health-related functions on behalf of the Local Authority. 		Yes			
	10.2 Agree formal and legal arrangements to make payments to, or receive payments from, a Local Authority or pool funds for the purpose of joint commissioning.		Yes			
	10.3 For the purposes of collaborative commissioning arrangements with a Local Authority, make the services of its employees or any other resources available to the Local Authority; and receive the services of the employees or the resources from the Local Authority.		Yes			
	10.4 For the purposes of joint commissioning arrangements with other CCGs, to <ul style="list-style-type: none"> • delegate any of the CCGs commissioning functions to another CCG • exercise any of the Commissioning Functions of another 		Yes			

	<p>CCG; or</p> <ul style="list-style-type: none"> • exercise jointly the Commissioning Functions of the CCG and another CCG; <p>and for the purposes of the above; to:</p> <ul style="list-style-type: none"> • make payments to, or receive payments from, another CCG; or • make the services of its employees or any other resources available to another CCG; or • receive the services of the employees or the resources available to another CCG. 					
	10.5 For the purposes of joint commissioning arrangements with other CCGs, to establish and maintain a pooled fund made up of contributions by all of the CCGs working together jointly.		Yes			
	10.6 Approve decisions that individual members or employees of the Group participating in joint arrangements on behalf of the Group can. Such delegated decisions must be disclosed in this scheme of reservation and delegation.		Yes			
	10.7 Approve decisions delegated to joint committees established under section 75 of the NHS Act 2006.		Yes			
	10.8 Authority to enter into strategic or other transformation discussions with its partner organisations, on behalf of the CCG		Yes			
	<p>10.9 For the purposes of joint commissioning arrangements with NHS England/Improvement, to make arrangements to exercise any of their respective specified commissioning functions jointly.</p> <p>And for the purposes of the above;</p> <ul style="list-style-type: none"> • may include other CCGs, a combined authority or a local authority; 		Yes			

	<ul style="list-style-type: none"> • may establish a Joint Committee to exercise the commissioning functions in question; • may be on such terms and conditions (including terms of payment) as may be agreed between NHS England/Improvement/Improvement and the CCG • develop and agree with NHS England/Improvement/Improvement a framework setting out the arrangements of joint working. 					
11.Commissioning and Contracting for Clinical Services	11.1 Approval of the arrangements for discharging the Group's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.		Yes			
	11.2 Approve the Group's policies and procedures to support the arrangements for discharging the Group's statutory duties associated with its clinical and non-clinical commissioning functions.					Joint Strategic Commissioning Committee
	11.3 Approve arrangements for co-ordinating the commissioning of services with other Groups and or with the local authority, where appropriate.		Yes			
12. Communications	12.1 Provide oversight of the strategy and individual commissioning plans for delivering patient involvement and meetings the public sector equality duty.					Assuring Involvement Committee
	12.2 Approving arrangements including supporting policies and procedures for handling Freedom of Information requests.					Audit Committee
	12.3 Determining arrangements for handling Freedom of Information requests.			Yes		

	12.4 Approval of the Group's Communications and Engagement Strategy		Yes			
13. Delegated functions related to the commissioning of primary medical services under section 83 of the NHS Act	13.1 Approval of GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract.					Primary Care Commissioning Committee
	13.2 Approval of newly designed enhanced services (Local Enhanced Services and Directed Enhanced Services)					Primary Care Commissioning Committee
	13.3 Approval and design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)					Primary Care Commissioning Committee
	13.4 Approval to establish new GP practices in an area					Primary Care Commissioning Committee
	13.5 Approval of practice mergers					Primary Care Commissioning Committee
	13.6 Approval of discretionary payment (e.g. returner/retainer schemes)					Primary Care Commissioning Committee

Prime Financial Policies

1. INTRODUCTION

1.1. General

- 1.1.1 The prime financial policies are part of the Group's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation (SoRD) found at in this document.
- 1.1.2 In support of these Prime Financial Policies, we have prepared more detailed policies, approved by the Chief Finance Officer (CFO), known as detailed financial policies. The Group refers to these prime and detailed financial Policies together as the clinical commissioning Group's financial policies.
- 1.1.3 These Prime Financial Policies identify the financial responsibilities which apply to everyone working for the Group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Chief Finance Officer is responsible for approving all detailed financial policies.
- 1.1.4 A list of the Group's detailed financial policies will be published and maintained on the Group's website at
- ADD WEBLINK HERE
- 1.1.5 Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the Chief Finance Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the Group's constitution, standing orders and scheme of reservation and delegation.
- 1.1.6 Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2 Overriding Prime Financial Policies

- 1.2.1 If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal

meeting of the Clinical Commissioning Group Governing Body's Audit Committee for referring action or ratification. All of the Group's members, employees have a duty to disclose any non-compliance with these prime financial policies to the Chief Financial Officer as soon as possible.

1.3 Responsibilities and delegation

- 1.3.1 The roles and responsibilities of the Group's members, employees, members of the Clinical Commissioning Group Governing Body, members of the Clinical Commissioning Group Governing Body's committees and sub-committees and members of the Group's committees and sub-committees and persons working on behalf of the Group are set out in section 2.2 of Standing Orders in the Constitution.
- 1.3.2 The financial decisions delegated by members of the Group are set out in the Group's scheme of reservation and delegation in this document and in SFIs in appendix 4 of the Constitution.

1.4 Contractors and their employees

- 1.4.1 Any contractor or employee of a contractor who is empowered by the Group to commit the Group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that such persons are made aware of this.

1.5 Amendment of Prime Financial Policies

- 1.5.1 To ensure that these policies remain up-to-date and relevant, the Chief Financial Officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the Audit Committee, the Chief Financial Officer will recommend amendments, as fitting, to the Clinical Commissioning Group Governing Body for approval. As these prime financial policies are an integral part of the Group's Governance Handbook, the CCG must send any changes approved to NHS England/Improvement/Improvement within 14 days for review.

2. INTERNAL CONTROL

Policy - The Group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.

- 2.1. The Clinical Commissioning Group Governing Body will set up an Audit Committee with terms of reference agreed by the Clinical Commissioning Group Governing Body.

- 2.2. The Accountable Officer has overall responsibility for the Group's systems of internal control.
- 2.3. The Chief Financial Officer will ensure that:
- financial policies are considered for review and update annually;
 - a system is in place for proper checking and reporting of all breaches of financial policies; and
 - a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

Policy - The Group will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews.

- 3.1. In line with the terms of reference of the Clinical Commissioning Group Governing Body's Audit Committee, the person appointed by the Group to be responsible for internal audit and the Audit Commission appointed external auditor, will have direct and unrestricted access to Audit Committee members and the Chair of the Clinical Commissioning Group Governing Body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.
- 3.2. The person appointed by the Group to be responsible for internal audit and the external auditor, will have access to the Audit Committee and the Accountable Officer to review audit issues as appropriate. All Audit Committee members, the Chair of the Clinical Commissioning Group Governing Body and the Accountable Officer will have direct and unrestricted access to the Head of Internal Audit and external auditors.
- 3.3. The Chief Financial Officer will ensure that:
- a) the Group has a professional and technically competent internal audit function; and
 - b) the Clinical Commissioning Group Governing Body's Audit Committee approves any changes to the provision or delivery of assurance services to the Group.
- 3.4. The scope of Internal Audit will include review, appraise and report upon policies, procedures and operations in place to:-
- (i) establish and monitor the achievement of the organisation's objectives;

- (ii) identify, assess and manage the risks to achieving the organisation's objectives;
- (iii) ensure the economical, effective and efficient use of resources;
- (iv) ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations;
- (v) safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption;
- (vi) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

4. FRAUD

Policy - The Group requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The Group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered.

- 4.1. The Clinical Commissioning Group Governing Body's Audit Committee will satisfy itself that the Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.
- 4.2. The Clinical Commissioning Group Governing Body's Audit Committee will ensure that the Group has arrangements in place to work effectively with NHS Counter Fraud Authority.
- 4.3. Further guidance on conduct of staff can be found in the CCG's Anti-fraud, Bribery & Corruption Policy.

5. EXPENDITURE CONTROL

- 5.1. The Group is required by statutory provisions to ensure that its expenditure does not exceed the aggregate of allotments from the NHS England/Improvement/Improvement and any other sums it has received and is legally allowed to spend.
- 5.2. The Accountable Officer has overall executive responsibility for ensuring that the Group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.
- 5.3. The Chief Finance Officer will:

- a) provide reports in the form required by the NHS England/Improvement/Improvement;
- b) ensure money drawn from the NHS England/Improvement/Improvement is required for approved expenditure only is drawn down only at the time of need and follows best practice;
- (c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of the NHS England/Improvement/Improvement.

6. ALLOTMENTS

6.1. The Chief Financial Officer of the Group will:

- (a) periodically review the basis and assumptions used by the NHS England/Improvement/Improvement for distributing allotments and ensure that these are reasonable and realistic and secure the Group's entitlement to funds;
- (b) prior to the start of each financial year submit to the Group's Clinical Commissioning Group Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and
- c) regularly update the Group's Clinical Commissioning Group Governing Body on significant changes to the initial allocation and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

Policy - The Group will produce and publish an annual commissioning plan that explains how it proposes to discharge its financial duties. The Group will support this with comprehensive medium term financial plans and annual budgets.

- 7.1. The Accountable Officer will compile and submit to the Clinical Commissioning Group Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.
- 7.2. Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the Clinical Commissioning Group Governing Body
- 7.3. The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Clinical Commissioning Group Governing Body. This report shall include explanations for variances.

These variances must be based on any significant departures from agreed financial plans or budgets.

- 7.4. The Accountable Officer is responsible for ensuring that information relating to the Group's accounts or to its income or expenditure, or its use of resources is provided to the NHS England/Improvement as requested.

8. ANNUAL ACCOUNTS AND REPORTS

Policy - The Group will produce and submit to the NHS England/Improvement accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by the NHS England/Improvement.

- 8.1. The Chief Financial Officer will ensure the Group:
- a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Clinical Commissioning Group Governing Body;
 - b) prepares the accounts according to the timetable approved by the Clinical Commissioning Group Governing Body;
 - c) complies with statutory requirements and relevant directions for the publication of annual report;
 - d) considers the external auditor's management letter and fully address all issues within agreed timescales; and
 - e) publishes the external auditor's management letter, which forms part of the Clinical Commissioning Group's Annual Report, on the Group's website at

<https://www.shropshireccg.nhs.uk/policies-and-reports/reports-and-publications/annual-report/>

<https://www.telfordccg.nhs.uk/who-we-are/publications/annual-reports>

9. INFORMATION TECHNOLOGY

Policy - The Group will ensure the accuracy and security of the Group's computerised financial data

- 9.1. The Chief Finance Officer is responsible for the accuracy and security of the Group's computerised financial data and shall
- a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Group's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons,

deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

- b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
 - c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
 - d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.
- 9.2. In addition the Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10 ACCOUNTING SYSTEMS

Policy - The Group will run an accounting system that creates management and financial accounts

- 10.1 The Chief Finance Officer will ensure:
- a) the Group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the NHS England/Improvement;
 - b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.
- 10.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

11 BANK ACCOUNTS

Policy - The Group will keep enough liquidity to meet its current commitments.

- 11.1. The Chief Financial Officer will

- a) review the banking arrangements of the Group at regular intervals to ensure they reflect any Secretary of State directions, best practice and represent best value for money.
- b) manage the Group's banking arrangements and advise the Clinical Commissioning Group Governing Body on the provision of banking services and operation of accounts.
- c) prepare detailed instructions on the operation of bank accounts.

11.2 The Clinical Commissioning Group Governing Body shall approve the banking arrangements.

12 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

Policy - The Group will operate a sound system for prompt recording, invoicing and collection of all monies due.

The Group will seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the Group or its functions.

The Group will ensure its power to make grants and loans is used to discharge its functions effectively.

12.1 The Chief Financial Officer is responsible for:

- a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;
- b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;
- c) approving and regularly reviewing the level of all fees and charges other than those determined by the NHS England/Improvement or by statute. Independent professional advice on matters of valuation shall be taken as necessary;
- d) for developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

Policy - The Group:

- **will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending;**

- **will seek value for money for all goods and services;**
- **shall ensure that competitive tenders are invited for;**
 - **the supply of goods, materials and manufactured articles;**
 - **the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and**
 - **for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals.**

- 13.1. The Group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the Group's Clinical Commissioning Group Governing Body.
- 13.2. The Clinical Commissioning Group Governing Body may only negotiate contracts on behalf of the Group, and the Group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:
- a) the Group's standing orders;
 - b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and
 - c) take into account as appropriate any applicable NHS England/Improvement or the Independent Regulator of NHS Foundation Trusts (NHS Improvement) guidance that does not conflict with (b) above.
- 13.3. In all contracts entered into, the Group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the Group.
- 13.4 Further guidance on tendering and contracting procedures can be found in the CCG's Finance Policy.

14. COMMISSIONING

Policy - Working in partnership with relevant national and local stakeholders, the Group will commission certain health services to meet

the reasonable requirements of the persons for whom it has responsibility.

- 14.1. The Group will coordinate its work with the NHS England/Improvement, local NHS Trusts, other clinical commissioning Groups, local providers of services, local authority, including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.
- 14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Clinical Commissioning Group Governing Body detailing actual and forecast expenditure and activity for each contract.
- 14.3. Where the Group makes arrangements for the provision of services by non-NHS providers it is the Accountable Officer who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided. Before making any agreement with non-NHS providers, the Group should explore fully the scope to make maximum cost-effective use of NHS facilities.
- 14.4. The Chief Financial Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under agreements. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT AND INSURANCE

Policy - The Group will put arrangements in place for evaluation and management of its risks.

- 15.1 The Accountable Officer shall ensure that the Group has a programme of risk management, in accordance with current Department of Health controls assurance framework requirements, which must be approved and monitored by the Clinical Commissioning Group Governing Body. The Clinical Commissioning Group Governing Body will delegate this function to the Clinical Commissioning Group Governing Body's Audit Committee, which will ensure the Group's statutory obligations are met.
- 15.2 The programme of risk shall include:
 - a) a process for identifying and quantifying risks and potential liabilities.
 - b) engendering among all levels of staff a positive attitude towards the control of risk

16. PAYROLL

Policy - The Group will put arrangements in place for an effective payroll service

16.1 The Chief Finance Officer will ensure that the payroll service selected:

- a) is supported by appropriate (i.e. contracted) terms and conditions;
- b) has adequate internal controls and audit review processes;
- c) has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2 In addition the Chief Finance Office shall set out comprehensive procedures for the effective processing of payroll

17. NON PAY EXPENDITURE

Policy - the Group will seek to obtain the best value for money goods and services received.

17.1. The Clinical Commissioning Group Governing Body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers

17.2. The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Financial Officer will:

- a) advise the Clinical Commissioning Group Governing Body on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the Group's scheme of reservation and delegation;
- b) be responsible for the prompt payment of all properly authorised accounts and claims;
- c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

17.4 Further guidance on non-pay expenditure can be found in the CCG's Finance Policy.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

Policy - the Group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place policies to secure the safe storage of the Group's fixed assets.

18.1 The Accountable Officer will:

- a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;
- b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.
- d) be responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2 The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

18.3 Further guidance on capital investment, fixed asset registers and security of assets can be found in the CCG's Finance Policy.

19 RETENTION OF RECORDS

Policy – the Group will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance

19.1 The Accountable Officer shall:

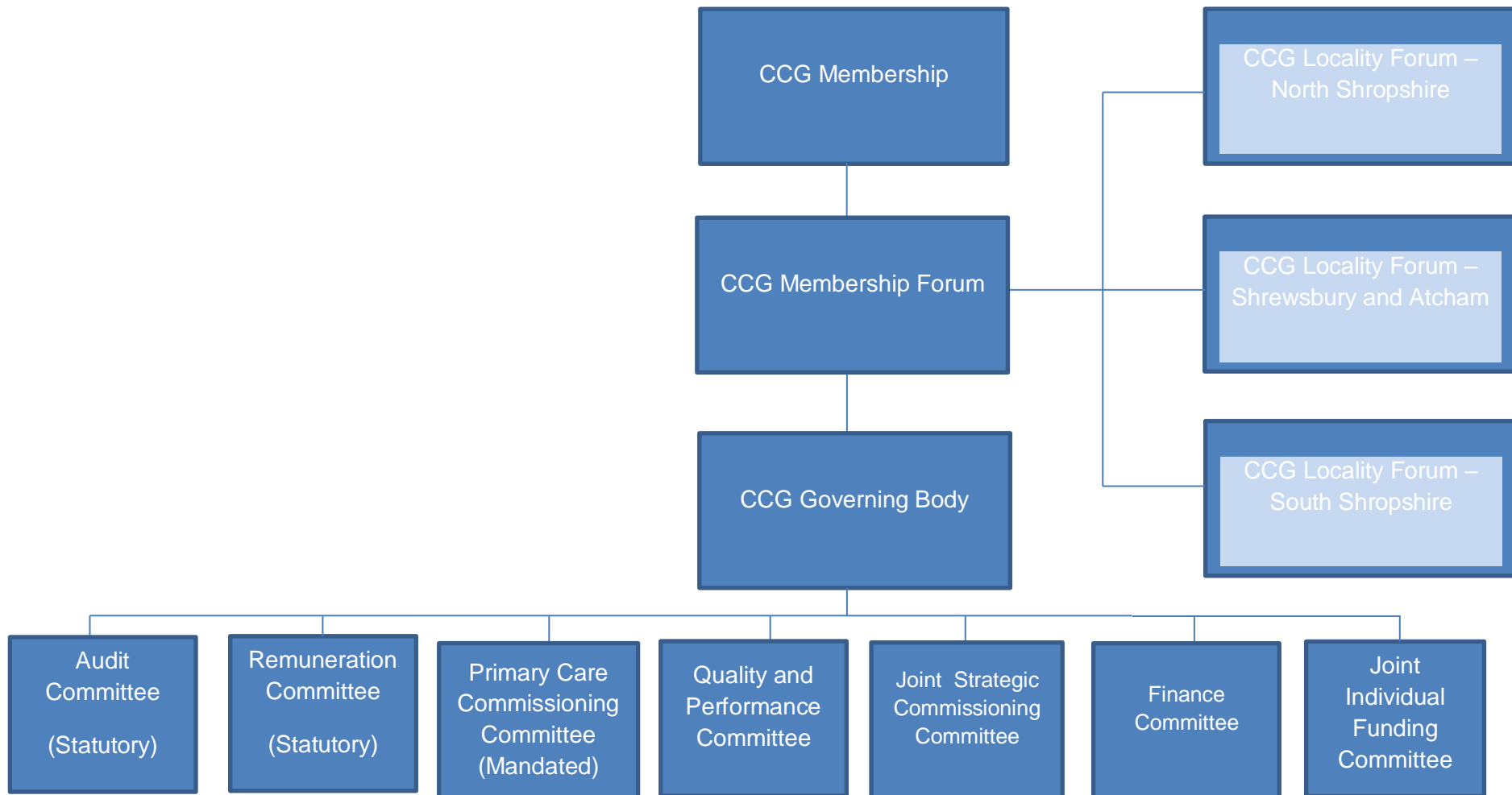
- a) be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance;
- b) ensure that arrangements are in place for effective responses to Freedom of Information requests;
- c) publish and maintain a Freedom of Information Publication Scheme.

20 TRUST FUNDS AND TRUSTEES

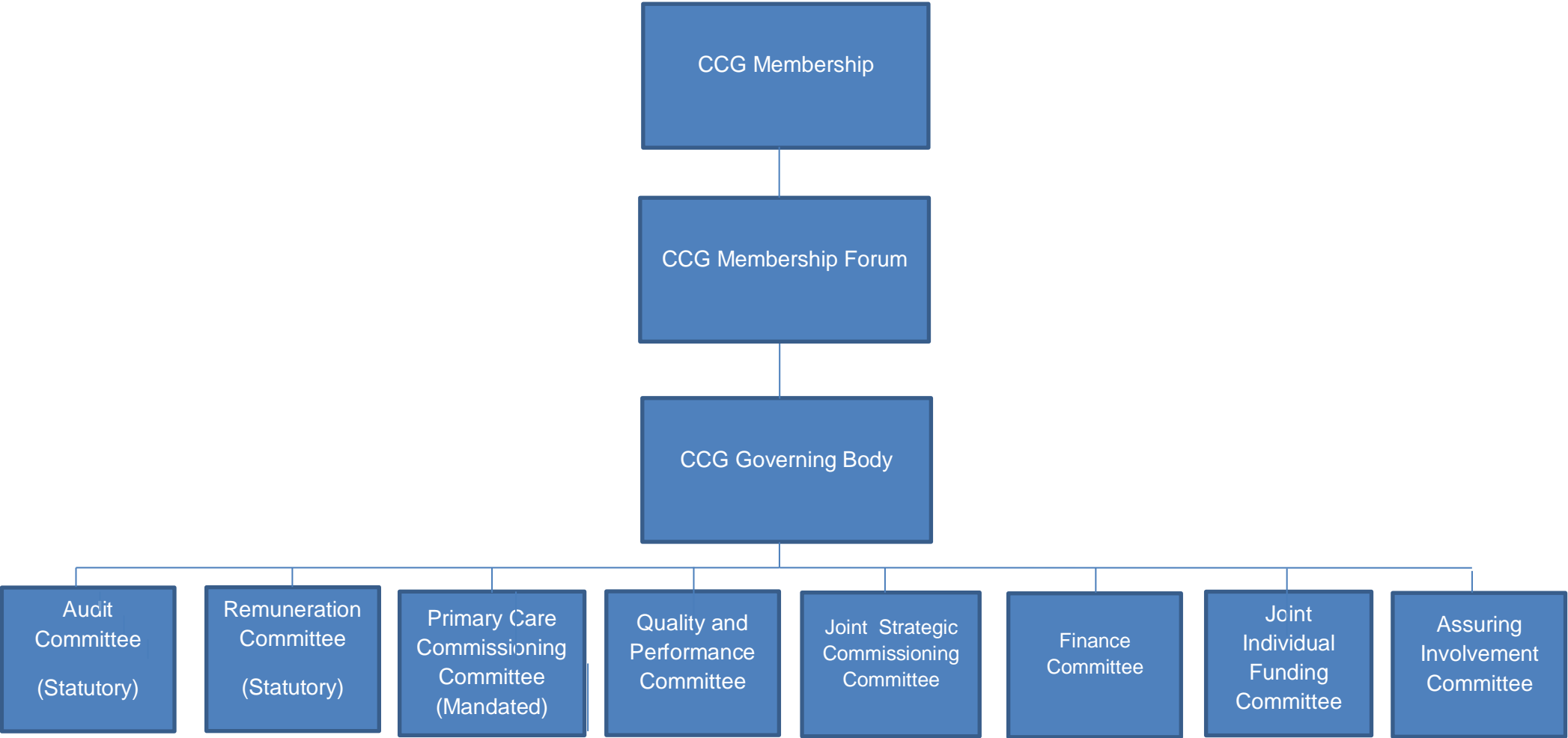
Policy – the Group will put arrangements in place to provide for the appointment of trustees if the Group holds property on trust

- 20.1 The Chief Finance Officer shall ensure that each trust fund which the Group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

Shropshire CCG Committee Structure



Telford and Wrekin CCG Committee Structure



CCG Committee Summary

The following table briefly describes the roles of each of the committees reporting to the Group and the Governing Body:

Governing Body Committees outlined in this CCG Governance Handbook which are not statutory or mandated:	
Quality and Performance Committee	Oversees and provides assurance to the Clinical Commissioning Group Governing Body on performance and quality of commissioned services.
Assuring Involvement Committee (AIC)	Provides assurance to the CCG Governing Body that the CCG is meeting its statutory duties with regard to securing patient involvement in proposals on new or changing services and to meeting its public sector equality duty.
Finance Committee	Oversees delivery of the financial plan and the development and delivery of QIPP savings.
Governing Body Committees outlined in more detail in the CCG Constitution which are statutory or mandated:	
Audit Committee (Statutory)	Provides the Group's Clinical Commissioning Group Governing Body with an independent and objective view of the Group's internal control system.
Remuneration Committee (Statutory)	Makes recommendations to the Clinical Commissioning Group Governing Body about the remuneration, fees and other allowances for employees and for people who provide services to the Group.
Primary Care Commissioning Committee (Mandated)	Considers and approves primary care commissioning decisions, delegated to the Clinical Commissioning Group from NHS England/Improvement.
Group Committees outlined in this CCG Governance Handbook which are not statutory or mandated:	
Membership Forum	Provides both an engagement and decision making mechanism for the membership as a whole.
Membership Forum	Provides a membership decision making mechanism for those decisions reserved to the Membership.
Locality Forum	Provides the engagement and involvement mechanism between the CCG Governing Body and

	the membership as a whole.
Joint Committees with other CCGs	
Joint Individual Funding Committee	Approves commissioning decisions for individual funding requests on behalf of the Group.
Joint Strategic Commissioning Committee	Advises and makes decisions on the development of strategic commissioning that includes business plans and service redesign.

Non-statutory/mandated CCG Committee Terms of Reference

Finance Committee

Terms of Reference

1. Introduction

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

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

- the delivery of the CCG's statutory financial duties;
- the development and achievement of the CCG's Medium Term Financial Strategy and Financial Recovery Plan;
- the delivery of organisational Quality, Innovation, Productivity and Prevention (QIPP) plans;
- the monthly financial performance against plan;

and to provide assurance to the Governing Body and identify key issues and risks requiring discussion or decision by the Governing Body or the Joint Commissioning Committee.

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

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

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

1.6 The Finance Committee may meet 'in-common' with the Finance Committee of NHS Shropshire Telford and Wrekin CCG.

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

- To approve policies and procedures specific to the Committee's remit which include, but are not limited to:
 - Financial policies and procedures;

Contracting and procurement policies and procedures.

2. Membership

2.1 The membership of the committee will be as follows:

- 2 lay members
- 1 GP/Primary Health Care Professional Governing Body members
- Board Secondary Care Doctor

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

- Executive Director for Finance (CFO)
- Executive Director for Transformation

3. Chairing Arrangements

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

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

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

4. Secretary

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

5. Quorum

5.1 The quorum is a minimum of 2 members.

5.2 To ensure that the quorum can be maintained, Committee members are able to nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained.

5.3 If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

5.4 If the committee is not quorate, the meeting may;

- proceed if those attending agree, but no decisions may be taken; or
- in accordance with clause 6.5.4 invite an additional and temporary member or members to attend; or
- may be postponed at the discretion of the Chair.

5.5 The committee will endeavour to make decisions by reaching a consensus. Where a consensus cannot be reached, the Chair will escalate the committee's views on the issue for consideration by the Governing Body.

5.6 For all Governing Board committees, the details of the process for decision making and holding a vote will be the same as set out in standing orders.

5.7 In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 6.5.4 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

6 Frequency and notice of meetings

6.1 The committee will meet as required, but at least four times per year and meetings will be called by the chair of the Committee giving at least 5 working days notice.

6.2 Draft minutes will be produced by the minute taker within 7 days of the meeting and circulated to the Chair of the committee for comment within 5 days. They will be presented to the next meeting for committee for approval and the chair will then sign them within 5 days.

6.3 Full minutes of the Finance Committee will be sent to those in attendance at the Committee.

6.4 The agenda and supporting papers will be circulated to all members at least five working days before the date of the meeting, unless there are exceptional circumstances for individual papers agreed in advance with the Chair.

6.5 Extraordinary meetings may be held at the discretion of the Chair. A minimum of seven working days' notice should be given when calling an extraordinary meeting.

6.6 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.

7 Remit and responsibilities of the committee

The Committee will be responsible for exercising the following functions:

- 7.1 Oversee the development of the CCGs' finance strategies and annual financial plans including, underlying assumptions and methodology used, ahead of review and approval by the CCG Governing Body.
- 7.2 Monitor progress against financial plans and approved budgets, scrutinising the adequacy of proposed remedial action plans where plan delivery is off target.
- 7.3 Scrutinise the reported position on finance, triangulating finance, QIPP and contract activity information.
- 7.4 Scrutinise major shifts in spending, demand pressures and triangulation with financial recovery/turnaround plans.
- 7.5 Review the CCG's monthly financial performance (including performance against savings programmes) and provide assurance to the Governing Body and identify the key issues and risks requiring discussion or decision by the Governing Body.
- 7.6 Review at the request of the CCG Governing Body specific aspects of financial performance where the Governing Body requires additional scrutiny and assurance.
- 7.7 Review performance against the "finance and use of resources" elements of the NHS Assurance Framework including value for money.
- 7.8 Review programme delivery, ensuring delivery of clinical objectives and value for money, including the delivery of QIPP objectives, and the appropriate management of risks and opportunities.
- 7.9 Address particular financial performance matters referred to it by the Governing Body or Joint Commissioning Committee, and provide reports to the Governing Body or Joint Commissioning Committee on areas of financial performance as requested.
- 7.10 Oversee arrangements for data quality to ensure confidence in the contract activity and finance information being used for monitoring and reporting purposes.
- 7.11 To monitor the use of CCG Charitable Funds.
- 7.12 To monitor the CCGs cash limit and resource limit.
- 7.13 Review and approve policies specific to the Committee's remit.
- 7.14 Oversee the identification and management of risks relating to the Committee's remit.
- 7.15 Ensuring economy, efficiency and effectiveness in the use of CCG resources.

8. Relationship with the Governing Body

8.1 The Chair will prepare reports from the Finance Committee which will be presented to the Governing Body at its next scheduled meeting. The reports will include the main items discussed and decisions made by the Committee. A summary regarding issues relating to primary medical care services will be submitted to the subsequent meeting of the Primary Care Commissioning Committee.

9. Policy and best practice

9.1 The committee will apply best practice in the decision making processes it will follow, seeking independent advice where required and ensuring that decisions are based upon clear and transparent criteria.

10 Conduct of the committee

10.1 The committee is expected to conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice.

10.2 Members of the committee are expected to declare conflicts of interest as set out in the constitution.

10.3 Annually the committee will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference should be approved by the CCG Governing Body.

Date to be reviewed: April annually

Quality and Performance Committee

Terms of Reference

1. Introduction

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

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

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

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

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

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

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

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

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

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

2 Membership

2.1 The membership of the committee will be as follows:

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

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

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

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

3 Chairing arrangements

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

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

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

4 Secretary

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

5 Quorum

5.1 The quorum is a minimum of 2 members.

5.2 To ensure that the quorum can be maintained, Committee members are able to nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained.

5.3 If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

5.4 If the committee is not quorate, the meeting may;

- proceed if those attending agree, but no decisions may be taken; or
- in accordance with clause 6.5.4 invite an additional and temporary member or members to attend; or
- may be postponed at the discretion of the Chair.

5.5 The committee will endeavour to make decisions by reaching a consensus. Where a consensus cannot be reached, the Chair will escalate the committee's views on the issue for consideration by the Governing Body.

5.6 For all Governing Board committees, the details of the process for decision making and holding a vote will be the same as set out in standing orders.

5.7 In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 6.5.4 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

6 Frequency and notice of meetings

6.1 The committee will meet as required, but at least four times per year and meetings will be called by the chair of the Committee giving at least 5 working days notice.

6.2 Draft minutes will be produced by the minute taker within 7 days of the meeting and circulated to the Chair of the committee for comment within 5 days. They will be presented to the next meeting for committee for approval and the chair will then sign them within 5 days.

6.3 Full minutes of the Finance Committee will be sent to those in attendance at the Committee.

6.4 The agenda and supporting papers will be circulated to all members at least five working days before the date of the meeting, unless there are exceptional circumstances for individual papers agreed in advance with the Chair.

6.5 Extraordinary meetings may be held at the discretion of the Chair. A minimum of seven working days' notice should be given when calling an extraordinary meeting.

6.6 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.

7 Remit and responsibilities of the committee

The Committee will be responsible for exercising the following functions:

7.1 Performance: Oversee the management of the CCG's performance and delivery of agreed outcomes by:

- a) monitoring performance against national and local targets.
- b) monitoring performance against the standards, targets and outcomes set out in the CCG's operational and strategic plans.
- c) reviewing the CCG's benchmarked performance against statutory frameworks including the NHS Outcomes Framework and Improvement and Assessment Framework.
- d) ensuring action plans are developed and implemented to address any areas of unsatisfactory performance and drive improvement.
- e) overseeing the continuous development of the scope, format, presentation and mechanisms of the system of performance reporting
- f) reviewing those risks on the CCG risk register and Governing Body Assurance Framework which have been assigned to the committee and ensure that appropriate and effective mitigating actions are in place
- g) seeking assurance that the CCG is fulfilling its statutory duties for equality and diversity, as set out in the Equality Act 2010
- h) Ensuring economy, efficiency and effectiveness in the use of CCG resources.

7.2 Quality of commissioned services: The committee will ensure the effective delivery of quality performance across the full range of commissioned services and seek assurances that sound systems for quality improvement and clinical governance are in place in line with statutory requirements, by:

- a) monitoring the quality performance of all providers, including detailed reports on services that are commissioned across acute, community and primary care

- b) reviewing specific action plans or recovery plans as they relate to quality
- c) approving arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes, including the arrangements for dealing with exceptional funding requests
- d) reviewing quality performance with regard to commissioning for value
- e) approving the process for undertaking Quality Impact Assessments.

7.3 Patient experience: The committee will seek assurance that effective systems are in place to monitor and improve patient experience by:

- a) scrutinising arrangements for ensuring that patient feedback and engagement are embedded in the commissioning cycle and meet legal duties.
- b) reviewing themes and trends and ensuring lessons learned are translated into changes in way services are provided.
- c) approving the CCG's arrangements for the handling of patient complaints, concerns or enquiries in accordance with relevant regulations.
- d) reviewing the delivery of the CCG's equality improvement plan in relation to Goals 1 and 2 of the NHS Equality Delivery System (better health outcomes for all/improved patient access and experience).
- e) approving the process for undertaking Equality Impact Assessments.
- f) reviewing the CCG's benchmarked performance against NHS Oversight Framework, Patient and Community Engagement Indicator.

7.4 Clinical Effectiveness: The Committee seeks to gain assurance that there are effective systems and processes in place to monitor and gain oversight of clinical effectiveness. This will include:

- a) receiving assurance that there is appropriate monitoring of compliance with guidance including NICE guidelines and technical appraisals
- b) monitoring the performance of trusts against the agreed Commissioning for Quality and Innovation scheme (CQUINs)
- c) receiving Quality Account updates
- d) receiving assurance that providers have robust clinical audit procedures that address trust priorities, facilitate service improvement and provide assurances that agreed clinical standards are being met

7.5 Safety: The committee shall seek assurances regarding safety by:

a) receiving assurance that the accepted recommendations of national inquiries and national and local reviews have been considered and actioned with respect to the CCG and commissioned services including primary care

b) overseeing safeguarding arrangements to assure that the CCG's statutory responsibilities for safeguarding children and adults at risk are met and that robust actions are taken to address concerns via receipt of regular reports

c) overseeing and seeking assurance that effective systems are in place in relation to CCG services including serious incident management, continuing healthcare and medicines management

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

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

8. Relationship with the Governing Body

8.1 The Chair will prepare reports from the Quality and Performance Committee which will be presented to the Governing Body at its next scheduled meeting. The reports will include the main items discussed and decisions made by the Committee. A summary regarding issues relating to primary medical care services will be submitted to the subsequent meeting of the Primary Care Commissioning Committee.

9. Policy and best practice

9.1 The committee will apply best practice in the decision making processes it will follow, seeking independent advice where required and ensuring that decisions are based upon clear and transparent criteria.

10. Conduct of the committee

10.1 The committee is expected to conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice.

10.2 Members of the committee are expected to declare conflicts of interest as set out in the constitution.

10.3 Annually the committee will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference should be approved by the CCG Governing Body.

Date to be reviewed: April annually

Joint Strategic Commissioning Committee

Terms of Reference

1. Introduction

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

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

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

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

2. Purpose

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

2. Authority

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

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

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

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

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

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

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

- Acute services
- Specialist services
- Community services
- Maternity Services
- Urgent care – 111 services
- Emergency and non emergency Transport services
- Mental Health services
- Prescribing (Strategic)
- Equipment services
- Services commissioned via a Section 75 agreement
- Childrens' Services
- Individuals Commissioning
- Learning disabilities
- Shared grants
- Care closer to home
- Specialised Commissioning

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

3. Duties

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

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

- Reviewing and approving business cases and service change requests and redesign

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

3.2 When making decisions the Committee will ensure that:

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

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

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

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

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

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

4. Membership

4.1 The membership of the committee will be as follows:

- Lay member Primary Care
- Lay member Governance
- 2 GP/Primary Health Care Professional Board members, 1 elected from Shropshire CCG membership and 1 elected from Telford and Wrekin CCG membership

- Registered Nurse
- Accountable Officer
- Executive Director Finance
- Executive Director Quality
- Executive Director Transformation

4.2 The committee will be chaired by the lay member for Primary Care

4.3 The committee will appoint the Lay Member for Governance as the Vice Chair.

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

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

4. Quoracy and voting

4.1 The quorum is a minimum of 5 members, 1 of which must be a lay member and 1 a clinician.

4.2 A duly convened meeting of the Committee at which quorum is present, shall be competent to exercise all or any of the authorities, powers and directions vested in or exercisable by it.

4.3 To ensure that the quorum can be maintained, Committee members are able to nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained.

4.3 If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

4.4 If the committee is not quorate, the meeting may;

- proceed if those attending agree, but no decisions may be taken; or
- in accordance with section 8.4.10 of the Constitution for Shropshire CCG and clause 6.4.10 of the Constitution for Telford and Wrekin CCG invite an additional and temporary member or members to attend; or
- may be postponed at the discretion of the Chair.

4.5 Members of the Joint Commissioning Committee have a collective responsibility for the operation of the Committee. They will participate in discussions, review

evidence and provide objective expert input to the best of their knowledge and ability. The committee will endeavour to make decisions by reaching a consensus.

4.6 However, where a consensus cannot be reached, the Committee chair will call on each voting member to cast a vote. Where a minimum of 50% of the voting committee membership in attendance at the meeting in question are in agreement, a recommendation/decision will be carried and will be binding on both CCGs.

4.7 In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 6.5.4 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

4.8 The Standing Order for the Joint Commissioning Committee, attached as an appendix to these terms of reference, outline the procedures to follow for voting.

5. Operation of the Committee

5.1 Meetings will be held monthly or as otherwise agreed.

5.2 Meetings of the Committee shall be held in public unless the Joint Commissioning Committee resolves to exclude non-voting attendees and/or observers and/or public from a meeting. In which case the meeting, in whole or in part, may be held in private.

5.3 The Standing Orders of both CCGs apply to the meetings of the Joint Strategic Commissioning Committee.

5.4 Secretarial support will be provided to ensure appropriate support to the Chair and committee members in relation to the organisation, recording and conduct of meetings.

6. Conduct of the Committee

6.1 Members of the committee shall at all times comply with the standards of business conduct and managing conflicts of interest as laid down in the CCGs Constitutions and the Managing Conflicts of Interest Policies.

6.2 All declarations of interest will be declared at the beginning of each meeting and actions taken in mitigation will be recorded in the minutes.

7. Accountability and Reporting

7.1 The Committee is accountable to the Governing Body of Shropshire CCG and the Governing Body of Telford and Wrekin CCG.

7.2 The committee will produce an annual report to the Governing Body of

Shropshire CCG and Governing Body of Telford and Wrekin CCG following annual review to consider the Committee's aims, objectives, strategy and progress.

7.3 A Chair's summary will be presented to the next scheduled Governing Body of Shropshire CCG and Governing Body of Telford and Wrekin CCG to provide assurance following each Committee meeting highlighting by exception, risks and progress against objectives and actions taken to mitigate issues.

8. Disputes and termination

8.1 Should the Joint Commissioning Committee arrangements prove to be unsatisfactory, the Governing Body of Shropshire CCG and Governing Body of Telford and Wrekin CCG can decide to withdraw from the arrangement by giving a minimum of six (6) months' notice to the other CCG.

8.2 Where any dispute arises between the member CCGs or where the Committee cannot reach a decision in accordance with its terms of reference, the member CCGs must use their best endeavours to resolve that dispute on an informal basis at the next meeting of the Joint Committee.

8.3 Where any matter referred to dispute resolution is not resolved under 8.2, any Party in dispute may refer the dispute to the Accountable Officers of the relevant CCG, who will cooperate in good faith to recommend a resolution to the dispute within ten (10) Working Days of the referral.

8.4 If the dispute is not resolved under Clauses 8.2 and 8.4, any CCG in dispute may refer the dispute to NHS England/Improvement and each CCG will co-operate in good faith with NHS England/Improvement to agree a resolution to the dispute within ten (10) Working Days of the referral.

8.5 Any referral to NHS England/Improvement under Clause 8.4 shall be to the Regional Director of NHS England/Improvement/NHS Improvement.

8.6 Where any dispute is not resolved under Clauses 8.1. to 8.4, any CCG in dispute may refer the matter for mediation arranged by an independent third party and any agreement reached through mediation must be set out in writing and signed by the member CCGs in dispute.

9.0 Review of the Committee

9.1 The committee will produce an annual work plan in consultation with the Governing Body of Shropshire CCG and Governing Body of Telford and Wrekin CCG.

9.2 The committee will undertake an annual self-assessment of its performance against the annual plan, membership and terms of reference. This self-assessment will form the basis of the annual report. Any resulting proposed changes to the terms

of reference will be submitted to the Governing Body of Shropshire CCG and Governing Body of Telford and Wrekin CCG for approval.

9.3 These terms of reference and membership will be reviewed at least annually following their approval.

Joint Individual Funding Committee

Terms of Reference

1. Introduction

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

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

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

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

2. Membership

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

2.2 The following are members of the committee:

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

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

3. Chairing Arrangements

3.1 The Committee will be chaired by the Lay Member.

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

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

3. Secretary

3.1 Secretarial support for the committee will be provided by the CCG IFC designated administrative support. Their role will be to support the chair in the management of the committee's business.

4. Quorum

4.1 The Committee's quorum will include 3 of the members listed in section 2 above, one of whom must be a lay member and one a clinical member.

4.2 To ensure that the quorum can be maintained, Committee members are able to nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained.

4.3 If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

4.4 If the committee is not quorate, the meeting may;

- proceed if those attending agree, but no decisions may be taken; or
- in accordance with clause 6.5.4 invite an additional and temporary member or members to attend; or
- may be postponed at the discretion of the Chair.

4.5 The committee will endeavour to make decisions by reaching a consensus. Where a consensus cannot be reached, the Chair will escalate the committee's views on the issue for consideration by the Governing Body.

4.6 For all Governing Board committees, the details of the process for decision making and holding a vote will be the same as set out in standing orders.

4.7 In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 6.5.4 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

5. Frequency and notice of meetings

5.1 Meetings will be held monthly. Where individual funding requests are not forthcoming the scheduled meeting may be cancelled by the Executive Lead for Commissioning (or Deputy). Where individual funding requests are received prior to the next scheduled meeting, the Executive Lead for Commissioning and a CCG GP/Primary Care Health Professional Board member of the CCG Governing Body, may exercise their discretion to convene an urgent meeting of the stage 2 IFC.

5.2 The Committee meeting will be formally minuted and a record of the committee's decision will be kept on the patient's file. Once minutes are approved as an accurate account of the meeting, they will be signed off by the chair. 6.1 The committee will meet as required, but at least four times per year and meetings will be called by the chair of the Committee giving at least 5 working days notice.

5.3 Draft minutes will be produced by the minute taker within 7 days of the meeting and circulated to the Chair of the committee for comment within 5 days and the chair will then sign them within 5 days. Copies of minutes will not be circulated to committee members for their retention and will not be placed in the public domain in order to preserve patient confidentiality.

5.4 The agenda and supporting papers will be circulated to all members at least five working days before the date of the meeting, unless there are exceptional circumstances for individual papers agreed in advance with the Chair.

6. Remit and responsibilities of the panel

6.1 The IFC has delegated authority from NHS Shropshire Clinical Commissioning Group and NHS Telford and Wrekin Clinical Commissioning Group Governing Bodies to make decisions in respect of funding for individual cases.

6.2 Requests for funding will be considered on exceptional grounds and must demonstrate exceptionality on:

- Clinical grounds (based on evidence from the referring clinician)

and/or

- As a result of NHSTW's internal systems failure (e.g. where delay on the part of NHSTW has placed a patient outside of any time limits).

6.3 Requests for funding on exceptional grounds will be considered against the limited resources available to the CCG at the time the particular funding request is being determined. Other exceptional circumstances not envisaged by CCG may emerge in individual requests.

6.4 To discharge the remit and responsibilities set out in these terms of reference through a committee in common approach with other CCGs if this is required to support collaborative commissioning.

7. Relationship with the CCG Governing Body

7.1 The committee will produce for the CCG Governing Body an annual report which outlines as a minimum the numbers of requests received, the areas of service provision they related to, how many were upheld, the numbers of appeals made and numbers upheld.

8. Policy and best practice

8.1 The committee will apply best practice in the decision making processes it will follow, seeking independent advice where required and ensuring that decisions are based upon clear and transparent criteria.

9. Conduct of the committee

9.1 The committee is expected to conduct its business in accordance with the national guidance and relevant codes of conduct/good governance practice.

9.2 Members of the committee are expected to declare conflicts of interest as set out in the constitution.

9.3 Annually the committee will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference should be approved by the CCG Governing Body.

10. Decision Making

10.1 For all other Group's committees and sub-committees, including the Clinical Commissioning Groups Governing Body's committees and sub-committees, the details of the process for decision making and holding a vote will be the same as set out in standing order 3.8.

Date to be reviewed: April annually

Joint Individual Funding Appeal Panel

Terms of Reference

1. Introduction

1.1 The Joint Individual Funding Appeal Panel (Stage 3) (IFAP) is established in accordance with NHS Shropshire and NHS Telford and Wrekin Clinical Commissioning Groups' Constitutions. These terms of reference set out the membership, remit responsibilities and reporting arrangements of the panel and shall have the effect as if incorporated into the constitution.

2. Membership

2.1 The membership of the Joint Appeal Panel will be:

- 1 lay member
- 1 Executive Director or Director (any executive director or director involved in the original review of the funding request cannot be a member of the appeal panel)

2.2 The panel will be chaired by a lay member.

2.3 Members of the appeal panel should not have been involved in previous considerations of the request.

2.4 In the event of the Panel not being quorate due to a conflict of interest, the Panel may, in accordance with clause 8.4.10 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

3. Secretary

3.1 Secretarial support for the panel will be provided by the CCG IFC designated officer support. Their role will be to support the chair in the management of the panel's business and for drawing the panel's attention to best practice, national guidance and other relevant documents.

4. Quorum

4.1 The quorum will be two members from section 2 above, with one a lay member and one an Executive Lead.

4.2 In exceptional circumstances and where agreed with the Chair prior to the meeting, members of the Individual Funding Appeal Panel may participate in meetings by telephone, by use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

5. Frequency and notice of meetings

5.1 The appeal panel will be convened when necessary to consider appeals against individual funding requests. Meetings must be convened within 1 month of the receipt of an appeals letter, or as soon as is reasonably practicable thereafter.

5.2 The designated officer will provide the following information to the appeal panel at least 5 working days prior to the meeting taking place:

- Background to the request
- Personal details of the patient
- Information in relation to the condition
- Notes of the meeting of the stage 2 IFP
- The decision of the panel conveyed to the patient
- All other relevant information.

6. Remit and responsibilities of the panel

6.1 The Panel is responsible for determining whether proper process has been followed when considering an individual funding request. The panel must decide whether, based on the information presented, there is:

- No evidence of a failure to consider the request through the process outlined in this document – decision upheld;

Or

- Evidence of a failure to consider the request through the process outlined in this document – request is referred back to stage 2 – IFC

6.2 It is important to note that the appeal panel will not consider new information which was not previously considered by the stage 2 IFC in support of the case. If new information becomes available the stage 2 IFC should be asked to reconsider the case in light of this.

6.3 The patient may represent himself/herself at the meeting and/or be represented by a parent, guardian, carer or appropriate advocate.

6.4 At its discretion the appeal panel may permit others to attend where it is deemed it would be necessary or helpful for those to be invited. The designated officer support may give guidance on who it would be relevant to invite.

6.5 The appeal panel will notify the patient and the referring clinician in writing of its decision within 5 working days of the appeal hearing.

6.6 To discharge the remit and responsibilities set out in these terms of reference through a committees in common approach with other CCGs if this is required to support collaborative commissioning.

7. Policy and best practice

7.1 The panel will apply best practice in the decision making processes it will follow, seeking independent advice where required and ensuring that decisions are based upon clear and transparent criteria.

8. Conduct of the panel

8.1 The panel is expected to conduct its business in accordance with the national guidance and relevant codes of conduct/good governance practice.

8.2 Members of the panel are expected to declare conflicts of interest as set out in the constitution.

8.3 Annually the panel will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference should be approved by the CCG Governing Bodies.

9. Decision Making

9.1 For all other Group's committees and sub-committees, including the Clinical Commissioning Group Governing Body's committees and sub-committees, the details of the process for decision making and holding a vote will be the same as set out in standing order 3.8.

Date to be reviewed: April annually

Assuring Involvement Committee

Terms of Reference

TW CCG ONLY

1. Introduction

The Telford and Wrekin CCG Assuring Involvement Committee (the Committee) is established by the Governing Body in accordance with NHS Telford and Wrekin Clinical Commissioning Group's Constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the clinical commissioning Group's constitution and standing orders.

2. Membership

The Committee members will total 12 and shall be appointed by the Clinical Commissioning Group and may include members who are not part of the existing CCG membership or governance structure.

The following are voting members of the Committee:

- a) Chair
- b) Vice Chair
- c) 9 Appointed Public Members
- d) CCG Lay Member for PPI

The Chair, Vice Chair and Appointed Public Members are volunteers appointed via an open recruitment process, initially on set up of the Committee with a mixed tenure for 3 years and 4 years to ensure that member's tenure is staggered. Thereafter tenure of Chair, Vice Chair and Appointed Public Members will be a three year term. At the end of the appointment, public members must stand down, but previous public members may reapply again through the open recruitment process.

Meetings will normally be attended by:

- Director of Corporate Affairs
- Head of Communications and Engagement
- Patient Engagement Specialist

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

The Chair and Vice Chair will be appointed from an open recruitment process from those members of the public applying and meeting the role criteria. In the event of the chair being unable to attend all or part of the meeting, the Vice Chair will chair the meeting. If neither the Chair nor Vice Chair unable to chair all or part of the meeting, a chair for that meeting will be appointed by those Committee members in attendance, through a majority vote by show of hands for that particular meeting.

In the event of the Committee not being quorate due to a conflict of interest, the Committee may, in accordance with clause 8.4.10 of the Constitution and in order to ensure that the relevant meeting is quorate, invite an additional and temporary member or members to attend.

3. Secretary

The secretarial support will be provided by CCG Engagement Services/PA team. The Director of Corporate Affairs will be responsible for supporting the Chair/Vice Chair in the management of the Committee's business and for drawing the Committee's attention to best practice, national guidance and other relevant documents, as appropriate.

4. Quorum

The Committee's quorum will include 5 of the voting members listed in section 2 above.

The Committee will make decisions, wherever possible, by consensus. However, if this is not possible, a decision put to a vote at the meeting shall be determined by a majority of the votes of members present and who have voting rights. In the case of an equal vote, the Chair of the Committee meeting will have a second and casting vote.

In exceptional circumstances and where agreed with the Chair prior to the meeting, members of the Committee may participate in meetings by telephone, by use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

5. Frequency and notice of meetings

The committee will meet as required, but at least four times per year and meetings will be called by the chair of the Committee giving at least 5 working days notice.

Draft minutes will be produced by the minute taker within 7 days of the meeting and circulated to the Chair of the committee for comment within 5

days. They will be presented to the next meeting for committee for approval and the chair will then sign them within 5 days.

Full minutes of the Finance Committee will be sent to those in attendance at the Committee.

The agenda and supporting papers will be circulated to all members at least five working days before the date of the meeting, unless there are exceptional circumstances for individual papers agreed in advance with the Chair.

Extraordinary meetings may be held at the discretion of the Chair. A minimum of seven working days' notice should be given when calling an extraordinary meeting.

With the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.

6. Remit and responsibilities of the Committee

The Committee has been established to ensure on behalf of the CCG Governing Body that the CCG is fulfilling two of its key statutory duties:

- 1) that the CCG has made arrangements to secure public involvement in planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements; and
- 2) that the CCG meets the public sector equality duty.

In order to do this effectively, the Committee will act as a “critical friend” and provide certainty to the CCG Governing Body via regular reporting by the Chair of Committee to CCG Governance meetings, by:

- scrutinising the development and implementation of strategies supporting the CCG's commissioning functions with regard to public involvement, communications and equalities for presentation to the CCG Governing Body for ratification;
- scrutinising the development of policies and procedures supporting the CCG's commissioning functions with regard to public involvement, communications and equalities for presentation to the CCG Governing Body for ratification;
- undertaking the CCG self-assessment of the Equality Delivery System (EDS) on behalf of the Governing Body, using the evidence it has been presented with during the previous 12 months;
- scrutinising the action plan and progress of implementation arising from the annual self-assessment of the Equality Delivery System;
- scrutinising commissioners plans for communicating, involving, engaging and consulting with the public on designing pathways and services, service change proposals and decommissioning to ensure they are meaningful and robust and identifying any risks and related mitigation;

- scrutinising the outcomes of public involvement, engagement and consultation and ensuring that the CCG can demonstrate how its decision making has been influenced by involvement, engagement and consultation – “you said, we did”;
- promoting innovation, best practice and value for money in the collection of patient experience and opinion of CCG commissioned services;
- scrutinising and approving the content of the annual patient experience report for inclusion in the CCG’s Annual Report;
- appointing members of the Committee to ongoing major projects undertaken by the CCG, wholly or in partnership with others, that requires continuing scrutiny of the project’s patient communication and involvement/engagement/consultation plans; and
- overseeing the development of the CCG’s membership model, providing expertise and direction to ensure the development of an informed, diverse and active membership.
- providing general advice and guidance on how the CCG should seek public involvement and engagement.

To discharge the remit and responsibilities set out in these terms of reference through a committees in common approach with other CCGs if this is required to support collaborative commissioning.

7. Relationship with the Governing Body

The Committee is accountable to the CCG Governing Body for its responsibilities as outlined in section 6 above and so the Chair of the Committee will prepare a report following every meeting that will be presented at the following CCG Governing Body which will:

- Provide information on the key items discussed;
- identify any concerns the Committee has to the Board that require particular attention or escalation at an executive level; and
- recommend outside or other independent professional advice to be authorised by the CCG Governing Body or the attendance of outsiders with relevant experience if it considers it necessary.

A representative of the Committee, which may be the Chair or another Public Appointed Member of the Committee, will be invited to attend the CCG Governing Body meetings as a non-voting participant.

8. Policy and best practice

The Committee will apply best practice in the decision making processes it will follow, seeking independent advice where required and ensuring that decisions are based upon clear and transparent criteria.

9. Conduct of the Committee

The Committee will conduct its business in accordance with any national guidance and relevant codes of conduct/good governance practice/adherence to confidentiality where required. The Committee will have regard at all times of the Nolan seven principles of public life and Members of the Committee will be expected to sign a confidentiality agreement.

Members of the Committee are expected to declare conflicts of interest as set out in the constitution and to sign a code of conduct and confidentiality statement. At the start of every meeting the Chair will ask members of the Committee to declare any new interests not already declared on the CCG's register of interests or any interests that conflict with specific items on that meeting agenda. It will be for the Chair to determine what mitigating action is taken where a conflict arises.

Annually the Committee will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference will be approved by the CCG Governing Body and Practice Forum, for ratification by NHS England/Improvement.

10. Decision Making

For all other Group's committees and sub-committees, including the Clinical Commissioning Group Governing Body's committees and sub-committees, the details of the process for decision making and holding a vote will be the same as set out in standing order 3.8.

Date to be reviewed: April annually

Membership Forums Terms of Reference

SHROPSHIRE ONLY

1. Introduction

1.1 The Membership Forums (the Forum) are established by the Group in accordance with NHS Shropshire CCG Clinical Commissioning Group's Constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Forum.

1.2 The Forums are constituted as Committees of the Group and there are three covering the following geographical areas:

North Shropshire
Shrewsbury and Atcham
South Shropshire

1.3 The Forums have been established by the Group to assist the Governing Body to secure effective participation of each member of the Group.

1.4 The Locality Forums exist to provide the Governing Body with advice in order that it is informed by the clinical commissioning Group members (members) within the locality. This recognises the importance of local knowledge and its application in allowing the clinical commissioning Group to discharge its functions successfully.

1.5 The Forums also provide a conduit for the Governing Body to communicate effectively with practice representatives and the membership of the clinical commissioning Group.

1.6 The Forums will actively contribute to the identification of quality improvements and key priorities of the CCG. The Forums will own the delivery of these improvements and key priorities, together with its members within its locality. This committee is responsible for raising awareness with its members and ensuring two way dialogue and feedback.

1.7 The Forums are jointly accountable to the member practices within the locality.

2. Membership

2.1 The membership of the Forums are composed of the Practice Representatives nominated by their practices to represent their practice within the designated geographical boundaries of the respective Locality Forum.

2.2 Also attending are practice managers from each practice within the designated area.

2.3 The Forums will be chaired by a GP or healthcare professional or practice manager elected by the Practice Representatives of each Forum by a simple majority for a tenure of 3 years. This individual can be a GP, other healthcare professional or practice manager working within the CCG as a whole but does not have to be from within the locality area.

2.4 Other directors and senior managers will be invited to attend where appropriate.

3. Secretary

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

4. Quorum

4.1 The quorum is 50% of the total number of practices within the designated locality area.

4.2 To ensure that the quorum can be maintained, Forum members are able to nominate a suitable deputy to attend a meeting of the Forum that they are unable to attend. Forum members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained.

4.3 If any Forum member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

4.4 The committee will endeavour to make decisions by reaching a consensus. Where a consensus cannot be reached, the Chair will escalate the committee's views on the issue for consideration by the Governing Body.

5 Frequency and notice of meetings

5.1 The Forums will meet as required, but at least four times per year and meetings will be called by the chair of the respective Forum giving at least 5 working days notice.

5.2 Draft minutes will be produced by the minute taker within 7 days of the meeting and circulated to members of the Forum for comment within 5 days. The chair will then sign them within 5 days.

5.3 Full minutes of the Forums meetings will be sent to those in attendance at the Forum.

5.4 The agenda and supporting papers will be circulated to all members at least five working days before the date of the meeting, unless there are exceptional circumstances for individual papers agreed in advance with the Chair.

5.5 Extraordinary meetings may be held at the discretion of the Chair. A minimum of seven working days' notice should be given when calling an extraordinary meeting.

5.6 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.

6 Remit and responsibilities of the Forum

6.1 The Forums are responsible for ensuring the Governing Body is informed by the members of the clinical commissioning Group and that local knowledge is fed into the decision making process of the Group.

6.2 The Forums are responsible for ensuring that members have the opportunity to contribute to the development of policy and commissioning strategy.

6.3 The roles will include, but are not limited to:

- 2.3.1 advising the Board of locality forum priorities;
- 2.3.2 advising members in the locality of the work of the Forum and CCG;
- 2.3.3 consulting with members in the locality on behalf of the Governing Body where requested to do so or otherwise appropriate;

6.4 supporting the Governing body in delivering the objectives of the clinical commissioning Group;

6.5 supporting members of the locality to engage with the clinical commissioning Group (CCG);

6.6 participation and engagement with other locality forums on the development of the CCGs commissioning plans;

6.8 participation in the development of clinical pathways in accordance with best practice.

6.9 Additionally the Forums are accountable for:

- communication of the CCGs policies to locality members; and
- upholding the Standing Financial Instructions, Standing Orders and Delegation of Powers.

7. Relationship with the Governing Body

7.1 The Chair will prepare reports from the Forum meeting which will be presented to the Governing Body at its next scheduled meeting. The reports will include the main items discussed and any issues that require escalation.

7.2 The Chair of each Forum will meet regularly with the CCG Chair to discuss issues in more detail and share with other Forum Chairs.

8 Conduct of the committee

8.1 The committee is expected to conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice.

8.2 Members of the committee are expected to declare conflicts of interest as set out in the constitution.

8.3 Annually the committee will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference should be approved by the Group at a Membership meeting.

Date to be reviewed: April annually

Shropshire and Telford & Wrekin STP

Primary Care Strategy 2019/20 Operational Plan Progress Report: April 2020

This report provides a monthly update on the Shropshire and Telford and Wrekin STP Primary Care Strategy. It provides an update on the work undertaken since the last report and the actions to be taken in the coming weeks to provide assurance to the Primary Care Commissioning Committees and NHS England that progress is being made towards delivery and highlights identified areas of risk.

Given the current Covid-19 crisis this report, inevitably, reflects the fact that the majority of the Primary Care Teams' work over the past month or so has been focused on addressing the challenges of the crisis. Also, due to the impact of Covid-19, the usual RAG rating has not been done for this report.

The report includes nine individual reports as follows:

No.	Programme	Progress Status
1	Primary Care Networks and Models of Care	
2	Prevention and Addressing Health Inequalities	
3	Improving Access to Primary Care	
4	Ensuring a Workforce fit for the future	
5	Improvements to Technology and Digital Enablers	
6	Ensuring a High Quality Primary Care Estate	
7	Optimising Workflow and Addressing Workload Pressures	
8	Auditing Delegated Statutory Functions and Governance Arrangements	
9	Communications and Engagement	

Progress Status Key		
On schedule	Behind schedule with mitigating actions in place	Behind schedule

It should be noted that the Progress Status RAG rating relates to the extent to which the key objectives in the programme are being met. The individual risks in each programme are those that, if not mitigated, might cause the programme to go off schedule – therefore there are examples of programmes with a Green Progress Status that have one or more risks.

Programme 1	Primary Care Networks and Models of Care	Months covered	March/April 2020
Update by:	Steve Ellis	Progress Status	
Outcomes – Anticipated (taken from the PC Strategy)			
<ul style="list-style-type: none">To ensure that Primary Care Networks (PCN) are set up by 1st July 2019, including the appointment of a Clinical Director for each PCNTo ensure that PCNs are set up in a way that enables nationally mandated community and social care services to be provided from 1st April 2020			
Summary Status (update on each Anticipated Outcome)			
Anticipated Outcome		Summary Status	
<ul style="list-style-type: none">To ensure that Primary Care Networks (PCN) are set up by 1st July 2019, including the appointment of a Clinical Director for each PCN		<ul style="list-style-type: none">All PCNs have been set up, including the appointment of CDs for each PCN.	
<ul style="list-style-type: none">To ensure that PCNs are set up in a way that enables nationally mandated community and social care services to be provided from 1st April 2020		<ul style="list-style-type: none">The outbreak of the Covid-19 pandemic has meant that, nationally, the expectations from NHSE/I around delivery of the new service specifications has reduced, however we have seen improved communications and working with community nursing teams and practice nursing teams.	
Key Activities and Updates from the Last Period			
<ul style="list-style-type: none">Discussions have taken place with all Clinical Directors to assess the extent to which PCNs can support the response from general practice to the Covid-19 crisis. PCN CDs are part of the Primary Care Covid-19 Sub-groupThe updated guidance on the PCN DES contract has been sent out to all Clinical Directors and lead Practice ManagersMeetings have taken place to improve closer working between community and practice teams.			
Key Actions Planned for Next Period			
<ul style="list-style-type: none">Further discussions will be held with Clinical Directors about how the PCNs will be able to deliver the reduced contractual expectations from NHSE/I as a result of the Covid-19 situationThe CCG will build on the improved working relationship between community and primary care towards delivery of the care close to home programme of work, specifically around the management of LTCs,			
Risks			
No.	Risk	Rating	Mitigation
1	There is a risk around the availability of workforce to deliver the extended hours DES which will form part of the PCN DES.	9	This risk has been exacerbated by the Covid-19 situation. Mitigation includes telephone triage for all appointments, additional use of online consultation, telephone calls and video consultation.
2	Notwithstanding the fact that NHSE/I have delayed significant parts of the service specs there is a risk that the Covid-19 situation will affect PCNs’ ability to deliver.	12	Discussions will need to continue with Clinical Directors around the new plans for implementation of the service specs.

Programme 2	Prevention and Addressing Health Inequalities	Month covered	March/April 2020
Update by:	Janet Gittins	Progress Status	
Outcomes – Anticipated (taken from the PC Strategy)			
<p>The overarching outcome is to improve the health of the population and reduce health inequalities, specifically improvements will be made in the following areas:</p> <ul style="list-style-type: none">• Improvements in the uptake of physical health checks for the seriously mentally ill• Consideration to specific actions to support people with Learning Disabilities and Autism and delivery of the required increase in the number of health checks• Improvement in the cardiovascular disease and Type 2 Diabetes prevention and management programmes• Improvements to Dementia diagnosis rates• Introduction of prevention and management programme for respiratory disease• Programme of work to reduce Antimicrobial Resistance• Improved skills and capabilities to motivate patients and support behaviour change• Improved ability to recognise risky health behaviours and connect patients/ people to support in the community			
Summary Status (update on each Anticipated Outcome)			
Anticipated Outcome		Summary Status	
<ul style="list-style-type: none">• Improvements in the uptake of physical health checks for the seriously mentally ill		<ul style="list-style-type: none">• The outbreak of the Covid-19 pandemic has meant that patients have not been called into practice to complete SMI checks as anticipated.	
<ul style="list-style-type: none">• Consideration to specific actions to support people with Learning Disabilities and Autism and delivery of the required increase in the number of health checks		<ul style="list-style-type: none">• The outbreak of the Covid-19 pandemic has meant that progress with this work has been delayed.	
<ul style="list-style-type: none">• Improvement in the cardiovascular disease and Type 2 Diabetes prevention and management programmes		<ul style="list-style-type: none">• The NPDD programme continues remotely with the new service provider starting from 1st April 2020.	
<ul style="list-style-type: none">• Improvements to Dementia diagnosis rates		<ul style="list-style-type: none">• No progress update available	
<ul style="list-style-type: none">• Introduction of prevention and management programme for respiratory disease		<ul style="list-style-type: none">• The 2019-20 training programme with Primary Care was completed	
<ul style="list-style-type: none">• Programme of work to reduce Antimicrobial Resistance		<ul style="list-style-type: none">• No progress update available	
<ul style="list-style-type: none">• Improved skills and capabilities to motivate patients and support behaviour change		<ul style="list-style-type: none">• Social Prescribing continues, supporting people remotely.	
<ul style="list-style-type: none">• Improved ability to recognise risky health behaviours and connect patients/ people to support in the community		<ul style="list-style-type: none">• Priority has been given to support those people most vulnerable in the community during COVID-19. The Health and Social Care system are working together provide support and access to services to those in need	
Key Activities and Updates from the Last Period			
<ul style="list-style-type: none">• The CCG IPC team are working in collaboration with all system partners across the STP. There is representation of IPC on the primary care task and finish group, advice and support is ongoing answering daily queries, signposting towards updated national guidance, advice on the procurement of PPE and input into the safe flow of hot/cold sites.• Living Well Taking Control started at the new Shropshire provider of the NDPP. The programme has evolved to offer remote support only during the COVID-19 pandemic.• Shropshire Council has set up new Local Resilience Teams to support local people through this time.			

<p>They can offer food and support to those in need.</p> <ul style="list-style-type: none"> The Health and Social Care sector are working closely together to support those who are most vulnerable and those shielding during this time. Services have been changed to offer remote support where possible. 			
Key Actions Planned for Next Period			
<ul style="list-style-type: none"> Ongoing action from the Health and Social Care system to support those most vulnerable and those shielding across Shropshire. NDPP continues supporting referrals remotely. 			
Risks			
No.	Risk	Rating	Mitigation Support Requested
1	There is a significant risk regarding funding for local lifestyle services (particularly weight management and smoking cessation) given the savings required in local authority public health budgets, e.g. Shropshire Council is currently consulting on significant reductions in services	12	Discussions are taking place directly with between SCCG and Public Health through the CCC and CCC working group to understand and prioritise those at most risk. In addition, they are also part of the STP Prevention and Place cluster, and the Shropshire HWBB. In the short term SIP has been prioritised and work is underway to determine how best to utilise the remaining resources, particularly Healthchecks and Social Prescribing, as well as the NDPP and other local services to target those most in need; in the medium and longer term the system will work together to ensure a robust prevention and place based approach that supports healthy weight and smoking reduction.
2	There is a risk around the pace at which data and intelligence around population health management can be obtained, analysed and used to design and commission services. This risk also includes the need for clarity around the meaning of "Population Health Management" and the extent to which current work is overly focused on a small, specific population group.	6	Continued work with the STP Population Health Management group to ensure that there is a shared understanding of the scope and limitations of this programme.
3	This programme cannot be defined as accurately as the STP would like due to the fact that the national dashboard has not yet been delivered	9	Request update from regional NHS England team to clarify when the dashboard might be delivered

Programme 3	Improving Access to Primary Care	Month covered	March/April 2020
Update by:	Darren Francis	Progress Status	
Outcomes – Anticipated (taken from the PC Strategy)			
<ul style="list-style-type: none">To maintain and improve 7 day access to General Practice both through face-to-face appointment and technological solutionsEnsure at least 75% utilisation of extended-hours appointments by March 2020Direct booking for 111 for in-hours and extended access appointmentsIncreased access and patient satisfaction			
Summary Status (update on Outcomes)			
Anticipated Outcome		Summary Status	
<ul style="list-style-type: none">To maintain and improve 7 day access to General Practice both through face-to-face appointment and technological solutions		<ul style="list-style-type: none">Across both CCGs both Extended Access (GPFV) and the PCN DES Extended Hours continue to be delivered, albeit within the context of additional pressures as a result of the Covid-19 pandemic.	
<ul style="list-style-type: none">Ensure at least 75% utilisation of extended-hours appointments by March 2020		<ul style="list-style-type: none">Utilisation was lower in March and April than it has been to dateUtilisation is estimated at around 70% across the STP	
<ul style="list-style-type: none">Direct booking for 111 for in-hours and extended access appointments		<ul style="list-style-type: none">NHS111 able to book into 100% of practices for In Hours and PCN DES Extended Hours appointments. For Extended Access appointments at hubs, currently working with Regional Commissioners to implement.	
<ul style="list-style-type: none">Increased access and patient satisfaction		<ul style="list-style-type: none">Monitoring of utilisation and delivery of both Extended Access (GPFV) and the PCN DES Extended Hours will continue with any changes being agreed and implemented as required	
Key Activities and Updates from the Last Period			
<ul style="list-style-type: none">The vast majority of the appointments are being delivered as either telephone or video consultations, rather than face to face – although there are still a number of face to face appointments being provided where this is the only option and also following a triage call to screen for Covid symptomsOverall provision of EA appointments was less in March and April – for example the Shrewsbury PCN suspended sessions from 23rd March and Oswestry had some staff illness that impacted their delivery.Overall the service is currently running at around 70% utilisation (including the DNAs – which incidentally are close to zero currently).			
Key Actions Planned for Next Period			
<ul style="list-style-type: none">The majority of PCNs across the STP are hopeful that they can continue to deliver both the extended access and extended hours services, providing there are no significant changes in circumstance. Both CCGs are working with any networks that have expressed concerns over the provision of extended access services to understand the barriers in their delivery.The CCG will work with all delivery groups and PCNs to address these barriers by, for example, the additional use of GP LocumsA technical solution has now been found to NHS111 booking into Extended Access appointments by allowing the regional Adastra system to view EA appointments at hubs and transfer all patient information correctly. Current trajectory from Regional Commissioners indicates implementation by end May 2020 (or sooner if possible)Review the delivery of Extended Access during COVID-19 and provide a recommendation to the Exec team on alternative use for funding as appropriate.			

Key issues relating to Care Quality and Improvement			
Risks			
No.	Risk	Rating	Mitigation Support Requested
1	There is a risk around the availability of workforce to deliver the extended hours DES which will form part of the PCN DES.	9	This risk has been exacerbated by the Covid-19 situation. Mitigation included additional use of online consultation, telephone calls and video consultation.
2	The consultation has taken place around the content of the service specifications to be delivered by PCNs from April. This has resulted in a considerable amount of negative feedback from practices across the country to NHSE. There is a risk that practices will disengage from PCNs if the content of the specifications is not changed	9	NHSE/I have delayed significant parts of the service specs because of the Covid-19 pandemic. Discussions will need to continue with Clinical Directors around the new plans for implementation of these specs.

Programme 4	Ensuring a Workforce fit for the future	Month covered	March/April 2020
Update by:	Phil Morgan	Progress Status	
Outcomes – Anticipated (taken from the PC Strategy)			
<ul style="list-style-type: none"> From 2019 as part of the additional roles reimbursement scheme there is funding to increase the number of clinical pharmacists in Primary Care From 2020 there will be national funding from the reimbursement scheme to introduce physician associates and first contact physiotherapists and from 2021 first contact community paramedics Employment of these staff can be direct by Networks or through other NHS or voluntary organisations The work programmes initiated as part of the GPFV continue for the retention and recruitment of GPs and other clinical professionals As well as retention, recruitment and increased multidisciplinary working there will be increased opportunities for flexible/ mobile working, interoperability and portfolio careers. Clinical Directors will provide the compassionate leadership in primary care to lead the complex, practical, financial and cultural challenge ahead Learning/education also remain important elements of the development of the workforce with Protected Learning Time sessions being adapted to meet the future needs of working in Networks 			
Summary Status (update on each Anticipated Outcome)			
Anticipated Outcome	Summary Status		
<ul style="list-style-type: none"> From 2019 as part of the additional roles reimbursement scheme there is funding to increase the number of clinical pharmacists in Primary Care 	<ul style="list-style-type: none"> To date four Clinical Pharmacists are being funded via the ARRS across the STP. Two of these are in the Shrewsbury PCN, one in the South West Shropshire PCN and the other in the Newport PCN. Notwithstanding the Covid-19 situation other PCNs are considering recruitment of CPs 		
<ul style="list-style-type: none"> From 2020 there will be national funding from the reimbursement scheme to introduce physician associates and first contact physiotherapists and from 2021 first contact community paramedics 	<ul style="list-style-type: none"> The CCGs have been liaising with the PCNs to ensure that PCNs are aware of these roles. There has been little appetite for PAs, due to the perceived high level of supervision they would need if working across a PCN. However, 3 PAs have joined local practices as part of the PA Internship scheme – after the end of their internship they may be able to deliver a PCN role. 		
<ul style="list-style-type: none"> Employment of these staff can be direct by Networks or through other NHS or voluntary organisations 	<ul style="list-style-type: none"> PCNs are aware of the different employment models. Notwithstanding the Covid-19 situation some of the STP's PCNs are liaising with external providers to host the ARRS Social Prescribing Link Worker role. 		
<ul style="list-style-type: none"> The work programmes initiated as part of the GPFV continue for the retention and recruitment of GPs and other clinical professionals 	<ul style="list-style-type: none"> A significant amount of work has been carried out to commission and deliver retention/resilience events for GPs. However, due to the Covid-19 situation this is now on hold Prior to the Covid-19 situation five newly-qualified GPs were supported via NHS England funding. Other clinical professionals have accessed training and development using NHS England funding. Due to the Covid-19 situation this has been put on hold. 		
<ul style="list-style-type: none"> As well as retention, recruitment and increased multidisciplinary working there will be increased opportunities for flexible/ mobile working, interoperability and portfolio careers. 	<ul style="list-style-type: none"> As part of the GP retention funding package practices and PCNs were encouraged to bid for funding for projects/initiatives based around flexible/ mobile working, interoperability and portfolio careers – a number of such bids have been funded and are progressing as well as possible, given the Covid-19 situation. 		

<ul style="list-style-type: none"> Clinical Directors will provide the compassionate leadership in primary care to lead the complex, practical, financial and cultural challenge ahead 	<ul style="list-style-type: none"> Clinical Directors have been provided with information on a range of support and development packages. Bids have been received from PCNs against the PCN Development Fund – this will be picked up again when capacity allows during the Covid-19 situation.
<ul style="list-style-type: none"> Learning/education also remain important elements of the development of the workforce with Protected Learning Time sessions being adapted to meet the future needs of working in Networks 	<ul style="list-style-type: none"> Both CCGs have been continuing to develop their existing approaches to PLT to take account of the future need of PCNs and the wider workforce. These approaches are being reviewed in the light of the Covid-19 situation.

Key Activities and Updates from the Last Period

- The main focus within this workstream has been on understanding the impact of the Covid-19 situation on workforce levels and capacity.
- Key workforce/staffing data has been collected, daily, from all practices to enable the CCGs to understand any hotspots around staffing capacity
- A GP Locum “bank” has been established, allowing practices that are struggling to find locums to request details of other locums with capacity.
- Refresher training has been provided by the CCG, via NB Medical, for around ten GP Returners who have returned to practices as a result of the national initiative
- Testing for symptomatic practice staff and their symptomatic household members has been introduced, as part of a system-wide staff testing regime across health and social care
- As part of the overall support for practice staff the General Practice Nurse Facilitator (GPNF) continues to provide remote support for practice nurses on both general and Covid 19 related subjects. These include;
 - Facebook live group every Monday evening at 7.30. This allows for an interactive conversation between nurses who may be working away from the practice. They are able have peer supervision and ask questions of the group in a safe environment.
 - Closed Facebook group – providing information on e-learning opportunities for practice nurses and general information on Covid 19 and other topics.
 - WhatsApp group which again offers support but throughout the week as questions can be posed to group members (Please note that no PID or specific patients are discussed during the meetings just general practice nursing queries.)
 - Dealing with specific nurse queries on a one to one basis
 - As requested by CCG/HEE GPNF continues to send information out to PNs ie Queen’s Nursing Institute e-learning and request to participate in survey.

Actions Planned for Next Period

- The collection of workforce/staff data will be reviewed – both as a result of a greater understanding of the issues for practices and the development of a system-wide approach to tracking staffing levels
- Ongoing demand for refresher training from other GP returners will be monitored and addressed
- Reporting of the impact of the testing on staffing levels will be developed
- The GPNF’s future plans include looking to set up local remote meetings on specific topics such as anticoagulation and conducting video and telephone consults

Risks

No.	Risk	Rating	Mitigation Support Requested
1	The lack of space, and pressures on GPs around providing mentoring, are making it difficult for GP trainees and	8	The CCGs are completing an estates review to help identify future requirements. HEE is reviewing clinical supervision funding.

	other clinical students to be placed		
2	There is a risk that the investment in training and development will put pressure on staffing in practices – i.e. some practices may be reluctant to allow staff to take on e.g. fellowships	8	Work with PCN Clinical Directors and senior partners to understand the extent of this problem and develop local solutions.
3	Capacity of practices to engage in key elements of the 10 High Impact Actions including projects within the national Time for Care Programme.	6	Information will be provided to practices about those practices that have had positive experiences of the various 10 High Impact Actions and the Time for Care programme.
4	Development of Training Hub not fully realised with uncertainty around hosting and funding of staff. This could impact on ability to deliver on national programmes	8	CCGs primary care teams working with HEE to identify and resolve issues and look realistically at local options.
5	Practice Nurse Facilitator vacancy from March 2020 – impact on delivery of GPN 10 point plan if not filled	8	Approval gained to advertise post Post currently out to advert All local practice nurses alerted to opportunity

Programme 5	Improvements to Technology and Digital Enablers	Month covered	March/April 2020
Update by:	Sara Spencer	Progress Status	
Outcomes – Anticipated (taken from the PC Strategy)			
<ul style="list-style-type: none"> The use of technology will enhance models of care The core level of digitisation will be met by 2024 including the withdrawal of the use of fax machines by 2020 The CCGs will ensure that all GP Practices and PCNs are technically enabled to provide the required functionality and interoperability of systems The NHS App will be available and promoted in Shropshire and some practices will commence online consultations from May 2019 Online and video consultations across all practices by 2021 At least 25% of appointments will be available for online booking by July 2019 Many patients are already able to request their repeat prescriptions electronically; however this will be a default position from April 2019 There is currently limited patient access to medical reports. This will be increased with full access by 2020 and patients will be able to input their own information Improvements to electronic and integrated decision trees with direct links to create referrals so that GPs are one click away from advice and diagnostic information 			
Summary Status (update on each Anticipated Outcome)			
Anticipated Outcome		Summary Status	
<ul style="list-style-type: none"> The use of technology will enhance models of care 		<ul style="list-style-type: none"> There has been a greatly increased use of technology within general practice as a result of the Covid-19 situation – e.g. online consultation and video consultation 	
<ul style="list-style-type: none"> The core level of digitisation will be met by 2024 including the withdrawal of the use of fax machines by 2020 		<ul style="list-style-type: none"> This is complete 	
<ul style="list-style-type: none"> The CCGs will ensure that all GP Practices and PCNs are technically enabled to provide the required functionality and interoperability of systems 		<ul style="list-style-type: none"> Office 365 will be available soon for all practice staff. GP connect will provide interoperability between practices 	
<ul style="list-style-type: none"> The NHS App will be available and promoted in Shropshire and some practices will commence online consultations from May 2019 		<ul style="list-style-type: none"> The NHS App is available and promoted by Shropshire CCG 	
<ul style="list-style-type: none"> Online and video consultations across all practices by 2021 		<ul style="list-style-type: none"> All practices can offer their patients online consultation. 	
<ul style="list-style-type: none"> At least 25% of appointments will be available for online booking by July 2019 		<ul style="list-style-type: none"> All practices have the capability to offer 25% of appointments online. This is part of the contract and is fulfilled from July 2019. 	
<ul style="list-style-type: none"> Many patients are already able to request their repeat prescriptions electronically; however this will be a default position from April 2019 		<ul style="list-style-type: none"> Repeats can be requested through the NHS App and Patient Access 	
<ul style="list-style-type: none"> There is currently limited patient access to medical reports. This will be increased with full access by 2020 and patients will be able to input their own information 		<ul style="list-style-type: none"> Access is available from the NHS App and Patient Access 	

<ul style="list-style-type: none"> Improvements to electronic and integrated decision trees with direct links to create referrals so that GPs are one click away from advice and diagnostic information 	<ul style="list-style-type: none"> To be confirmed
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Key Activities and Updates from the Last Period

- The project to migrate practices to the health and social care network (HSCN) has been escalated in the CCG to red status. NHS Digital has highlighted STW CCGs as a significant outlier and a risk to breaching the transition network closure in August 2020. Daily meetings are in place with all stakeholders to mitigate this risk.
- In response to the COVID-19 pandemic there have been a number of technological solutions to support practices in providing primary care. The virtual desktop infrastructure solution is available to all practices in support of providing a remote working solution to practices.
- To ensure that GPs and other staff who are self-isolating and/or who prefer to work remotely, VDI logins and passwords have been provided across all practices
- The national procurement has supplied 193 laptops to the practices in support of the COVID-19 pandemic. The CCG has sourced iPads, headsets and smartcard readers. These have been allocated to all practices and delivered this week
- Web cameras to support video consultation have been in limited supply, the CCG is still identifying sources to ensure that practices receive an allocation to support the new primary care model
- IT support over the past month to practices has enabled them to transform their services to triage and consult remotely. The IT support has worked with the practice teams to ensure that all staff are able to login and use all new applications
- There has been a significant increase in the use of online consultation with all practices working now able to use online consultation
- All practices are using a telephone triage system to reduce face-to-face consultations
- There has been an increase in the use of video consultation with all practices now being able to offer this to patients

Actions Planned for Next Period

- All practices will be able to offer online consultation.
- Put in place hardware to support the use of video consultations
- Agree with execs the rollout of EPS2 to the dispensing practices
- Continue to evaluate the use of VDI mobile to justify further development for practice remote working
- Put in place vigilant cyber security measures to reduce the risk of cyber attack

Risks

No.	Risk	Rating	Mitigation Support Requested
1.	The CCG has been highlighted as a national outlier in the migration to HSCN and will incur significant charges if they breach the closure of the transition network in August 2020.	12	Daily project management calls and close liaison with the provider (RedCentric) and NHS Digital to ensure that practices migrate.
2.	Delays in the announcement of the central funding for Office 365 will impact upon the delivery plan for practices	9	On-going discussion with NHSE to establish the procurement pathway

Programme 6	Ensuring a High Quality Primary Care Estate	Month covered	March/April 2020
Update by:	Tom Brettell	Progress Status	
Outcomes – Anticipated (taken from the PC Strategy)			
The completion of an Estates Strategy for Primary Care will facilitate a range of outcomes that will ensure a high quality primary care estate:			
<ul style="list-style-type: none">• support identification of the priorities for investment• identify opportunities for savings, efficiencies and capital receipts, both short and long term• improve patient pathways and patient care• create an integrated estate to support delivery of Integrated Care Teams• support a wider range of integrated services at a community level including health and care villages• creation of high-quality working environments that attract new healthcare staff & develop training facilities that support on-going staff development• help develop primary care at scale via the PCN's• support the prevention agenda through community facilities and specialist supported housing			
Summary Status (update on each Anticipated Outcome)			
Anticipated Outcome		Summary Status	
<ul style="list-style-type: none">• Support identification of the priorities for investment		<ul style="list-style-type: none">• All of the work designed to deliver against the anticipated outcomes has been put on hold due to Covid.• This is because the work is designated as Business as Usual and, therefore, is not as high priority as previously.• Normal activity will resume once the current situation ends. In the meantime, any progress that can be made towards producing the combined estates strategy is being undertaken, wherever possible	
<ul style="list-style-type: none">• Identify opportunities for savings, efficiencies and capital receipts, both short and long term			
<ul style="list-style-type: none">• Improve patient pathways and patient care			
<ul style="list-style-type: none">• Create an integrated estate to support delivery of Integrated Care Teams			
<ul style="list-style-type: none">• Support a wider range of integrated services at a community level including health and care villages			
<ul style="list-style-type: none">• Creation of high-quality working environments that attract new healthcare staff & develop training facilities that support on-going staff development			
<ul style="list-style-type: none">• Help develop primary care at scale via the PCN's			
<ul style="list-style-type: none">• Support the prevention agenda through community facilities and specialist supported housing			
Key Activities and Updates from the Last Period			
<ul style="list-style-type: none">• Shawburch – Full Business Case was presented to an extraordinary PCCC in March. More work to be done on the financial proposals, involving both CCG DoF and regional NHSE/I colleagues (ETTF Team)• Shifnal- FBC agreed with planning permission to be submitted. Currently on hold.• Riverside- Building works continuing- Covid 19 may delay practice re-location• Whitchurch – Judicial Review still in progress, revised application submitted 25 March 2020			
Actions Planned for Next Period			
<ul style="list-style-type: none">• Shawburch – Progress the financial issues and confirm outcome in May• Shifnal- Progress overall project once COVID situation has settled• Riverside- monitor COVID situation in relation to practice re-location• Whitchurch – Await outcome of revised application – this may be delayed by COVID-19			
Risks			
No.	Risk	Rating	Mitigation Support Requested
1.	Possibility that current revenue funding	12	Work is progressing with the Finance

	is not sufficient to support medium to long-term estates planning.		team to determine and forecast the level of financial risk.
2.	Risk to Whitchurch project from the Judicial Review	12	A revised application has been submitted which may enable the project to progress, albeit with further delays.
3.	Projects that require ETTF funding have been delayed by COVID-19 and risk losing access to the capital grants	12	Ongoing discussions with NHSE/I via Glenn Francke to ensure that the funding remains secured despite the delays.

Programme 7	Optimising Workflow and Addressing Workload Pressures	Month covered	March/April 2020
Update by:	Jenny Stevenson	Progress Status	
Outcomes – Anticipated (taken from the PC Strategy)			
<ul style="list-style-type: none"> Continued support will be available via the National Primary Care Resilience programme and the Releasing Time to Care Programme, enabling GPs and Managers to think and plan to identify new ways of making better use of resources (e.g. premises, IT, workforce, HR, back office functions, staff) Continued support to deliver the 10 high impact changes Strong public awareness campaigns explaining wider practice team roles and services provided by a range of healthcare professionals - patients will in the future be seen by a wider range of healthcare professionals To promote self-care and alternative sources of advice and treatment Social Prescribing, Care Coordination, and Link Workers will continue to identify and support those who lack the confidence or knowledge to get involved with community groups or to approach agencies on their own GP Practices will be supported to use the new demand and capacity tools to identify how appointments are used and the effect of seasonal variation 			
Summary Status (update on each Anticipated Outcome)			
Activity	Summary Status		
<ul style="list-style-type: none"> Continued support will be available via the National Primary Care Resilience programme and the Releasing Time to Care Programme, enabling GPs and Managers to think and plan to identify new ways of making better use of resources (e.g. premises, IT, workforce, HR, back office functions, staff) 	<ul style="list-style-type: none"> 7 Shropshire CCG practices and 3 T&W CCG practices participated in the Productive General Practice Quickstart (PGPQS) programme during 2019 (one SCCG practice completed both wave 8 and 9) Prior to the start of the Covid-19 situation the CCGs submitted an expression of interest to participate in the next wave of the PGPQS programme, which would have taken place between April and July 2020. This has now been suspended. A Practice Manager Development Programme has been commissioned from PCC and started during February and March for SCCG. Due to the Covid-19 situation it has now been suspended until later in the year. 6 T&W CCG practice managers have accessed coaching & mentoring via the NHS England offer. 		
<ul style="list-style-type: none"> Continued support to deliver the 10 high impact changes 	<ul style="list-style-type: none"> Ongoing training being offered to practices to support active signposting and productive workflow. Links to IT in relation to consultation types. See below for self-care. 		
<ul style="list-style-type: none"> Strong public awareness campaigns explaining wider practice team roles and services provided by a range of healthcare professionals - patients will in the future be seen by a wider range of healthcare professionals 	<ul style="list-style-type: none"> Resources for practices are being developed by the CCG communications team. These are currently being finalised in order to be shared for review. 		
<ul style="list-style-type: none"> To promote self-care and alternative sources of advice and treatment 	<ul style="list-style-type: none"> Self-care campaigns and resources have been developed by the medicines management team. Self- Care Awareness week put a real focus on this during November 2019, and resources continue to be available and promoted. 		

<ul style="list-style-type: none"> • Social Prescribing, Care Coordination, and Link Workers will continue to identify and support those who lack the confidence or knowledge to get involved with community groups or to approach agencies on their own • 	<ul style="list-style-type: none"> • A Shropshire Social Prescribing & Community Wellbeing Workshop took place on 12th December 2019 with representation from PCN Clinical Directors, Management Leads and C&CCs. • A development programme for the SCCG C&CCs has been delivered by PCC with two workshops held in Dec 2019 and March 2020. Attendance was good – over 60% of C&CCs attended at least one of the workshops with many attending both. Topics covered included communication as a key skill and the C&CC peer support network, the challenges of their role, the changing climate within social prescribing and the development of PCNs. Largely very good feedback overall. • Public Health's Social Prescribing project continues to be provided in a number of SCCG practices. This continues to be provided in a different format during the Covid pandemic (i.e. over the telephone rather than face to face). • Discussions around the Link Worker role are ongoing. • An interactive social prescribing session took place on the 5th March 2020 for all T&WCCG practice managers including the new social prescribing link workers. The session evaluation was excellent
<ul style="list-style-type: none"> • GP Practices will be supported to use the new demand and capacity tools to identify how appointments are used and the effect of seasonal variation 	<ul style="list-style-type: none"> • Practices have been asked to confirm whether they are utilising the demand and capacity tool within EMIS. Feedback was sought at a Provider Forum meeting and experiences were mixed. • Practices encouraged to provide feedback via the NHS England/NHS Digital link • NECCS have been contacted to request engagement with STW practices on optimisation of the workload tool.

Key Activities and Updates from the Last Period

- Practices have reduced their face to face contacts with patients during the Covid-19 pandemic and are using total triage systems. Processes for optimising workflow will have been adapted to new ways of working, including working remotely.

Key Actions Planned for Next Period

- Discussions are to be held with practices to starting thinking about returning to (or moving forward to??) a 'new normal' - it is likely that some of the new ways of working will continue which will change some workflows in practice.
- Consider how the CCGs can help facilitate development work capitalising on these new and rapid progressions – to encourage reflection and analysis on what is working and what needs changing, and to hold onto the momentum which has increased 10-fold over the space of a month.
- Consider how the development programmes on offer (e.g. Time for Care) help facilitate this, how development programmes just completed (C&CCs) or ongoing (PM development) can help consolidate the good, discard the not so good, and take the learning forward from this new position of working

Risks

No.	Risk	Rating	Mitigation Support Requested
1	Capacity of practices to engage in key elements of the 10 High Impact Actions	6	Information will be provided to practices about those practices that

	including projects within the national Time for Care Programme.		have had positive experiences of the various 10 High Impact Actions and the Time for Care programme. There is an area on TeamNet for this - need to encourage more sharing and for practices to access and make use of this space
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Programme 8	Auditing Delegated Statutory Functions and Governance Arrangements	Month covered	March/April 2020
Update by:	Corrine Ralph	Progress Status	
Outcomes – Anticipated			
Improvements to the full range of delegated statutory functions and governance arrangements via reviews of:			
<ul style="list-style-type: none">the current compliance with statutory functionsthe internal governance processes to ensure we are fully compliant in all aspectsthe roles and responsibilities of both the CCGs and NHS England in the light of current governance arrangementscurrent governance arrangementsarrangements for procurement, financial governance and patient engagement in decision making			
Summary Status (update on each Anticipated Outcome)			
Anticipated Outcome – improvements to:		Summary Status	
<ul style="list-style-type: none">Current compliance with statutory functions		<ul style="list-style-type: none">In place – audit will identify variation that can be integrated into the organisational development plans	
<ul style="list-style-type: none">Internal governance processes to ensure we are fully compliant in all aspects		<ul style="list-style-type: none">Review of processes not completed in detail.	
<ul style="list-style-type: none">Clarity around the roles and responsibilities of both the CCGs and NHS England in the light of current governance arrangements		<ul style="list-style-type: none">Significant changes expected due to the organisational development of NHSE – with the creation of a GP hub for the region.	
<ul style="list-style-type: none">Current governance arrangements		<ul style="list-style-type: none">Working ongoing	
<ul style="list-style-type: none">Arrangements for procurement, financial governance and patient engagement in decision making		<ul style="list-style-type: none">Focused work remains outstanding – due to forthcoming organisational changes	
Key Activities and Updates from the Last Period			
<ul style="list-style-type: none">Evidence submitted to internal audit in line with the terms of reference for the audit.Meeting with auditors and Shropshire CCG team taken place in March 2020 – the Telford and Wrekin meeting was cancelled due to the emerging COVID situation.Draft report received for Telford and Wrekin CCG – some gaps in assurance identified.			
Key Actions Planned for Next Period			
<ul style="list-style-type: none">To address gaps in assurance and prepare reports for audit committees			
Risks			
No.	Risk	Rating	Mitigation Support Requested
	There is the potential for there to be different governance arrangements/interpretation in each of the CCGs. This may make the audit more difficult to complete consistently. (this work may be of value as part of the organisational development as the two CCG start the transition into one organisation)	4	To ensure the involvement in of the corporate governance lead in the developmental work.
	Local experts from NHSE have been re-deployed into other functions as part of the NHSE reorganisation with changes in NHSE function. This means that there is lack of a loss of system knowledge. This could delay decision making.	4	Sound transition plans agreed jointly between NHSE and the CCGs. Good handover of responsibilities Reproduction of memorandum of understanding that sets out responsibilities

Programme 9	Communications and Engagement	Month covered	March/April 2020
Update by:	Andrea Harper	Progress Status	
Outcome – Anticipated			
To develop and document communications and engagement activity strategically, and across the work streams, to support the delivery of the Long Term Plan and alignment to the Shropshire Sustainability and Transformation Partnership (STP) Primary Care Strategy 2019-2024.			
Summary Status (update on the Anticipated Outcome)			
<ul style="list-style-type: none"> Focus has been on supporting the Primary Care Network strategically and operationally through the initial Coronavirus first wave and the subsequent the lockdown Key priority has been the cascading of information from both an operational perspective and strategic overview 			
Key Activities and Updates from the Last Period			
<ul style="list-style-type: none"> GP Membership vote has been completed to support the transition to a single strategic commissioner Delivery of huge resource of key information on Coronavirus for practices to cascade and share with patients across different platforms Support for the development and delivery of clinical messaging for the GP practice network on C 			
Corporate <ul style="list-style-type: none"> Communications and Engagement Strategy – initial meeting on Nov 5 and proposed amendments shared on Nov 30. Strategy to be revised and further queries clarified. Completion date expected in 2020 due to work commitments and leave. Workforce project - appointment guidance and signposting resource for front line practice staff is now on a final draft and includes key information on roles within practices to lay the foundations for further workplace comms projects. Updated GP 'NB Medical training' video shared with the comms team. Website narrative drafted, approved and uploaded to the Shropshire CCG website. New 'GP Resilience' webpage created and link to video included. GP Membership Vote: <ul style="list-style-type: none"> 12 March – Draft Constitution and Draft Governance sent out to GPs and Practice Managers for both Telford and Shropshire. 27 March – Emails sent out to GPs and PMs outlining the adoption of a new constitution and saying a vote would be taking place. They were also asked to nominate a representative from each practice Survey designed and set up on the vote Spreadsheet on practice representatives set up 6 and 7 April – reminder sent out about the vote on 7 April 7 April – Responses counted 8 April – Result emailed out to GPs and practices Coronavirus <ul style="list-style-type: none"> Web copy and patient information from Portcullis Surgery reviewed and updated by the comms team in order to soften the language for patient use. Resources cascaded (including: FAQs for high risk patients, safeguarding yourself and others, support for carers, families and those with health conditions, looking after your mental health, social distancing and protecting older people and vulnerable people, coronavirus and vulnerable people) Website copy and Twitter schedules drafted for each topic. Practice Bulletin: Weekly Practice Bulletin and last one sent out on 16 March. Decision taken to put it on hold during COVID-19. Any info received by Comms that is relevant to GPs has been sent to the Locality Managers to include on TeamNet. 			

- Promotion of primary care services during lockdown
- Joint comms completed on announcement of services open
- STP wide project to encourage booking of appointments at primary care
- Dr Julian Povey in BBC Radio Shropshire interview promoting the booking of appointments, particularly for cancer patients and those with any concerns or worries.
- Service changes – numerous and on-going including phlebotomy
- Promotion of PPE information and ordering information
- Hot sites promotion for symptomatic patients – press release/social media/web sites/practice resources
- Closure information packs - ready on standby for any emergency announcements

Riverside Reopening

- Shropshire Star press enquiry received Tuesday, 3 March, requesting an update on Riverside Medical Practice following the flooding. Statement prepared with Primary Care team and practice staff and issued.
- Press release drafted on the reopening of Riverside Medical Practice following liaison with the Primary Care team and practice staff. Release issued on Friday, 27 March.
- Press enquiry from BBC Radio Shropshire received as a result of the release with Dr Sarah Harwood briefed by the comms team and interviewed live on the Breakfast Show on Monday, 30 March. Dr Harwood covered key messages on GPs response to COVID-19 too, including the technology available to help GPs work from home and the intense pressure on POD.

POD

- Major challenges with intense pressure on both POD at Shropshire and Telford led to press releases, web copy and a social media schedule. The press releases included – No Need to Stockpile Paracetamol (please see below) and Stop Panic Ordering Repeat Prescriptions. There was also a social media schedule to drive home the don't #stockpile message.

Paracetamol Stockpiling

- Press release drafted and shared for approval with the Primary Care and Medicines Management teams. Key message included people not needing to stockpile paracetamol as it was affecting the national supply. Release issued Thursday, 26 March.

GP appointment/online bookings

- Website and Twitter schedule updated following changes to online bookings for some practices. Liaison with Angie Parker and Jacqui Seaton to update as required.
- Don't visit GP – website banner & social media
- Don't Just Turn Up at GP – website banner, social media

COVID-19 Assessment Centres

- Press release drafted for the hot site development at Shrewsbury Town Football Club (STFC) following liaison with the Primary Care team and STFC CEO. Quotes included from Dr Julian Povey and Brian Caldwell (CEO). Release issued Wednesday, 1 April.
- Photocall arranged with Shropshire Star and agreed with STFC for images and drone footage.
- Reactive statement prepared in readiness for press enquiry.
- Key message document drafted and approved for use across multiple CCG teams/channels due to the specificity of the hot site's function.
- Twitter schedule drafted, approved and uploaded to TweetDeck following approval on the key messages.
- Press enquiry received following press release distribution. Media briefing developed as a result of

this offering the press an exclusive tour of the assessment centre and interview with Steve Ellis and Dr Kieran McCormack. This took place on Friday, 3 March facilitated by the comms team.

- Media briefing notes prepared for Steve Ellis, Dr Kieran McCormack, Lisa O'Brien and Jamie Ricketts from the Shropshire Star.
- Front page news picture secured with the Shropshire Star (Monday, 6 March), including follow up piece on page 2 and a picture of the wider team. Coverage also gained on BBC Radio Shropshire's hourly bulletins.
- Website copy drafted and approved for use on the 'Coronavirus' webpage, news section and a dedicated quicklink on both CCG homepages.
- Twitter responses prepared by the comms and customer care teams and approved by Primary Care following tweets about the STFC hot site. Questions included transport to the site and the appointment pathway.
- 'Breathe on them Salop' banners on entry to the assessment centre raised with Steve Ellis, Nicky Wilde and Sam Tilley for consideration/action.

COVID-19 Assessment Centre – follow-up

- Community contribution release drafted by the comms team and shared with the PCNs for update and distribution following liaison with practice staff. Coverage secured Saturday, 11 April in the Shropshire Star.
- Press enquiry received from the Shropshire Star about plans for the Telford site. Press release on Telford site shared in response to the enquiry.

Easter Bank Holiday Weekend

- Press release drafted and shared with Primary Care and pharmacy colleagues for approval. Release issued Wednesday, 8 April.
- Website copy drafted, approved and uploaded to the CCG websites, including a homepage banner and quicklink.
- Twitter schedule drafted, approved and uploaded to TweetDeck to cover the bank holiday weekend.

Vulnerable People Registration

- Updated website copy and tweets drafted following MP briefing on Thursday, 16 April. The key message being that people can still register with their GP or hospital clinician as a 'vulnerable person'.

Campaigns

Self-Care programme – Shropshire CCG

- The final campaign topic for the self-care programme was Mild Dry Skin. This included tailored resources promoting self-care techniques and encouraging patients to consult their pharmacist for advice. This included an information poster and top tips guide, website copy with further information, as well as social media activity and press release.

Medicine Cabinet Campaign – Shropshire CCG

- The bus advertising campaign launched on Monday, 6 January and will conclude Sunday, 2 February 2020 and will be monitored continually.
- The outdoor pillar campaign continues at five locations in Shrewsbury. The campaign will end on Sunday, 23 February with Medicines Management to monitor prescribing rates over the period.
- Additional pull-up banners have been ordered and delivered to 11 practices at their request. A further four banners have also been ordered for event work and use in waiting areas at SaTH.

The Big 6

- The topic covered in March was Head Injury. The resources pack included a press release, website content, and a social media schedule which was shared with all key partners. The Big 6 Campaign has been put on hold (abdominal pain was to be the next topic) during COVID-19 because of the danger of

mixed messaging.

Flu update

- Final push on staff flu vaccinations completed and dedicated information produced for both the Shropshire and Telford and Wrekin websites.
- Norovirus information also shared via both websites to support national winter comms campaign.
- Social media work continued during this period on Twitter to support national messaging.

NDPP

- The NDPP programme has been placed on hold as a result of the COVID-19 outbreak
- Second newsletter issue, including the Portcullis PM interview, completed and shared via the Practice Bulletin on Monday, 16 December.
- Patient information slides were also designed and written with key messages for the NDPP campaign. This was approved by commissioners and shared via the Practice Bulletin on Monday, 16 December for practices to use in their waiting areas.

Extended Access

- Extended Access for T&W CCG – a further update was completed on additional appointments over the festive season.

Winter

- Christmas and New Year opening times and signposting campaign completed. Key messaging included where to get help when your practice is closed and supported the STP work on winter communications.

Key Actions Planned for Next Period

Corporate

- Estates programme to be reviewed to develop a standalone comms plan to fulfil a key objective of making it publically accessible – this has now been deferred to February 2020 for comms activity.
- Communications and Engagement Strategy to be revised.
- Workforce project to launch as soon as sign-off.
- Influenza vaccination programme – pending further details from T&W.
- Marketing Group pending feedback from the STP on a generic local recruitment pack focussing on benefits of the region.
- Investigate the option of BMJ advertising opportunity and prepare a brief –pending.
- Promotion of video from recent GP training session, pending completion of additional filming – to be cascaded and shared through GP newsletters/web sites etc.
- GP Retention Fund – comms work to be scheduled pending further information.
- GP video - NHS award entry discussed with further work planned. Survey to be completed via Survey Monkey to share with attendees of the NB Medical course. Content shared with the comms team and work to progress.
- The GPFV Funding Survey draft for 2020-21 reviewed and revised by the comms team in collaboration with Primary Care. The survey has now been placed on hold and will be picked up at a later date.
- May Bank Holiday – details to be confirmed and full integrated comms plan to be rolled out.

Campaigns

Self-Care campaigns – Shropshire CCG – work currently on hold

- A design brief is currently in draft for a Dry Eyes poster and top tips guide to support the February self-care campaign. As usual, this will be accompanied by a media and social media campaign and will conclude the six month campaign.
- Comms team to discuss further campaign work with Medicines Management to continue momentum and further support the department's QIPP targets.

NDPP – work currently on hold

- Communications plan currently in draft to support commissioners and Primary Care colleagues during the NDPP provider transition.
- January's NDPP issue currently in draft which will include an interview with Kerry Wooton from Bishops Castle Medical Practice on programme implementation and boosting referral rates.
- Local case studies to be used in campaign work supported by NHSE and programme providers and as preparation ahead of Diabetes Week 2020.

The Big 6 – last topics deferred

- The last two topics of the Big 6t campaign will be launched January/February. Work on a press release, website content, and a social media schedule to begin shortly.

Risks

No.	Risk	Rating	Mitigation Support Requested

Risk Scoring Key	
Probability	
1. Rare	The event may only occur in exceptional circumstances (<1%)
2. Unlikely	The event could occur at some time (1-5%)
3. Possible	Reasonable chance of occurring at some time (6-20%)
4. Likely	The event will occur in most circumstances (21-50%)
5. Almost certain	More likely to occur than not (>50%)
Impact	
1. Insignificant	No impact on PC Strategy outcomes, insignificant cost or financial loss, no media interest
2. Minor	Limited impact on PC Strategy , moderate financial loss, potential local short-term media interest
3. Moderate	Moderate impact on PC Strategy outcomes, moderate loss of reputation, moderate business interruption, high financial loss, potential local long-term media interest
4. Major	Significant impact on PC Strategy , major loss of reputation, major business interruption, major financial loss, potential national media interest
5. Severe	Severe impact on patient outcomes, far reaching environmental implications, permanent loss of service or facility, catastrophic loss of reputation, multiple claims, parliamentary questions, prosecutions, highly significant financial loss

IMPACT	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
		Probability				

Agenda item: GB-2020-05.064
Shropshire CCG Governing Body meeting: 13.05.20

Committee Meeting Summary Sheet	
Name of Committee:	Clinical Commissioning Committee
Date of Meeting:	19 th February 2020
Chair:	Sarah Porter Lay Member
Key issues or points to note: <ul style="list-style-type: none">• MSK Shadow Alliance Board established. Terms of Reference and Governance agreed at Transformation Board. Implementation Group to meet weekly.• Smoking in Pregnancy and Weight Management Following concerns raised by members of the committee and discussion regarding the closure of this service from March it was agreed to request a paper from Mrs Robinson, PH, to understand proposed arrangements from April 2020.	
Actions required by Governing Body Members:	

**MINUTES OF SHROPSHIRE CLINICAL COMMISSIONING COMMITTEE (CCC) MEETING HELD IN
ROOM K2, WILLIAM FARR HOUSE AT 9.00AM ON WEDNESDAY 19 FEBRUARY 2020**

Present:

Mrs Sarah Porter (Chair)	Lay Member for Transformation
Dr Matthew Bird	South Locality Chair
Dr Alan Leaman	Secondary Care Consultant
Mr Kevin Morris	GP Practice Manager Board Representative
Dr Julie Davies	Director of Performance & Delivery
Dr John Pepper	GP Board Member
Dr Julian Povey	CCG Chair
Mr Meredith Vivian	Lay Member for Patient & Public Involvement
Mrs Sam Tilley	Director of Planning
Mrs Chris Morris	Director of Nursing & Quality
Mrs Trudy Attfield	Personal Assistant (Minute taker)

In Attendance:

Lisa Wicks	Agenda Item CCC-20/02/014 – Shropshire Care Closer to Home update
Alison Massey	Agenda Item CCC-20/02/015 Care Homes presentation

Apologies:

Dr Jessica Sokolov	Medical Director
Mrs Claire Skidmore	Chief Finance Officer
Mr David Evans	Accountable Officer
Mrs Nicky Wilde	Director of Primary Care
Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Dr Finola Lynch	GP Board Member
Mrs Rachel Robinson	Shropshire County Council
Dr Priya George	GP Board Member

CCC-20/02/011 Apologies - Apologies were noted as above.

CCC-20/02/012 Members' Declarations of Interest

1.1 Mrs Porter requested that attendees declared any potential conflicts of interest regarding the Committee agenda.

- Mrs Tilley advised that she was the Director of Planning for both Shropshire and Telford and Wrekin CCG.
- Dr Davies advised that she was the Director of Performance for both Shropshire and Telford and Wrekin CCG.

**CCC-20/02/013 Minutes of Previous Meetings/Matters Arising
Minutes 22 January 2020**

- Dr Bird advised that 8.2 referred to the use of NOAC as an alternative to Tinzaparin but said that paragraph required rewording for clarity. Dr Bird to forward amended paragraph to Mrs Attfield
- Dr Pepper highlighted that wording within paragraph 7.3 should be changed from .. when phoning through to RJAH to ***“when phoning through to the Orthopaedic Teams at RJAH”*** and... it was appropriate to go through A&E to ***inappropriate*** .
- 8.1 It was agreed that the word modify in the first sentence should be changed to ***“modified”***.

The CCC Action Tracker was discussed and updated as appropriate.

CCC Working Group Update

- 2.1 Dr Davies gave a brief update on agenda items discussed at the last CCC Working Group:

Smoking in Pregnancy Services and Weight Management Briefing

- 2.2 Following discussions it was agreed that the services were not progressing at the expected rate. Dr Davies and Mrs Morris had escalated the high risk with regard to the smoking in pregnancy service through the System Executive's Group (formally known as Senior Leader's Group) as the current arrangements were due to finish at the end of March 2020. Mrs Robinson had been asked to submit a more detailed paper to the March CCC which outlined arrangements from April onwards.

ACTION: Mrs Robinson to present detailed paper with regard to the Smoking in Pregnancy Service outlining arrangements from April onwards

- 2.3 Discussions were held around the smoking cessation service in general. It was noted that the service had historically been funded by the Council but this was currently not running. It was agreed that Public Health would need to ensure clarity around the whole of the cessation service within the update paper to the March CCC meeting.
- 2.4 Mr Vivien asked if members whether they felt that there was a need for a public statement at a Governing Body meeting to ensure that it was clear that this had been actioned correctly through the various escalation processes to try and ensure that the service was delivered. Dr Davies highlighted that the challenge was that the current service arrangement would cease by the end of March 2020 so this would need to be raised at the March Board. Mrs Tilley suggested that this could be raised at the March Board as a high level risk and discussions took place as to whether this would be an item to be added to the risk register as would have considerable impact on patient outcomes. It was agreed that the risk would be entered within the Quality and Performance report for discussion at the March Board with a recommendation to enter onto the risk register.

ACTION: Risk to be highlighted at the March Board under the Quality and Performance Report with a recommendation to enter onto the Risk Register. Dr Davies/Mrs Morris to take forward

Care Home Update – on agenda.

Stroke – 6/12 month review -

- 2.5 Discussion had been held at Executives meeting and it was agreed that because of the different arrangements across the two sites that the arrangements would remain as they are at present and a piece of work would be carried out that would evaluate the arrangements/benefits in Telford and then compare and contrast the findings against the arrangements in Shropshire and try to find a controlled group but work this through the Joint Commissioning Committee with the Local Authority before coming back through the Working Group and Clinical Commissioning Committee.

MSK Update

- 2.6 A final MSK Transformation Board had been held and the transfer of the governance had now been agreed and the alliance agreement was progressing. A shadow MSK Alliance Board had been formed and a first meeting held. The Terms of Reference and Governance structure had been agreed at the Transformation Board. The shadow Alliance Board would be reporting through the Acute Cluster. An Alliance Implementation Group would also be meeting on a weekly basis and the final detailed project plan was currently being completed. It was still hopeful that the new model would go live from July.

CCC-20/02/014 – Shropshire Care Closer to Home Update

- 3.1 Ms Wicks updated members and advised that the Frailty front door position was that this was operational but workforce issues still remained, particularly around the Matron on both sites. At the last Programme Board the sub-group were tasked with looking into this and they would report back to the next Programme Board.
- 3.2 Case Management – The Committee had approved the funding for the continuation at the last CCC. A project plan had been produced which outlined how to move to neighbouring practices, the engagement plan, how to undertake consent and risk stratification. This was being led by the Service Improvement Lead from the Community Trust.
- 3.3 Phase 3 – SaTH had now signed off the Impact Assessment. A paper would be brought back to March CCC outlining the full impact assessment of the new models with proposals how to take the work forward.
- 3.4 Workforce Challenges – Ms Wicks advised that a paper would be taken to the next Executives meeting advising that the service would remain to run Saturday to Tuesday per week only due to health staffing issues. The paper would also identify next steps. A meeting was currently being held every Friday to identify solutions. Ms Wicks agreed to bring the performance dashboard to March CCC which would show the impact of the service.

ACTION: Ms Wicks to bring Performance Dashboard to March CCC with regard to workforce challenges.

- 3.5 Dr Povey asked if this had been raised at the Senior Executives Group (Formally SLG) as if this was not working then would need to look at changing the model. Ms Wicks advised that Mr David Stout had agreed to raise this to the Senior Executives Group to highlight that a review needed to take place to understand what workforce availability there was. At a recent Cluster Meeting it was agreed that a productivity review was required of current workforce to ensure that staff were being utilised at the right levels to optimise the resource of staff already in place.
- 3.6 Mr Vivien said that believed that there was confusion between the admission avoidance project and the interaction with the Care Closer to Home and suggested that would be beneficial for a communication to be sent to GPs to help clearly define the boundaries. Ms Wicks agreed to liaise with Mrs Andrew Harper to action this.

ACTION: Ms Wicks to liaise with Mrs Harper re. communication circulation around admission avoidance and the interaction with the Care Closer to Home

CCC-20/02/015 – Care Homes Presentation

- 4.1 Mrs Massey gave a presentation from the Care Home Working Group. Dr Davies gave a brief background explaining that this was a positive piece of work which informed how work had been undertaken with Care Homes and hoped that the slides showed members the benefits/impact that was being achieved.
- 4.2 Dr Povey commented that he did not see a mention of PCN DES. Mrs Massey explained that the Working Group would be covering this work and would support information going forward once the contract for PCN had been agreed. Discussions had been held with Primary Care colleagues and data received that related to Care Homes and Primary Care Networks so would now be able to link these going forward.

- 4.3 Dr Bird highlighted that he was surprised that the comparison data for Shropshire against Telford Wrekin was so noticeable different with regard to AE attendance. Mrs Massey explained that Telford & Wrekin had the Care Home MDT and focused on issues around individual Care Homes with regard to quality and safety within Care Homes and then looked at advanced care planning, condition of frailty and deterioration and were now targeting care homes that were identified as an issue. It was noted that the figures were around a weighted population and Mrs Massey said that she would need to revisit and enter narrative/detail and would feedback to ensure that this data was correct as agreed that there was such a large difference.
- 4.4 Discussions were held around the bed rate against admissions and it was noted that the 5% measure should be looked at as a potential indication that Care Homes may need support and could offer this to them. It was noted that Shropshire was not high in terms of admission rates from Care Homes. It was noted that it would be useful to measure data against other areas/national data.
- 4.5 It was agreed that there was a need to acknowledge all the hard work undertaken within Care Homes and to encourage the continuation with the constructive support offered. It was agreed to formally communicate thanks to all staff involved for all their hard work. Mrs Massey to work with Dr Davies to produce the communication.
- 4.6 Dr Davies advised that next steps would be to bring back a formal report in 3 months to May CCC when the data was all to hand to include additional narrative and recommendations.

**ACTION: A formal communication to be sent to all staff thanking them for their hard work.
A formal report to be brought back to May CCC to include detailed narrative and recommendations.**

CCC-20/02/016 - Pain Services Management Update

- 5.1 Dr Davies advised that the paper presented for information gave an update on the position of Pain Management Services following a notification from SaTH of their intention to close their Chronic Pain Service.
- 5.2 Following work carried out the SaTH Chronic Pain Service had agreed that they would now remain open at the current time. This would be kept under careful review. Dr Davies had arranged to meet Mrs Bev Tabernacle to identify how, as a system; they were managing the risks associated with the business continuity for a number of single handed services.

CCC-20/02/017 – Any Other Business

There were no further items for discussion

Date of Next Meeting

The next meeting of the Clinical Commissioning Committee would be held on Wednesday 18 March 2020 at 9.00am in Room K2, William Farr House.

Agenda item: GB-2020-05.064
Shropshire CCG Governing Body meeting: 13.05.20

Committee Meeting Summary Sheet	
Name of Committee:	Clinical Commissioning Committee
Date of Meeting:	18 th March 2020
Chair:	Sarah Porter Lay Member
Key issues or points to note: <ul style="list-style-type: none">• Care Closer to Home Due to Covid 19 commissioning activity paused but committee discussed that this would allow for further discussion and extra preparation time with providers whilst still maintaining momentum. An investment proposal for County rollout of Case Management was approved in principle subject to further guidance being received• VBC Policy approved for publicity and implementation• Gamete Storage This policy was agreed. The policy was written in line with T&W Fertility policy. SCCG's fertility plan will be reviewed and aligned across both CCG's• Locally Commissioned Services – Safe Prescribing of Medicines Policy approved	
Actions required by Governing Body Members:	

**MINUTES OF SHROPSHIRE CLINICAL COMMISSIONING COMMITTEE (CCC) MEETING HELD IN
ROOM K2, WILLIAM FARR HOUSE and via TELECONFERENCE AT 9.00AM
ON WEDNESDAY 18 MARCH 2020**

Present:

Mrs Sarah Porter (Chair)	Lay Member for Transformation
Mr Meredith Vivian	Lay Member for Patient & Public Involvement
Dr Alan Leaman	Secondary Care Consultant
Dr Julie Davies	Director of Performance & Delivery
Dr Stephen James	Clinical Director/GP Board Member
Mrs Laura Clare	Deputy Director of Finance
Dr Jessica Sokolov	Executive Director of Transformation
Ms Maggie Bayley	Interim Director of Quality
Dr Finola Lynch	Clinical Director/GP Board Member
Dr Deborah Shepherd	Clinical Director/GP Board Member

In Attendance:

Lisa Cliffe	For Agenda Item 03/021 - Shropshire Care Closer to Home
Alison Massey	For Agenda Item 03/020 - Care Homes Update
Rose Howard-Jones	For Agenda Item 03/022 – 2020/21 VBC Policy
Clare Mitchell-Harding	For Agenda Item 03/024 – Safe Prescribing of Medicines LCS

Apologies:

Mrs Claire Skidmore	Chief Finance Officer
Mr David Evans	Accountable Officer
Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Mrs Rachel Robinson	Shropshire County Council
Mrs Chris Morris	Executive Nurse
Dr John Pepper	GP Board Member

CCC-20/03/018 Apologies

- 1.1 Apologies were noted as above.

CCC-20/03/019 Members' Declarations of Interest

- 2.1 Dr Lynch informed members that she would be taking up an interim post for Clinical Director for Primary Care Network South West from August.
- 2.2 Dr James reported that his mother was currently using one of the Care Homes noted in the Care Homes Update.
- 2.3 No other declarations were noted.

CCC-20/03/020 Minutes of Previous Meetings/Matters Arising

3.1 Minutes 19 February 2020

The minutes were agreed as being a true and accurate record of the meeting held on 19 February 2020.

The Action Tracker was discussed and updated as appropriate. It was noted that an action missing from the tracker relating to paragraph 2.4 in the minutes.

Dr Davies proposed that any current actions which were not business critical were paused for the time being. Members agreed with this proposal however the risk will need to be closely monitored around each individual area.

3.2 MSK Update

Dr Davies updated members that she had attended the MSK Alliance Board and things are continuing to progress although this may be impacted by the current COVID-19 situation. The financial and activity levels are in the process of being agreed along with the formal alliance agreement; these should be complete by the end of March. In terms of implementation the operational group have completed the due diligence on changes to the new model of care advised that this would be clinically safer and more robust to start this from 1 September; this was supported by the Board however this is the latest date that will be acceptable. The KPI's and Risk Share Agreements have already been approved. It was confirmed that from April to June there would be block arrangements across the country.

3.3 Care Homes Update

Alison Massey highlighted the level of information which is currently received relating to care homes which unfortunately has no narrative to provide any understanding. They are currently working towards a dashboard to give assurance on issues which may be picked up from the high level data. It will be key to work through bench marking, acceptable values and decision making at the Working Group. The data will be recorded month on month and year on year so data can be compared. The Community Health Services will need to be incorporated into the work in order to understand the level of activity at Care Homes that Community Services are dealing with; this piece of work will be undertaken in order to move forward. Ms Massey informed members that a deep dive into Care Homes is happening to look at what the system issues may be and what the care home specific issues are so these can be separated. It is hoped that the deep dive will help to establish the quality improvement relationship with Care Homes.

CCC-20/03/021 – Shropshire Care Closer to Home Update

4.1 Update of Case Management NEL Admission Avoidance

Mrs Cliffe informed members that the paper was intended to share the good news and to capture the impact of the case management at a patient level. She further reported that they did actually deliver and good feedback was received. Assurance has been given by the acute Trust that demand can be managed in the community. Across Shropshire and Telford and Wrekin there are 53 practices and the pilot was running at 8 of those with 42% of those eligible at the practices being case managed and significant reductions in A&E attendance and admission were seen. Therefore the potential if this were scaled up would be great; there will be a 2 scale approach to this. It is hoped this will be a STP priority for the coming year. There is also a proposal for HUB staff which is hoped to be ready for whole county roll out by November. Work has been on going with the BI Team and SaTH around attendances and how these are being managed going forward. Further discussion was held around the finer details of the scheme. It was felt there was an opportunity to improve gaining consent within the scheme in order to raise the 42% uptake this could be done digitally in a much simpler way.

4.2 Phase 3 Impact Assessment Update

Mrs Cliffe highlighted that the paper outlines the models and working with colleagues and provider organisations to complete an impact assessment of services; she explained the various models and how each one worked to the committee. The main issues raised were around IT and workforce and solutions are being looked at. The key limiting factor will be getting the IG and data sharing right and this will improve the consent process by making it simpler which will enable more people to sign up. It is hoped to bring all IG colleagues together across the system. Query was raised as to whether Care Closer to Home was drawing nursing staff out of SaTH and as it isn't up and running yet this is not the case however going forward this would need to be monitored; discussion was held around this and the impact it will have. This will be discussed at the STP Workforce Group. Any decisions will come from the System Priority Setting Exercise which states that this semi acute rapid response services needs to be in place across all STW within 2021 which cannot happen without the right IT therefore the paper will go to the next Programme Board for decision.

- 4.3 There are 3 areas which require agreement from today's committee:
Agree the sign off of the models and the service specification. Mrs Cliffe confirmed that a full impact assessment had been completed therefore members agreed sign off.
- Agree to escalate to STP to ensure vital alignment of enabling workstreams.** It was confirmed that this would go to the Shadow ICS Board and the Chief Execs would also discussed therefore members agreed to this escalation.
- Agree on one of the three options presented for taking forward and implementing.** The options are to pause and escalate, have controlled demonstrator sites in one area to test the model practically or whether providers get together to form an alliance for implementation.
- 4.4 The key points were discussed at length including the need for clear and precise deadlines, to ensure that escalation actually means escalation and that the system leaders lead appropriately so that they can be held to account. The digital group is looking at an integrated electronic care record however this will need to go through procurement which will delay implementation. Although members wanted to test the model the impact of COVID-19 had to be considered as there may not be capacity for implementation.
- 4.5 Members felt that linking option 1 and option 3 into 1 recommendation may be the best way forward by pausing and getting providers together to look at how to progress bearing in mind that commissioning activity will be paused in the short term which allows extra preparation time but keeps momentum going. **Members agreed with this proposal.**
- 4.6 **Investment Proposal for County roll out of Case Management**
 Mrs Cliffe reminded members that in January the roll out strategy had been signed off so that from April neighbouring practices working together to stabilise case management model and from November 2020 to move to a county roll out of case management aligned to a hubs model. The investment proposal for this has been developed by the workforce workstream of the system. It will need to be considered how the current workforce will be utilised to deliver as a next step. The investment numbers have been built in to the financial plan however operation planning is currently suspended due to COVID-19 and discussions are on going therefore it was suggested that the committee may approve in principal subject to further guidance. **Members agreed that this would be the best way forward given the current circumstances.**

CCC-20/03/022 – Draft Criteria – 2020/21 VBC Policy

- 5.1 Dr Davies apologised for the lateness of the paper and highlighted the work and effort which had gone into it. She highlighted the sections which had been updated and the proposed feedback back to providers. All feedback from providers was included in appendix 1 of the paper. Any further change in guidance can be reviewed throughout the year.
- 5.2 A minor change to the spinal decompression section was requested by Dr Leaman around the length of time that conservative measures were pursued as he felt that 3 months was adequate rather than 6; members discussed this and felt that further consideration and evidence was required before making the change. Comment was made that clinical need would need to be considered on an individual basis. It was confirmed that the policy states that patients on an urgent or emergency pathway would be exempt from this as there is an allowance in the policy around documented evidence that the surgery was performed as part of an urgent or emergency surgery. It is not specific in the NICE guidance it was been 6 months for considerable time in the policy.
- 5.3 It was also confirmed that RJAH had requested that the title be changed to 'spinal decompression/discectomy'.
- 5.4 **Members agreed to approve the policy for publication and implementation.** It was noted that the policy would be taken through PPQ Committee next week.

CCC-20/03/023 - Gamete Storage

- 6.1 Dr Davies informed members that there had been a gap in the commissioning care policy around this and the requests for this have been coming through IFR but a new policy was

required as the IFR route was not appropriate as it needed to ensure it covered patients who potentially have cancer treatment and also those undergoing gender reassignment.

- 6.2 The policy has been written in line with Telford's fertility policy and the age needs to be confirmed across the board before it's issued as there is a discrepancy. It needs to be made clear that if Gamete Storage is approved for a patient it is not a pre-requisite for the approval of fertility treatment. The timescales for storage were highlighted as anything over and above this would be considered on a clinically exceptional basis and would be subject to the IFR route.
- 6.3 Query was raised regarding the age difference between male and female who are eligible for the storage and it was confirmed that due to the difference in fertility rates depending on the age. This will need to be aligned across Shropshire and Telford and Wrekin. The national guidance will be checked to ensure the ages in the policy are correct.
- 6.4 It was commented that there is an urgency to review the current fertility policy but as this is not critical business due to the COVID-19 situation this would be delayed. The policy will be incorporated within the overarching fertility policy which will be aligned across both CCG's.
- 6.5 ***Members agreed that following confirmation from the national guidance around the age range they would approve the policy.***

CCC-20/03/023 - Safe Prescribing of Medicines Locally Commissioned Services

- 7.1 Ms Mitchell-Harding attended the meeting to talk through the paper with members; the main aim of the scheme is to increase the safety of prescribing. The intention is to look at all the LCS's across Shropshire and Telford to see where they can be aligned as a medicines team however there are a few areas which are unable to do this at this moment in time. Ms Mitchell-Harding highlighted the various schemes which would remain different.
- 7.2 The CHAS scheme would be run alongside the Safe Prescribing Scheme but this would then be decommissioned from October and the money would be reinvested back into this scheme which will cover the cost of the additional medicines and result in no change of funding. There is a fixed amount of money for the scheme
- 7.3 Part of the scheme is to try and address issues around shared care and there have been joint discussions Shropshire and Telford and Wrekin Primary Care with representatives from the LMC.
- 7.4 ***Members agreed to approve the policy.***

CCC-20/03/024 – Any Other Business

- 8.1 There were no further items for discussion

Date of Next Meeting

The next meeting of the Clinical Commissioning Committee would be held on Wednesday 15 April 2020 at 9.00am.

Agenda item: GB-2020-05.065
Shropshire CCG Governing Body meeting: 13.05.20

Committee Meeting Summary Sheet

Name of Committee:	Finance and Performance Committee
Date of Meeting:	26 Feb 2020
Chair:	Kevin Morris

Key issues or points to note:

- The position is worse this year than last as regards to worked up QIPP schemes than last year. There is still a gap with limited options available and joint working needs to improve to help close this.
- Next year it will be important not to over promise on what can be delivered.
- STP is not appearing to be bringing the system together as quick as hoped.
- Performance continues to be a challenge although cancer waits are improving.

Actions required by Governing Body Members:

- To note contents of the report

MINUTES OF THE
FINANCE & PERFORMANCE COMMITTEE
HELD IN MEETING ROOM B, WILLIAM FARR HOUSE, SHREWSBURY, SY3 8XL
ON WEDNESDAY 26 FEBRUARY 2020 AT 11.00AM

Present

Mr Kevin Morris (Chair)	GP Practice Board Representative
Mr Keith Timmis	Lay Member – Governance & Audit
Dr Julie Davies	Director of Performance
Dr Michael Matthee	North Locality Chair
Ms Sarah Porter	Lay Member – Transformation
Mrs Laura Clare	Deputy Chief Finance Officer
Ms Kate Owen	Head of PMO

Apologies

Mrs Claire Skidmore	Executive Director of Finance
Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Mr Meredith Vivian	Lay Member – Patient & Public Engagement
Mr Tim Woodhead	Deputy Director of Finance, NHSE/I– North Midlands

In Attendance

Mrs Faye Harrison	Personal Assistant (minute taker)
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FPC-2020.02.015 - Apologies

- 1.1 Apologies were noted as above.

FPC-2020.02.016 - Members' Declaration of Interests

- 2.1 No Declarations of Interest were noted.

FPC-2020.02.017 - Minutes of Previous Meeting held on 29 January 2020

- 4.1 The minutes were discussed and the following amendments were required:
- *Paragraph 12.4 – replace 'reconciliations' with 'accounts receivable'*
 - *Paragraph 13.2 – add in 'within diagnostic performance' after echocardiography'*
- After these amendments have been made the minutes were agreed as being a true and accurate record of the meeting held on 29 January 2020.

FPC-2020.02.018 - Matters Arising/ Action Tracker

- 5.1 The Action Tracker was discussed and updated as appropriate

FPC-2020.02.019 - Quality, Innovation, Productivity & Prevention (QIPP) Report

- 6.1 Ms Owen informed the committee that at Month 10 the 19/20 position has a forecast of £16.4m with a risk assigned against this of £1m and a mitigation of £200k. The risks are specifically around Care Closer to Home (demonstrator sites and admissions avoidance), CHC schemes and the HISU project. Ms Owen gave a brief explanation of these risks and these were discussed.

- 6.2 The risk around delivery of CHC QIPP was also discussed, however in order to mitigate this, substantive staff have been recruited and trained to pick up reviews so the backlog should soon be cleared. There remains an overarching risk around provider capacity to support schemes as well as uncertainty in the CCG structures which is delaying progress to date.
- 6.3 The main focus for 2020 was then discussed along with the pushback from the system which is now £40m for the system. There has been strong pushback on this and Julian Kelly will be visiting on 11 March 2020. Discussion was held around this and the 20/21 Finance Plan which cannot be submitted yet until the benchmark has been agreed.
- 6.4 Ms Owen reported that the current target is £22.6m which equates to 3% of the allocation for both CCG's. The identified schemes set out in Appendix C have been RAG rated and this was explained to members. The current gap is £6.1m. We are in a worse position this year than the previous 4 years, we haven't got enough schemes to deliver the target for 20/21 and the pressures are now greater. We also noted average delivery of QIPP is approximately 75% and more schemes than just the QIPP target are needed if we are expected to deliver the financial target for the CCG as a whole.
- 6.5 Cluster Groups were briefly discussed as it was not clear what the CCG leads are. Work is on going around this as well as Care Closer to Home. It will be key to engage the providers to take ownership and improve the joint way of working.
- 6.6 The QIPP Board was discussed as it was felt that this is currently quite disjointed as at the moment there are still 2 organisations which have different rules. The STP also needs to be considered as well as looking at different ways of working in order to pull everything together in a consistent approach. This would need to be considered as a risk going forward. The process around papers going to QIPP Board needs to be more robust as some are bypassing the pathway.
- 6.7 The Rightcare data was discussed and it was agreed that Julie Davies would bring an update to the next Committee. It was suggested that a quarterly update was also added to the agenda going forward.

Action:	Julie Davies to bring update on Rightcare Data to next Meeting
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- 6.8 Further discussion was held around the £6.1m gap and the additional £40m requested from NHSE/I and what was going to be done to progress the situation and what the implications are. All schemes require additional resource and workforce and it would also be key to ensure providers engage fully as they have signed up to the plan.
- 6.9 Members were informed that PwC have been commissioned nationally for challenged organisations by NHSE/I to carry out a desktop review. The focus will be on the 19/20 figures.
- 6.10 It was brought to members attention that Sir Neil MacKay would be attending the next Governing Body meeting and it was felt that he needed to be held to account around the STP as the transformational change has still not delivered and the system is not achieving. Balancing the system books is not just a CCG issue and joint working needs to be improved.
- 6.11 It was also highlighted that moving forward the QIPP savings needed to include an additional 20% - 25% to allow for slippage.

FPC-2020.02.020 – STP Finance Report (for information)

- 7.1 This report was brought for information only but any specific questions could be raised.
- 7.2 Shropshire are currently failing as a system although a lot is being delivered quality is not. The budget is unrealistic and the STP are failing to bring the organisations together.

FPC-2020.02.021 – 2020/21 Finance Plan

- 8.1 Mrs Clare informed members that the plan had been to bring an updated plan but with everything that has happened with NHSE there is now nothing additional to report. The possibility of having an additional Committee before the end of the month was discussed as plans can't be signed off without the committees approval.
- 8.2 It was commented that more information around block contracts would be required involving the growth percentages and activity figures.

Monthly Monitoring for Finance and Performance

FPC-2020.02.022 – Finance & Contracting Report

- 9.1 Mrs Clare reported that the position for Month 10 had not moved from the Month 9 forecast, however there were some adverse movements around emergency activity increasing within the out of area acute contract despite the Year End agreements with SaTH and RJAHS being agreed. Another area of concern is individual commissioning however this has been mitigated by improvements within Primary Care.
- 9.2 Concern was raised around the scale of the issues and focus needs to be on underlying delivery.
- 9.3 Query was made around a discrepancy of the amount of PPE in the report as it has been reported to External Audit as being zero. It was confirmed later in the meeting that an error had been made in the report and that this would be corrected.

FPC-2020.02.023 – Performance Report

- 10.1 Dr Davies reported that the Ambulance Service is still a challenge although activity for January was below plan however there were 411 4 hour breaches within A&E which is a concern. It was agreed at PPQ yesterday that a monthly ambulance report would be brought to the committee from April onwards. This will also focus on long waits and clinical waits. The committee also agreed to support to get this proposal on the Regional agenda.
- 10.2 With regard to RTT there are underlying issues with no admitted performance and workforce problems. Dr Davies requested to be linked in to future discussions around RTT recovery.
- 10.3 Diagnostics is also declining and a report is awaited on echocardiography. Demand into diagnostics has increased particularly around Primary Care requests for ultra sound have gone up. Additional capacity will be required to deal with this risk.
- 10.4 A&E performance is still a concern with focus required on admission avoidance and flow. There are still significant concerns which require actions to be put in place following recent CQC visits.

- 10.5 New data is now in place for 111 and the position around ambulance disposition has decreased but it is still higher than expected. More information will be required on the figures in order to hold the Ambulance Service to account at the Delivery Group.
- 10.6 There are concerns around staffing levels at ShropDoc which is causing an issue. A formal contract performance notice has been raised as there are currently not meeting their obligations in terms of their clinical contributions to Clinical Advisory Service. It will be key to understand what the underlying issues are as poor performance out of hours may be contributing to increase in demand.
- 10.7 Within the Cancer Service meeting targets is a challenge however the 2 week wait and breast symptoms are much better. Further challenge around the 62 days is on going. Slow progress around lung cancer is being made but the biggest issue is regarding urology. The Strategic Partnership Working between SaTH and UHNM has been acknowledged as being the best in the patch which is a positive.
- 10.8 IAPT waiting times were discussed as this is currently between 5-7 months for a face to face meeting. There are some concerns around data accuracy which is on the agenda at the escalation meeting. Contractual challenges with main providers are quite substantial and need to be managed more effectively.

FPC-2020.02.024 – Key Messages to the Governing Body

- The position is currently worse this year with regards to QIPP. The schemes aren't as worked up as they should be and there is still a gap with limited options to fill this. Joint working needs improvement.
- Next year it will be important not to 'over promise' and to pushback and stick to agreed figures
- STP not working to bring system together
- Performance continues to be a challenge although cancer waits are improved.

Members agreed to that if Sir Neil MacKay was attending next Governing Body meeting it would be good to get his views and to provide information and evidence, around how the STP has been effective on bringing services together and what is the timetable for delivery. It was thought giving prior notice of this via the AO.

FPC-2020.02.025 - Any Other Business

- 11.1 There were no items of Any Other Business

Date and Time of Next Meeting

Wednesday 25 March 2020, 11am – 1pm in Meeting Room K2, WFH

Agenda item: GB-2020-05.066
Shropshire CCG Governing Body meeting: 13.05.20

Committee Meeting Summary Sheet	
Name of Committee:	Quality Committee
Date of Meeting:	29 th January 2020
Chair:	Meredith Vivian, Lay Member, Patient and Public Involvement
<p>Key issues or points to note:</p> <ul style="list-style-type: none"> Ms Barbara Beale, Interim Director of Nursing at SaTH, attended the meeting to update members on key developments at The Trust. She advised QC that portfolios were being realigned to the new Executive Team with patient safety being escalated to a higher level of responsibility. ED activity was lower than in January 2019 yet performance on certain days during January this year was barely over 50%. The implications of issues surrounding discharges and how they affect admissions were discussed, and the significant variation in breaches between the two sites. The Committee requested on-going data to come back for review. The Committee discussed the unacceptably high level of trolley wait breaches at SaTH and identified the need for a more robust harm assessment to be put in place, one which took into account the patient experience and not just clinical harm. An update was received on the implementation and delivery of the Autistic Spectrum Disorder waiting list initiative and development of a sustainable model. The Committee heard that the backlog in those waiting for assessment was reducing. Louise Barnard, new CEO of SaTH, to be invited to the next Governing Body development session. 	
<p>Actions required by Governing Body Members:</p> <ul style="list-style-type: none"> To note for information. 	

Shropshire Clinical Commissioning Group

MINUTES OF THE QUALITY COMMITTEE **HELD IN MEETING ROOM B, WILLIAM FARR HOUSE** **AT 2.00PM ON WEDNESDAY 29 JANUARY 2020**

Present

Mr Meredith Vivian	Lay Member – Patient & Public Involvement (Chair)
Mr Keith Timmis	Lay Member for Audit & Governance
Mrs Sarah Porter	Lay Member for Transformation
Mrs Christine Morris	Executive Director of Quality
Dr Julie Davies	Director of Performance
Dr Alan Leaman	Secondary Care Consultant
Dr Finola Lynch	GP Member
Dr Jessica Sokolov	Executive Director of Transformation
Mr Joe Allan	Interim Head of Quality, Shropshire CCG
Mrs Chris Billingham	Personal Assistant; Minute Taker

QC-2020-01.001 (Agenda Item 1) - Apologies

Mr Vivian welcomed members to the meeting.

Apologies were received from Mrs Lynn Cawley and Mrs Gail Fortes-Mayer.

QC-2020-01.002 (Agenda Item 2) - Members' Declaration of Interests

There were no declarations of interest.

QC-2020-01.003 (Agenda Item 3) – SaTH Update

Mrs Barbara Beal, Interim Director of Nursing, Midwifery & Quality, and Ms Rhia Boyode, Acting Workforce Director, attended the meeting to provide an update on the current situation at SaTH.

Mrs Beal advised that in 2018 the Trust was placed in Special Measures. Subsequently, there had been many changes within the Trust, and the majority of the Executive team had changed.

A new Chief Executive - Louise Barnett - will commence employment with the Trust on 10 February 2020. The Deputy Chief Executive post has not been appointed to as Ms Barnett will be personally involved in the recruitment of that individual.

Mrs Beal referred to patient safety and governance, advising the meeting that one of the issues raised with new members of the Executive team was the portfolios of the team which were not aligned to best practice. Conversations and discussions had taken place around re-aligned portfolios, and Mrs Beal asked if she could attend the next meeting to share with the Committee details of the portfolio changes. The focus on patient safety is being escalated to a much higher level and is currently the subject of a piece of work which Mrs Beal is undertaking with members of the SaTH Executive team.

The Trust is not in a good financial position and James Drury, Interim Finance Director, is working with NHS Improvement to have tighter controls around financial probity, due diligence and governance.

Mrs Beal recognised that the Trust was facing a particularly challenging time. She felt the culture of the organisation needed addressing to ensure safety and quality were improved. She felt this would be achieved through strong clinical leadership.

The procedures around Serious Incidents have been reviewed and an Executive Serious Incident Review Group has been established to review all Serious Incidents reported within 72 hours. There is also a culture of resistance to change.

Recruitment challenges were discussed, many of which related to the difficulties encountered in encouraging applicants to relocate and work in rural Shropshire, with the accompanying challenges to career paths and career development.

Mr Vivian referred to the figures submitted to the Governing Body relating to trolley waits and the assessment of harm. The Harm Pro Forma focused on safety and clinical effectiveness but not patient experience.

The senior leadership team had reviewed the data and agreed that the increase was exceptional and unacceptable. The data showed that some patients had experienced trolley waits of up to 40 hours. A Patient Harm Review Group has been set up and a Manager recruited to review patient harm.

Staffing of the department was also an issue, with the hospital currently having 4 A&E Consultants instead of 16. Patient experience is also being reviewed and measures taken to improve the situation.

The reasons for the high turnover of staff were discussed and Ms Boyode advised that the main reasons for staff resignations were leadership, benefits, culture, and staffing issues. There is now much more focus placed on undertaking exit interviews in order to establish the reasons for staff leaving.

Dr Davies referred to Business Intelligence, which presented a real challenge to the organisation. Data is collected, but is never distributed or used to feed improvements to the service. Demand and capacity was also a concern - there are currently three demand and capacity models in use in the same hospital.

Mr Timmis had asked a question at Governing Body relating to the timetable to make SaTH safe to which he had not received a satisfactory answer. The CQC were quoted as stating "Such is the level of our concerns that in line with our guidance we would be looking to cancel or suspend services. The conditions we applied to SaTH do not seem to be having the desired impact on improving the safety of patients". Mr Timmis asked if, when Mrs Beal attended the next Committee, she would be in a position to answer the questions as to when services at SaTH would be safe. In his current position as a Lay Member, Mr Timmis felt extremely uncomfortable and he must question at what point he was failing in his duty in ensuring that there is adequate protection for a vital public service.

ACTION: Mrs Morris to establish the correct forum and place for Mrs Beal and other members of the SaTH Executive Team to provide a further update on the situation at SaTH - possibly at a Part 2 Confidential Board meeting.

Mrs Beal to attend the March or April Quality Committee to provide a further update on topics discussed in today's meeting.

Mrs Beal to attend the June Committee to provide an update regarding progress being made in relation to improvements at SaTH.

Mrs Beal and Ms Boyode left the meeting and Mr Vivian made the following observations:-

- He would prefer to have had time to prepare for the session
- In future it should be made clear to guests the reason why they have been invited and what the Committee wish to achieve from the session

The Committee agreed that there was still a lack of assurance around service provision and improving the service at SaTH.

QC-2020-01.004 (Agenda Item 4) – Minutes/Actions of Previous Meeting Held on 27 November 2019 and Action Log

The Committee requested that the following amendments are made to the minutes of the previous meeting:-

Page 1, Penultimate Paragraph

Mrs Morris referred to the red text in this paragraph which contained information supplied by Dr Borman relating to governance of Serious and Untoward Incidents at SaTH. She advised that this text had been highlighted in red in order to draw it to the attention of Committee members, but stated that the information would be redacted before being included in the Board papers published on the CCG's website.

ACTION: The Committee agreed that the minutes of the previous meeting should be redacted prior to inclusion in the Board papers, and also agreed that an un-redacted version should be submitted to the Part 2 Confidential Board meeting for information.

Page 1, Final Paragraph:

“Dr Davies referred to concerns that existed around monitoring of compliance and the consequence for non-compliance”.

This paragraph should read:-

“Dr Davies referred to concerns that existed around monitoring of compliance **and the lack of consequence** for non-compliance”.

Page 2, Paragraph 6:

“Mr Jeffries confirmed that there would be groups for which there were no SI's. Dr Leaman believed that it would have been beneficial to receive graphs for the other categories of SI's in order to identify any groups of SI's for which there are no signs of improvement”.

This paragraph should read:-

“Mr Jeffries confirmed that there would be groups of SI's **for which there were no graphs**. Dr Leaman believed that it would have been beneficial to receive graphs for the other categories of SI's in order to identify any groups for which there are no signs of improvement”.

Page 3, Provider Exception Report – Primary Care

“Mr Timmis queried Paragraph 23 of the report relating to a significant event within a Practice. He was particularly interested to establish whether this was linked to Severnside Practice or closure of the Whitehall Practice, as a commitment had been made that the closure of Whitehall has not caused any problems”.

This paragraph should read:-

“Mr Timmis queried Paragraph 23 of the report relating to a significant event within a Practice. He was particularly interested to establish whether this was linked to **Severn Fields Medical Practice** or closure of the Whitehall Practice, as a commitment had been made that the closure of Whitehall has not caused any problems”.

The Committee went on to discuss Mr Jeffries' handouts and Mr Timmis expressed concern that, from the information supplied, there appeared to be a “peak” in issues every December. The response from Mr Borman that the issues were “respiratory” and “related to winter” did not seem to align with the analysis of the statistics, and it must be questioned why every December there is a “spike”. Mr Timmis believed that someone from the CCG should accept Mr Borman's invitation to attend the SaTH Mortality Committee, and believed that this would be a good opportunity to understand what underpins the analysis.

Mr Timmis felt that Dr Borman's presentation needed greater scrutiny and evidence for the Committee to be fully assured that systems were in place to address patient safety concerns.

ACTION: Mr Vivian to email all members of the Governing Body to advise them of Mr Borman's invitation for a member of the CCG to attend the SaTH Mortality Committee, and request the name of a Board member who is willing to attend.

QC-2020-01.005 (Agenda Item 5) – Provider Exception Report

Mr Vivian requested that the information contained within Mr Allan's report should be condensed in future to report on issues of real concern to the Committee and not issues which are dealt with in the course of day to day workload. Mr Allan agreed with this view and confirmed that, in future, his report would be more streamlined and risk-based.

ACTION: Mr Allan to feed back to colleagues involved in compilation of the Provider Exception Report that only high level information should be reported to the Committee and not routine day to day events.

Mr Allan's report was taken as read and the Chair invited questions.

An ongoing issue had been identified with Shropcom around lack of capacity and extremely long waits for speech and language therapy. In addition to a capacity and performance issue, there is also a quality issue.

ACTION: Mr Allan to compile an Action Plan to monitor quality issues around speech and language therapy and update the next Committee.

Mr Timmis referred to the results of the CQC inspection, to which the CCG has no access. He also referred to previous enquiries made and legal advice taken by Mr Simon Freeman some time previously from Mills & Reeve in order to clarify where responsibility lay for quality at SaTH. The legal advice at that time was that “the CCG is directly accountable and are the legal custodians of quality at SaTH”.

Mrs Morris advised the meeting that legal advice had again been sought more recently, particularly around the 2013 Maternity Review, as to where liability sits with the CCG. The response received was “Whilst the CCG has oversight, it is for the Provider to deliver a quality commissioned service”.

ACTION: Mrs Morris to share with the Committee the recent legal advice received from Mills & Reeve regarding responsibility for quality of service provision at SaTH.

The Committee discussed the importance of a good evidence base and audit trail, as the CCG may be required to prove that the subject of quality at SaTH was raised repeatedly at both Quality Committee and Governing Body meetings.

Mrs Morris advised that, as a result of the actions identified at the recent Risk Summit, a meeting has been arranged on 25 February to discuss those sources of assurance.

Dr Leaman believed that the CCG and its predecessors should consider their own part in how the issues in Maternity arose and he would expect the review to examine all parts of the system and the actions they took to assure safety and quality of Maternity services. He felt that the creation of a new strategic clinical commissioning organisation provided an important opportunity to examine how best to commission and oversee services in the future.

SOAG

Most of the items within the SOAG report had already been discussed, but going forward Mrs Morris will bring the agreed update from the assurance meeting.

SaTH Risk Summit

The Risk Summit had been discussed earlier on the Agenda. A follow-on Risk Summit meeting had taken place the previous week, and Mrs Morris will bring a paper to the February Committee that details the outcome of that meeting. By that time the assurance meeting will hopefully have taken place with NHSE/I. The CCG has not been assured by the Risk Summit meetings that have taken place. The most concerning issue at the follow up Risk Summit is the opinion expressed by the CQC that “They had serious concerns; they did not see any improvement; and they are sure that patients are coming to harm”.

ACTION: Mrs Morris to update the February Committee with the outcome of the follow-on SaTH Risk Summit.

The meeting discussed ED activity, which was lower than in January 2019, yet performance on certain days during January this year was barely over 50%. The implications of issues surrounding discharges and how they affect admissions were discussed, and the significant variation in breaches between the two sites.

The CCG’s Harm Pro-Forma was discussed, and its triangulation with patient experience. Telephone calls had taken place with patients selected at random who had been in A&E for an extended period of time in order to hear details of their experience. However, SaTH was not keen to be involved or receive feedback.

The Committee discussed trolley breaches and the length of time patients were left on trolleys in corridors. Several members of the Committee provided examples of patients being extremely reluctant to be admitted to RSH, or completely refusing to be admitted.

QC-2020-01.006 (Agenda Item 6) – Maternity Position at SaTH

Mrs Ellis’s paper was taken as read and the Chair invited questions.

Mr Vivian referred to the Local Maternity System (LMS), one of the aims of which was “to enable most women to receive continuity of carer by 2021”. He referred to the use of the word “most” and Mrs Ellis confirmed that this referred to the national target of 51% as outlined in the trajectories table within the report.

Mrs Ellis replied that the original 23 cases provide recurring themes around ECG monitoring, and action has been taken. There are also recurring themes around the risks to mothers delivering in a Midwife Led Unit. Issues that the CCG are aware of relate to culture, compassion and kindness, communication, and resistance to change throughout the whole department.

Dr Leaman believed that the CCG should not wait for the findings of the Ockenden Review to put changes in place. Mrs Ellis confirmed that issues that are known about are being addressed.

Discussion followed regarding the importance of patient safety above all, which should not be sacrificed in order to provide patient choice. The Committee discussed the increase in the number of home births, and Dr Sokolov advised that, for low risk women, home births are as safe as hospital births. However, communication to patients around risk and the balance of risk must be as clear and explicit as possible.

QC-2020-01.007 (Agenda Item 7) – Winter Escalation and Quality Impact 12 Hour Trolley Breaches

This item was discussed at Agenda Item 5 - Provider Exception Report.

QC-2020-01.008 (Agenda Item 8) – ASD Trajectory Progress

The purpose of Ms Davis's report was to provide an update on the implementation and delivery of the ASD waiting list initiative and development of a sustainable model.

The report was taken as read and the Chair invited questions.

Dr Davies observed that 25% of parents had not responded to a letter from MPFT and asked if PAC could follow up on this. The figure contained a high proportion of Looked After Children on the waiting list, and Dr Davies queried whether the CCG were following this up with the relevant Local Authority.

Dr Davies also asked if the Committee could be confident that the backlog would be cleared by the revised target date of end of June 2020, and Ms Davis confirmed that it would be.

Mr Vivian referred to the lack of any form of assessment of the quality of the service and asked for reassurance that the quality of the service being provided is at the correct level. Ms Davis advised that this was measured by the normal quality processes put in place by MPFT. The other Provider used for other services actually captures outcomes from parents at the completion of each session.

Ms Davis asked the Committee to note that the Panel process in Telford was becoming well established and seemed to be successful. However, there is not quite as much robustness in Shropshire. Consequently, the Committee requested that Ms Davis provide the meeting with a formal update regarding ASD in three months' time. However, if any issues arise around robustness of the service in Shropshire then they must be escalated immediately.

ACTION: Ms Davis and Dr Davies to discuss follow up action relating to non-responders to MPFT letter and progress on the ASK Trajectory.

Ms Davis to update the April Committee regarding ASD.

QC-2020-01.009 (Agenda Item 9) – Points to Escalate to CCG Board

Mr Vivian will propose a presentation to the April Governing Body Development Session from Louise Barnett, the newly appointed Chief Executive of SaTH.

QC-2020-01.010 (Agenda Item 10) – Any Other Business

There was no other business.

QC-2020-01.011 (Agenda Item 11) – Date and Time of Next Meeting

The next meeting will take place on Wednesday 26 February 2020 commencing at 2.00 p.m. in Meeting Room A, William Farr House.

Agenda item: GB-2020-05.066
Shropshire CCG Governing Body meeting: 13.05.20

Committee Meeting Summary Sheet	
Name of Committee:	Quality Committee
Date of Meeting:	26 th February 2020
Chair:	Meredith Vivian, Lay Member, Patient and Public Involvement
<p>Key issues or points to note:</p> <ul style="list-style-type: none"> SaTH was rated “Inadequate” by Care Quality Commission (CQC) following an inspection in September 2018 and Risk Summits were held in December 2019 and January 2020. Workforce remains a significant challenge for SaTH with a high number of vacancies across both nursing and medical specialties. SaTH reported a Never Event in January 2020 relating to the wrong patient receiving an endoscopic procedure. The CQC published a maternity services report in December 2019 following an inspection in April 2019 and reported that during the inspection they found improvements in practice. There had been an unprecedented amount of 12 hour trolley breaches in SaTH - 850 during Q3. As a result of this, a much more robust process has been introduced for completion of harm reviews which are undertaken collaboratively with the CCG and the Trust. The Trust will provide a monthly report to CQRM of findings across the month and actions being put in place. SEND inspection week commencing 27 January 2020 - a joint area inspection by Ofsted and CQC for SEND took place, the report is awaited. The CCG has formally raised concerns relating to poor engagement from WMAS in CQRMs. 	
<p>Actions required by Governing Body Members:</p> <ul style="list-style-type: none"> The Governing Body is asked to note the issues above. 	

Shropshire Clinical Commissioning Group

MINUTES OF THE QUALITY COMMITTEE **HELD IN MEETING ROOM A, WILLIAM FARR HOUSE** **AT 2.00PM ON WEDNESDAY 26 FEBRUARY 2020**

Present

Mr Keith Timmis	Lay Member for Audit & Governance (Acting Chair)
Miss Maggie Bayley	Interim Executive Director of Quality & Nursing
Mrs Sarah Porter	Lay Member for Transformation
Dr Julie Davies	Director of Performance
Dr Alan Leaman	Secondary Care Consultant, Shropshire CCG
Ms Jayne Morris	HealthWatch, Shropshire
Mrs Chris Billingham	Personal Assistant; Minute Taker
Mrs Helen Bayley	Strategic Lead for Quality and Care Improvement Team

QC-2020-02.012 (Agenda Item 1) - Apologies

Mr Timmis welcomed members to the meeting.

Apologies were received from Mr Meredith Vivian, Mrs Chris Morris, Mrs Gail Fortes-Mayer, Dr Jessica Sokolov, Mr Joe Allan, Dr Finola Lynch, and Ms Lynn Cawley.

QC-2020-02.013 (Agenda Item 2) - Members' Declaration of Interests

There were no declarations of interest.

QC-2020-02.014 (Agenda Item 3) – Minutes/Actions of Previous Meeting Held on 29 January 2020 and Action Log

The Committee requested that the following amendments are made to the minutes of the previous meeting:-

Page 5, ASD Trajectory Progress

The Committee requested that the abbreviation PAC which was highlighted in red font should be written in full. The acronym should be PACC - Parent and Carer Council.

Reference to the "ASK trajectory" in the action point should read "ASD trajectory".

Mr Timmis referred to redaction of the minutes and suggested that a separate discussion should take place with Mr Vivian, Dr Leaman and Miss Maggie Bayley regarding the principles around recording sensitive issues in the minutes of the meeting.

ACTION: Mr Timmis to ask Mr Vivian to discuss future redaction of the minutes with Miss M Bayley and Dr Leaman.

QC-2020-02.015 (Agenda Item 4) – Provider Exception Report

The report was taken as read. Mrs Helen Bayley drew the following key issues to the attention of the Committee:-

- SaTH was rated "Inadequate" by Care Quality Commission (CQC) following an inspection in September 2018 and Risk Summits were held in December 2019 and January 2020.
- Workforce remains a significant challenge for SaTH with a high number of vacancies across both nursing and medical specialties.
- SaTH reported a Never Event in January 2020 relating to the wrong patient receiving an endoscopic procedure.
- The CQC published a maternity services report in December 2019 following an inspection in April 2019 and reported that during the inspection they found improvements in practice
- SEND inspection week commencing 27 January 2020 - a joint area inspection by Ofsted and CQC for SEND took place, the report is awaited
- CCG has formally raised concerns relating to poor engagement from WMAS.

There had been an unprecedented amount of 12 hour trolley breaches in SaTH - 850 during Q3. As a result of this, a much more robust process has been introduced for completion of harm reviews which are undertaken collaboratively with the CCG and Trust. The Trust will provide a monthly report to CQRM of findings across the month and actions being put in place.

The content and style of Mr Allan's report had been reviewed as a result of a request made by the Committee at the January meeting and positive feedback was given. An additional request was made by the committee that more detail was provided in relation to Never Events going forward, to ensure assurance is clearly stated.

ACTION: Mr Allan to provide a one-off update on Never Events so far, and incorporate them into the monthly Provider Report going forward.

International recruitment at SaTH continues, and 176 Indian nurses will be recruited by September 2020. However, the issues are not merely about recruitment, but also retention. A retention plan has been drawn up and Mrs Helen Bayley will bring a paper regarding the action plan to a future Committee.

Page 2, Provider Exception Report

The action point states that "Mrs Helen Bayley was to provide an update to a future Committee on the Action Plan for workforce retention at SaTH".

This should be amended to reflect the fact that an invitation was to be extended to SaTH to attend a future Quality Committee to update the meeting on their workforce retention plan.

ACTION: An invitation will be extended to SaTH to attend a future Quality Committee to update the meeting on their workforce retention plan.

A SEND inspection took place during week commencing 27 January 2020. This was a joint area inspection carried out by CQC and Ofsted across all partners and providers. The findings of the inspection were not unexpected, and key issues were speech and language therapy and waiting times. The CCG awaits feedback which is currently going through QA processes. A written notice is anticipated. Issues are believed to be around strategic leadership, waiting times, school exclusions and collaboration.

ACTION: Mrs Helen Bayley to provide an update to the April Committee on the SEND action plan.

Dr Davies expressed her concern that the ambulance service had not been attending CQRM. Performance was not acceptable at a Regional level.

ACTION: Mrs Helen Bayley to provide feedback to the next Committee as to whether ambulance service attendance at CQRM has been rectified.

QC-2020-02.016 (Agenda Item 5) – Risk Paper (including SOAG Report)

The paper provided an update on previous reports, key points of which were around the Mental Capacity Act and Managing Care of the Deteriorating Patient.

Miss Maggie Bayley advised that a Risk Summit had been held the previous day with key stakeholders from across the Region. The reason the Risk Summit was convened was as a result of the recent visit by CQC who had subsequently written to Dale Bywater, NHSE/I advising that there were a number of options to be considered in light of poor care found within the Emergency Departments during their visit. Options were – to limit the number of patients going into the organisation, limit the operating hours, and consider where Paediatrics are based.

Heidi Smoult, Deputy Inspector of Hospitals, CQC, presented her concerns regarding the recent visit to SaTH and was very concerned that the CQC had to keep returning and flagging up issues that, in her view, the system should already know about and should be supporting the organisation in resolving the issues. She referred to the absolute deterioration in basic care at SaTH and described poor care as being normalised and the staff no longer recognise what 'Good' looks like. She stated that some of the care that was given was good, but it was not consistent. She did not believe this was isolated to ED but related to the whole culture of the organisation.

Discussion had taken place at the Summit regarding debates which took place in 2018 in terms of whether Princess Royal should close at certain times because of capacity and pressures on medical staff. Agreement was reached that the work done and the contingency plan put in place at that time would be revised with all system partners to establish whether there was a need, for example, to restrict paediatrics overnight via ambulance into PRH or not, and whether it would have any effect. Additionally, all system partners agreed to provide support including pastoral support, training and additional staff to be deployed to support ED. It was

noted that SaTH acknowledged the issues raised and had taken steps to put additional resources in to support the EDs through a change in structure and following best practice from organisations that had been in similar situations.

A follow up Risk Summit will take place in four weeks as it was agreed that the System Oversight Assurance Group had not been effective in terms of managing the risk.

ACTION: Miss Maggie Bayley will provide the next Quality Committee with a briefing paper on the Agreed actions from the follow up Risk Summit.

Dr Leaman stated that he had long been of the opinion that A&E clearly cannot cope with its workload therefore work should be taken out of the A&E department, and patients who are currently being taken to A&E should be taken to a separate assessment area. He believed that other areas of the hospital should be prepared to finally share this burden.

Dr Davies questioned how the current crisis point had been reached and believed that there needed to be some significant reflection on the part of the regulators. Urgent and Emergency Care escalation meetings had taken place monthly; a SOAG process had been established; and a decision taken to close PRH in October 2018 which ultimately did not happen. Dr Davies believed that lessons needed to be learned elsewhere.

Dr Leaman referred to page 20 of the Month 9 Quality and People report, and in particular the elective Caesarian Section figures which were approximately half the figure expected. He then referred to the figures relating to Home Births and believed that, because of the position SaTH now finds itself in, the CCG must be doubly careful about where women give birth. It should not merely be about choice, but also about safety, and he questioned if it was advisable to be running home births at approximately twice the national average.

ACTION: Mrs Helen Bayley to raise Caesarian Section and Home Birth figures at the next CQRM, and also discuss with the new Director of Midwifery at SaTH in order to provide an update to the next Quality Committee.

Dr Leaman then referred to Page 25 of the report and Serious Incident Reporting. He noted that in December there were 2 Serious Incidents in Maternity during December alone. Quality Committee require assurance that Maternity is improving and that a very serious situation is being retrieved, and he did not feel that assurance at the present time.

ACTION: Mrs Helen Bayley to provide an update on the two Serious Incidents in Maternity to the next Quality Committee.

QC-2020-02.017 (Agenda Item 6) – Changes to Arrangements for Looked After Children

Mrs Braun provided a verbal update on changes to arrangements for Looked After Children.

A more robust process had been introduced since October 2019 to look at the specific health needs of Looked After Children and ensure that where placements are being funded, the CCG is only funding the children's health needs. Outcomes for the children are also being reviewed.

QC-2020-02.018 (Agenda Item 7) – Q3 Infection Prevention & Control Report

Mrs Bate attended the Committee on behalf of Mrs Kidson to present the Q3 Infection Prevention & Control report. Key points to note were:-

- Shrewsbury and Telford Hospital breached their *Clostridium difficile* infection year-end target in Quarter 3 and Shropshire CCG remains over trajectory.
- Robert Jones and Agnes Hunt Hospital is currently experiencing a significantly depleted specialist infection prevention and control resource, which is reported on the Trust Risk Register.
- An evolving respiratory infection detected in China caused by a new strain of Coronavirus has been reported. Local NHS providers including Primary Care have been requested to subscribe to the national daily update alerts, review their preparedness and operationalise the guidance as directed.

Mr Timmis queried the consequences of breaching targets such as those for *Clostridium Difficile*.

Mrs Bate replied that currently, all C Diff cases are reviewed by an external panel to determine if there is a lapse in care. Any cases that SaTH deem to *not* have a lapse in care are submitted to an Appeals Panel which consists of CCG members, members of the Infection Control team, Medicines Management and Public Health members. The cases are reviewed by the panel independently to determine a consensus of opinion as to whether or not there was a lapse in care. If there was a lapse in care, it will count against their target. If the lapses exceed their trajectory, that will then enforce the sanctioning process.

Mrs Bate confirmed that the depleted resources at Robert Jones Agnes Hunt Hospital did not pose any significant risk to patients as contingencies have been put in place.

Dr Leaman asked about preparations for Coronavirus. He understood that there was only one pod for assessing patients which was at PRH and queried why there was no pod at RSH.

Dr Davies replied that she understood the requirement to be that each Trust was to have a pod, but not necessarily each site.

ACTION: Dr Davies to ask Mrs Tilley, Head of Planning, to reply directly to Dr Leaman.

Discussion took place regarding assessment of patients in the PODS and whether this would be carried out by A&E staff or Urgent Care Centre staff. Dr Leaman believed that it should be Urgent Care Centre staff as A&E staff have no more capacity.

ACTION: Miss Maggie Bayley to clarify local arrangements and plans for staffing of the Coronavirus Pods with Mr Arne Rose.

QC-2020-02.019 (Agenda Item 8) – Patient Experience Q3

Mrs Blay reported that the main focus of patient dissatisfaction was poor discharges from SaTH. This feedback had prompted a deeper dive into areas of particular concern and a number of themes were identified that are now being taken forward to SaTH.

The Patient Experience account for Q3 had been supplied by a Care Home Manager and related to an elderly patient who had received poor care during her stay in hospital which ultimately compromised her diabetic condition and led to loss of mobility and independence. The experience caused a deterioration in her diabetes and the patient passed away in the nursing home two weeks after being discharged from hospital.

FALK, the non-emergency transport provider, had reported that they were identifying situations where they were being asked to transport patients but they did not feel that the patients were safe and they were therefore not prepared to transport them. Such feedback is being received from all areas and is now being triangulated. All possible routes will be utilised to engender change and improvements.

Mrs Blay invited questions and Dr Leaman referred to the practice of patients being discharged late at night. Mrs Blay advised that nursing homes expect late discharges, but the potential problem with that practice is that the discharge information is sent to the patient's GP and does not go back to the nursing home with the patient. Consequently, the nursing home does not know the outcome of the A&E attendance. The issue is not the time of the discharge, but the arrangements made around it.

Miss Maggie Bayley believed that there should be an electronic patient discharge summary, an issue that needs to be resolved.

Mrs Blay commented that the CCG must consider what steps they should be taking to improve discharge arrangements. Only then would Quality Committee consider submitting the report to the Governing Body as a patient experience.

ACTION: Mrs Blay and Miss Maggie Bayley will pick this up via CQRM and report back to the March Quality Committee before a decision is made as to whether it should be submitted to the Governing Body as a patient experience.

QC-2020-02.020 (Agenda Item 9) – Pressure Ulcer Report

The report compiled by Ms Jane Sullivan, Quality Lead for Shropshire Community Health Trust across both CCGs, was taken as read. Key points of the report were:-

- During Q1 – Q3 2019/20 the number of pressure ulcers reported remained similar for Grade 3 ulcers (16 in total) and has declined for Grade 4 (4 in total) and Unclassifiable (5 in total). For 2018/19 year there

were 37 Grade 3 and 5 Grade 4 pressure ulcers reported. This shows a reduction in 2019/20 to date for both Grade 3 and Grade 4 pressure ulcers.

- The majority of pressure ulcers were reported by the community teams. The most common theme was due to an equipment issue or delay in provision from Community Equipment Service (CES).
- SCHAT acknowledges that pressure ulcers remain the highest category of reporting for SI's with the highest numbers occurring within the community setting which has the most challenges for pressure ulcer prevention.
- SCHAT are addressing the equipment delays by improving the communication between the referrer/team and CES, provision of pressure relieving equipment at satellite stores and in cars to allow immediate issue, quicker decision making for more specialist equipment requests.
- Implementation of daily huddles where pressure ulcer management is discussed, and oversight of pressure ulcer management by senior nurses.
- Increased scrutiny, action plans and support for teams identified as reporting higher number of pressure ulcers than other equivalent SCHAT services.
- All root cause analysis (RCA) reports completed following the reporting of an SI are scrutinized by the Quality Lead with support from CCG colleagues as required. Pressure ulcers are reported each month to the CQRM and a themed review is to be presented March 2020.

The Committee discussed the reasons for the delay in provision of equipment from CES. Mrs Sullivan advised the meeting that previously, there was a facility whereby if a patient required a piece of equipment outside of normal working hours, it was possible to order it via another system.

ACTION: Ms Sullivan to investigate whether the option of ordering CES equipment via a different route outside normal working hours is still available.

QC-2020-02.021 (Agenda Item 10) – Points to Escalate to CCG Board

A briefing paper will be submitted to the Board in relation to the actions to be taken as a result of the Risk Summit.

QC-2020-02.022 (Agenda Item 11) – Any Other Business

Combined Safeguarding Report

- Mr Coan highlighted challenges currently being experienced in Shrewsbury and Telford hospitals due to the vacancy for an Adult Safeguarding Nurse being placed on hold while processes are reviewed and a decision is made as to how Safeguarding will operate going forward. The previous Safeguarding Lead is assisting with providing cover until the situation is resolved. Training of staff is also being affected by pressures on the wards.
- The CQC visited SaTH in regards to MCA and DOLS and the regulatory breach that happened in November. A training programme is in place which the CCG is monitoring.
- MPFT and DOLS remain proactive and review the challenges of children who are in the mental health capacity of A&E. On the children's ward there is no such engagement from Social Care and the Safeguarding team are currently working on a procedure around children on Section 136 mental health assessment.

Looked After Children

Mrs Braun advised the Committee that, since the report was compiled, an issue had been drawn to her attention by MPFT relating to escalation of a child from a London borough who came into area with a requirement to access CaMHS services. The Manager of the service had indicated that, because of capacity issues, proposed guidance had been produced which states that CaMHS will refuse to see out of area children who may require prescription monitoring; and children who are referred for routine CaMHS appointments must have lived in County for 3-4 months. It is not clear whether this proposed guidance has been signed off.

Mrs Braun has escalated the situation to Mrs Helen Bayley and also the Children's Commissioner and the situation will be raised with MPFT via the CQRM.

ACTION: Mrs Helen Bayley to raise the issues relating to Out of Area children accessing the CaMHS service at CQRM.

QC-2020-02.023 (Agenda Item 12) – Date and Time of Next Meeting

The next meeting will take place on Wednesday 25 March 2020 commencing at 2.00 p.m.

System A&E Delivery Board

Notes & Actions

Meeting Title	A&E Delivery Board	Date	28 January 2020
Chair	Dave Evans	Time	14:30 – 16:30
Venue / Location	The Aldridge Room, Halesfield		
Attendee's			
Present: Dave Evans (Chair) Claire Old Julie Davies Steve Gregory Pam Schreier David Stout Cathy Smith Roman Kuciaba Nicky Jacques Johnathan Rowe Nigel Lee Paul Shirley Tanya Miles Jayne Knott (note taker)		Dial in attendees: None	
1.Apologies: Cathy Riley: Lucy Roberts: Mark Tunstall: Andy Begley: Paula Clark;			
2. Minutes/Actions from previous meeting 26/11/19 Minutes of the previous meeting were approved as an accurate record. Actions: Winter plan - <ul style="list-style-type: none">• PE Pathway – Closed• Streaming – Closed• LA Community offer – Closed• DE and Claire still to discuss setting up workshop around Primary care with partners and GP – back to next Board. Emergency care Dashboard – on today's agenda. Ambulance demand – First Ambulance meeting with Nick Henry, Emma Bogle, Nigel Lee, Sara Biffen and Emma Pyrah took place this week. Should the Ambulance group be STP Ambulance group and Nick Henry to attend. Nigel Lee will follow-up. Emma Pyrah leading on workshop being set up. Powys LA bed issues – Claire Old met with them on Friday. Noted by Welsh Government that they have improved their delayed transfer of care, but still concerns which are being reported to Pauline Philip. Site visit prep – Dave Evans wrote a letter to Mark Brandreth and this was responded to. TOR – on today's agenda.			

3.	<p>Achieving one achievable action plan:</p> <p>How we get one plan together.</p> <p>Frailty Board starts up again 29 January – Claire Old had asked what are the overarching group leading us to in terms of frailty. In terms of the system priorities frailty did not feature in them. Challenge with money. Are we going to invest going forward? Who drives it? Needs to report into somewhere. Who's plan does it sit in so it doesn't get duplicated. We are clear in terms of the system prioritisation work but the challenge is around flow, internal and external so focus needed on this.</p> <p>There are various sub-set of work that we need to take place within that, frailty included. Dave Evans said that previous recovery plans around A&E performance which haven't delivered impact.</p> <p>Make sure we are very clear if we are going to have a programme of work around flow, that should be the basis of the plan. Then A&E performance should increase and get better. What influences A&E performance? What are we going to do about demand? How do we stop people getting to the front door?</p> <p>This Boards role is to be a strategic Board that sets the strategy for how we are going to improve performance and ensure that we deliver quality patient care for patients in the Urgent and Emergency care system. The A&E delivery group is there to enact the strategy. Part of this Boards role is to hold Organisations to account for doing what is in their gift and for contributing to the system flow improvement plan. What are the things being overseen by this Board? Map into overall governance structure. Isolate what are the things that are uniquely being overseen by this Board and fit into the overall governance.</p> <p>Claire Old to clarify assurance/ governance structure</p> <p>Senior leadership group (SLG) has been restructured and is now the CEO group accountable to the Shadow ICS Board.</p> <p>What has the impact been of stroke on flow, which needs to sit under the prevention and placed based care cluster.</p> <p>Plan key milestones, KPI's and hold ourselves as a system to account for delivery.</p> <p>Need to strategically define what we mean by flow. Next phase of key tasks and by when, first cut needs to be by end of February and operational version of it by end of March.</p> <p>Discuss outside of this meeting and agree who holds the ring.</p> <p>Action: Claire Old to clarify assurance/ governance structure</p> <p>Action: Cathy Smith to contact Lauren Leverton about the UEC transformation plan, to ask if this needs refreshing. New reporting mechanism from April.</p>
4.	<p>Review of High Impact Changes Q3– plan for 2020/21:</p> <p>High impact changes with demand and capacity and were we are up to with them, Q3 update from A&E delivery group as this is where they are monitored. Workshop will be arranged going forward which will review where we are with all of the HiC, this will pick up what our HiC need to be for next year, which will support the plan discussed above and the flow. They will have Executive ownership and reporting structure as before, Execs will be held to account on delivery. Data also needs reporting. Quantify impact.</p> <p>'Review HiC flash reports' to go on next agenda. These reports need to go to A&E delivery group every two weeks.</p> <p>New IT system for ED will have an impact, big change for Feb/March. Shropcom offered help to SaTH.</p>
5.	<p>ECIST Stocktake:</p> <p>There is a roundtable event planned for next Tuesday with partners, based around quality, finance and performance, and the challenges facing the Trust and the system. SaTH issues around workforce.</p> <p>Specific and broad range of challenges which needs an integrated approach to it.</p> <p>There will be more dedicated support from ECIST from April.</p>

	It was suggested that the ECIST recommendations need to be part of the flow plan, so the system owns them not the Trust. Single delivery action plan wanted not Multiple plans. The stroke bid has been submitted.
6.	<p>Measurement/Demand and Capacity – the challenge of BI support in this system:</p> <p>There is a deficit with BI capacity within the Trust which needs to be addressed. Data available but can't measure the impact and no resource to turn it into an impact analysis. Multiple models but need nominated resource within the Trust to own it. Urgently need capacity. Julie Davies to talk to Avril from CSU to seek temporary resource that could help move it forward. Nigel Lee said there was already a date in the diary to meet the CSU so Julie to join with James Drury and maybe Charles Millar.</p>
7.	<p>Dashboard:</p> <p>Board wants a highlight/exception report, discuss at SAED Group. Charles Millar to continue to hold the ring on this.</p> <p>Action: Nigel/Julie to meet with CSU and refine.</p>
8.	<p>TOR:</p> <p>Claire asked for the A&E Delivery Group TOR to be discussed and agreed.</p> <p>Change Dr Julie Davies to Director of Performance only.</p> <p>Should Dave still chair this group as conflict of interest as he chairs Board.</p> <p>Suggestion that the Chair should be a Commissioner rather than a provider, so potentially Julie Davies or Jess Sokolov, to be discussed.</p> <p>It was thought these meetings were too big and suggested just a core group.</p> <p>Workforce lead not required at every meeting.</p> <p>Change Mark Docherty to either Emma Bogle or Senior WMAS representative.</p> <p>Need a SaTH Clinical representative? Medic and Nurse.</p> <p>Need more discussions around GP Reps.</p> <p>Action: Claire Old to makes changes, take back to March group meeting and reform the group when the Chair has been decided and Governance structure tweaked. Then revisit TOR for this Board. Review how the meetings are working.</p>
9.	<p>Any other business:</p> <p>Claire asked the attendees for AOB and also their thoughts on the meeting and suggestions on whether we can do things differently.</p> <p>Cathy Smith – Would like the flash reporting mechanism looked at.</p> <p>Pam Schreier – Involvement with Comms in this meeting.</p> <p>Paul Shirley – Patient involvement, suggestion of regular slot for patient good news stories on agenda.</p> <p>Julie Davies – Have planned exception report and make it function more effectively.</p> <p>Nigel Lee – AOB: New CEO Louise Barnett starts on 10 February.</p> <p>Steve Gregory – AOB: Met CQUIN for flu. New CEO for Shropcom David Stout starts 2 March.</p> <p>David Stout – Narrow down business-like approach.</p> <p>Dave Evans – AOB, A&E Local, SaTH have put a proposition forward on how A&E Local could be delivered. Need to think through the governance of how that gets through the system. Price tag attached to this. Basic proposition would be 10:00-18:00 7 days a week, Consultant led service, supported by other staff sitting alongside the 24 hour UTC as part of Future Fit. This should go through IOG – SLG/ICS Shadow Board/CEO meeting – SaTH board and CCG Boards for sign off. Will need appropriate engagement with stakeholders and the public. Test and adjust staffing model. Dave Evans has a planned informal meeting with Councils. Will also speak to local MP's.</p>

	<p>➤ Could we Re-brand A&E Delivery board as an Urgent & Emergency Care Board?</p> <p>Nicky Jacques – Strengthen the assurance process. Happy to be invited to this Board.</p> <p>Tanya Miles – Be clear on Group and Board, similar discussions taking place at both meetings, make sure we are strategic as a Board</p> <p>Jonathan Rowe – First time at this meeting, has taken over from Clive Jones, found meeting useful.</p> <p>Roman Kuciaba – Be specific what we need from CSU, we need proper intelligence that will drive our actions.</p>

Summary of Actions

Agenda Item	Action required	Owner	By when
26.11.19	Winter Plan-		
3.	<ul style="list-style-type: none"> Dave Evans and Claire Old still to discuss setting up a workshop with other partners and GP's around primary care. 	Dave Evans/Claire Old	25.2.20
1.	Ambulance demand – First Ambulance meeting with Nick Henry, Emma Bogle, Nigel Lee, Sara Biffen and Emma Pyrah took place this week. Should the Ambulance group be STP Ambulance group and Nick Henry to attend. Nigel Lee will follow-up. Emma Pyrah to lead on workshop being set up.	Emma Pyrah/Nigel Lee	25.2.20
3.	Achieving one achievable action plan: Cathy Smith to contact Lauren Leverton about the UEC transformation plan, to ask if this needs refreshing.	Cathy Smith	25.2.20
	Assurance structure needs clarifying	Claire Old	
6.	Measurement/Demand and Capacity – the challenge of BI support in this system: Urgently need capacity. Julie Davies to talk to Avril from CSU to seek temporary resource that could help move it forward. Nigel Lee said there was already a date in the diary to meet the CSU so Julie to join with James Drury and maybe Charles Millar.	Nigel Lee/Julie Davies/Charles Millar	25.2.20
7.	Dashboard: Board wants a highlight/exception report, discuss at SAED Group. Charles Millar to continue to hold the ring on this. Action: Nigel/Julie to meet with CSU and refine	Nigel Lee/Julie Davies	25.2.20
8.	TOR: Claire Old to makes changes, take back to March group meeting and reform the group when the Chair has been decided and Governance structure tweaked. Then revisit TOR for this Board. Review how the meetings are working.	Claire Old	24.3.20

Agenda item: GB-2020-05.068
Shropshire CCG Governing Body meeting: 13 May 2020

Committee Meeting Summary Sheet	
Name of Committee:	South Locality Board Meeting
Date of Meeting:	9 January 2020
Chair:	Dr Matthew Bird
<p>Key issues or points to note:</p> <p>CCG Chair Update – an update was given about the appointment of new Executive Directors for the two CCGs, and an update about the final end of year budget position. Members were advised that work had been started on aligning the constitutions of the two CCGs.</p> <p>Ultrasound Guidance – Dr Leah Farrell, Consultant Radiologist from SaTH attended the meeting to talk through a guidance document that had been put together to clarify what could be referred and answered questions from Members about this.</p> <p>Other Business – It was confirmed that the Public Health team were offering to provide training for smoking cessation. Members also discussed services for opiate addition, and it was confirmed that the Medicines Management Team had completed some audits in relation to this.</p> <p>Medicines Management - A demonstration of the Eclipse Live system was given to Members with feedback from practices that had already been using the system.</p> <p>Community Respiratory Pathways – The community respiratory team gave an update on the new nurse-led service and the four elements: COPD service, oxygen assessment, pulmonary rehab and COPD self-management workshops.</p>	
<p>Actions required by Governing Body Members:</p> <ul style="list-style-type: none"> No actions required 	

Thursday 9 January 2020

Mayfair Community Centre, Church Stretton

Member Name	Practice	Attendance
Dr Matthew Bird (Chair)	Albrighton	Attended
Caroline Kilcoyne	Albrighton	Attended
Dr Dale Abbotts	Alveley	Apologies
Lindsey Clark	Alveley	Attended
Dr Paul Gardner	Bishop's Castle	Attended
Catherine Lowe	Bishop's Castle	Attended
Dr Gwen Potter	Bridgnorth	Attended
Sandra Sutton	Bridgnorth	Apologies
Dr Mathai Babu	Broseley	Attended
Nina Wakenell	Broseley	Apologies
Dr Bill Bassett	Brown Clee	Attended
Vicki Brassington	Brown Clee	Apologies
Dr Alex Chamberlain	Church Stretton	Attended
Emma Kay	Church Stretton	Attended
Dr Paul Thompson	Cleobury Mortimer	Attended
Mark Dodds	Cleobury Mortimer	Apologies
Dr Juliet Bennett	Clun	Attended
Peter Allen	Clun	Attended
Dr Mark Carter	Craven Arms	Attended
Susan Mellor-Palmer	Craven Arms	Attended
Dr Shailendra Allen	Highley	Apologies
Sudhanshu Consul	Highley	Apologies
Dr Catherine Beanland	Ludlow – Portcullis	Attended
Rachel Shields	Ludlow – Portcullis	Attended
Dr Graham Cook	Ludlow - Station Drive	Attended
Jodie Billinge	Ludlow - Station Drive	Apologies
Dr Jennie Bailey	Much Wenlock & Cressage	Apologies
Sarah Hope	Much Wenlock & Cressage	Apologies
Dr Richard Shore	Shifnal & Priorslee	Apologies
Theresa Dolman	Shifnal & Priorslee	Apologies
In Attendance	Organisation/Role	Attendance
Dr Julian Povey	CCG Clinical Chair	Attended
David Evans	CCG Accountable Officer	Apologies
Nicky Wilde	CCG Director of Primary Care	Apologies
Tom Brettell	CCG South Locality Manager	Attended
Heather Clark (Minute Taker)	CCG Personal Assistant	Attended
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	Attended
Shola Olowosale	CCG Locality Pharmacist	Attended
Dr Leah Farrell	SaTH Consultant Radiologist	Attended
Sarah Pezzaioli	SCHT Respiratory Team Leader	Attended
Natasha Carthy	SCHT South West Locality Respiratory Nurse	Attended

Minute No SLB-2020-01.001: Item 1 – Welcome & Apologies

- 1.1 Dr Matthew Bird, Locality Chair, welcomed and thanked Members for attending and introductions were made. Apologies received were recorded as above.

Minute No SLB-2020-01.002: Item 2 – Members' Declaration of Interests

- 2.1 Members were reminded of the requirement to complete a new Declaration of Interests form annually. No new declarations of interest were made for items on the agenda.

Minute No SLB-2020-01.003: Item 3 – Minutes of Formal Meeting held on 6 November 2019

- 3.1 The minutes of the meeting held on 6 November 2019 were agreed as a true and accurate record and were signed by the Chair.

Minute No SLB-2020-01.004: Item 4 – Matters Arising from Previous Meeting

- 4.1 Tom Brettell and Dr Bird gave the following updates about the actions from the previous meeting:

Minute No SLB-2019-11.097 – Public Health – Information about health checks had been sent out and were included with the meeting packs for Members.

Minute No SLB-2019-11.100 – SOOS – A letter had been sent to Julie Davies about the inequitable service in the South Locality, no formal response had been received about this yet.

Minute No SLB-2019-11.102 – RAS/MECS – Dr Bird advised that he had seen a draft guidance document about referral criteria for RAS (Referral Assessment Service) and MECS (Minor Eye Conditions Service) but that it needed to go through the Telford and Wrekin CCG Board before it could be circulated.

ACTION: Tom Brettell to forward MECS/RAS guidance document to Members once approved.

Minute No SLB-2020-01.005: Item 5 – CCG Chair's Update

- 5.1 Dr Julian Povey advised that interviews for the new Executive Team structure had taken place the week before Christmas and appointments had been made into some of the posts; this information had already been circulated to practices via the email bulletin. Vacancies remained for the Executive Director of Quality and Director of Partnerships roles. A number of directors would not be continuing with the CCGs and were currently in discussions with David Evans about how to move forward and the next steps for them in their careers. Up until March 2020 Fran Beck would be covering the Director of Partnerships role, and Chris Morris would be covering the Executive Director of Quality role. The following appointments had been made:

Executive Director of Finance – Claire Skidmore
Executive Director of Transformation – Jessica Sokolov
Director of Corporate Governance – Alison Smith
Director of Planning – Sam Tilley
Director of Performance – Julie Davies

- 5.2 The Executive Team were currently working on finalising their roles and responsibilities, and once this had been agreed would start to work on the structures for their directorates in order for the remaining CCG staff to go through the management of change process. Dr Povey advised that he thought there would be roles for most people, but that some may decide to take MARS (Mutually Agreed Resignation Scheme) if this is offered. A question was asked about the Director of Primary Care role that was in the previous structure, Dr Povey advised that at the moment it was not clear where this work was going to lie, and that most other CCGs didn't have a Director of Primary Care role but had Associate Directors or Heads of Primary Care.
- 5.3 Dr Povey explained that the CCG was coming to the time of year for the final settlement figure process. The aim would be for the CCGs to end the year £60m over budget (£47m of this was Shropshire, £13m Telford). The original plan was to be £22m over budget for Shropshire and to break-even for Telford. Dr Povey advised that the model would be changing in the near future and the government would be looking at the system as a whole with a system control total. The role of CCGs would become very different in the future and would be more about setting outcomes, monitoring quality, providing assurance and directions. CCGs will give the ICP (Integrated Care Providers) a set amount of money to deliver outcomes, and it would be up to the ICP how to deliver these outcomes.
- 5.4 As part of the movement towards a single CCG, as well as the need to make a single management team, there was also a need to align the governance and meetings of the two CCGs. This would become complicated if the constitutions of the CCGs were not aligned and therefore work on this had now started; any changes to the CCG constitution would need to be approved by Members. Proposals for this were being developed and also discussions about how to align the CCG Boards e.g. sharing lay members and secondary care doctor. There had been a strong feeling from localities that the locality

meetings needed to continue with Locality Chairs, but that perhaps the Chairs may not sit on the CCG Board as the roles were slightly different.

- 5.5 Dr Povey also gave a short update about SaTH (The Shrewsbury and Telford Hospital NHS Trust) which had experienced a very busy period over December and into the New Year with hundreds of 12 hour breaches in the past few weeks. He added that some patients had been on a trolley for 30-40 hours. ECIST (Emergency Care Intensive Support Team) were still supporting the hospital.

Minute No SLB-2020-01.006: Item 6 – Locality Chair's Update

- 6.1 Dr Bird advised that following the presentation at the last meeting about low risk diabetic foot screening a meeting was now needed to discuss this further. The meeting would be held on 19th February 2pm-3pm and could be a teleconference if needed. The commissioner was looking for a Practice Manager or Nurse that would be interested in taking part and asked anyone who was interested to advise Tom Brettell.

ACTION: Members to advise Tom Brettell if their Practice Manager/Nurse would be interested in taking part in the meeting about low risk diabetic foot screening on 19th February.

Minute No SLB-2020-01.007: Item 7 – Ultrasound Guidance

- 7.1 Dr Leah Farrell, Consultant Radiologist from SaTH, attended the meeting to talk about GP Ultrasound. Dr Farrell explained that there had been a steady increase in referrals and therefore a guidance document had been put together to clarify what could be referred as there were quite a few inappropriate referrals received which had created long waiting times. Dr Farrell added that it was also hard to find sonographers across the UK which had added to the problem, but SaTH had taken on two new people who would be starting in the next month or so.
- 7.2 A question was asked about how many ultrasound results were normal and abnormal as if the majority of the results were abnormal it was worth the number of referrals increasing. Dr Farrell was not aware of these figures, but also added that it was not always possible to find anything with some ultrasounds even if there was something wrong e.g. endometriosis.
- 7.3 A question was asked about the box to tick for referrals which states they are for the two week wait pathway as this no longer generated a two week wait referral. Members now had to tick the urgent box. Dr Farrell was not aware of this issue.
- 7.4 Dr Farrell talked through the guidelines for justification of ultrasound requests. She confirmed that if Members had clinical concerns that they stated this on referrals and that an investigation was needed - even if not in the guidelines. Members advised that it would be useful if referrals were rejected to have the name of who rejected the referral so that they were able to contact them if needed. Dr Farrell stated that all rejections should now have a name on them. Dr Beanland stated that a similar guideline document would be useful for x-rays. Dr Farrell advised that all the guidelines were also on iRefer if practices paid for a licence; it was questioned whether iRefer was still funded by the CCG.

ACTION: Tom Brettell to look into whether iRefer was still funded by the CCG.

- 7.5 Members questioned why direct referrals for CT/MRI could not be made following an ultrasound. Dr Farrell thought that this was because of funding; Dr Povey added that this was possibly due to internal funding in the hospital.
- 7.6 A discussion took place about walk-in x-rays, as patients were being sent to A&E if their injury had occurred within two weeks. This increased the burden on A&E when these patients could be easily managed at the walk-in clinic. Dr Farrell stated that she thought this was no longer happening and would feed this information back and look into why this was happening. Members reported that walk-in chest x-rays had been stopped at Ludlow Hospital and Dr Farrell advised that she would investigate the reason for this.

ACTION: Dr Farrell to find out why patients were being referred to A&E if injuries were within two weeks (from walk-in x-ray).

Dr Farrell to investigate why walk-in chest x-rays had been stopped at Ludlow Hospital.

Minute No SLB-2020-01.008: Item 8 – Any Other Business

- 8.1 Smoking Cessation - Dr Beanland asked about smoking cessation and noted that there was a lot of diversity in what everyone was doing. She asked whether any support could be given or training provided. Dr Povey advised that this had been raised with Rachel Robinson, Director of Public Health, as

this was a service they provided, and the CCG were currently in discussions with Public Health about what could be done. Guidelines had been written by the prescribing team about Champix which stated that GPs should not routinely prescribe this. Dr Bird added that Rachel Robinson attended the last locality meeting and she advised that there wasn't any money available to carry on the service and so Public Health decided to focus on the highest risk group of pregnant mothers instead. A letter had also recently been sent out from Rachel Robinson and Liz Walker, Head of Medicines Management at the CCG, about the Public Health team offering to provide training.

- 8.2 Opiate Addiction Services - Dr Potter stated that she thought there was a problem with opiate addiction in Bridgnorth and asked if other practices thought the same in their areas and if there was an appetite for a service. These patients were not eligible for the Community Substance Misuse Team and there needed to be a better system in place to support these patients. Shola Olowosale advised that the Medicines Management Team had completed some audits a few weeks ago and were hoping that the results may lead to a service being commissioned. Dr Beanland added that she had asked their practice alcohol counsellor if they could provide a service for this, they were happy to but their manager told him not to as this was not commissioned by the CCG. Dr Povey explained that alcohol services were commissioned by Public Health and not the CCG. A suggestion was made to expand the pain management service to include these patients as it would be more suitable for them than attending an addiction service.
- 8.3 February Locality Meeting - Members agreed that the Locality Board meeting would be cancelled in February as there was an LMC (Local Medical Committee) meeting being held the evening before. It was noted that if any agreements on things such as the CCG constitution were needed, that these could be done remotely. The meeting dates for 2020-21 were also agreed and would be circulated to Members.

ACTION: Heather Clark to email Members to confirm meeting cancellation in February and to confirm meeting dates for 2020-21.

Minute No SLB-2020-01.009: Item 9 – Medicines Management – Eclipse Live

- 9.1 Shola Olowosale presented information about the Eclipse Live system and gave a demonstration of the system to Members. The presentation included the following:
- Advice and guidance components - Eclipse Live, Radar and Diabetes Complete
 - How it supports patient safety and CQC requirements
 - How it works – data extracts, dashboard, identification of patients with reversible risk
 - Impact of Eclipse Live on outcomes
 - Alerts and examples of these
 - How it is a stand-alone programme or could be partnered with Scriptswitch
 - Regions already using the system
- 9.2 Shola explained that the blue alerts were currently turned off on the system as these were mainly for monitoring. The main alerts to focus on were the red alerts to help reduce emergency admissions; amber alerts still needed to be addressed but were not as urgent. Members queried the issue of using the system and not following up on the alerts once the information was known. Clare Michell-Harding advised that the information on Eclipse was taken directly from practice systems so was information that was already available on patient records. The system makes it easier to identify these patients that 'slip through the net'.
- 9.3 Catherine Lowe from Bishop's Castle advised that she had been using the system and explained that she set aside time each week to review and action the alerts as appropriate. Going forward administrators at the practice would be completing the weekly and monthly uploads of the practice data. Dr Povey added that he thought the online interface was very good and the system did help practices. Practices were asked to email Shola if they wanted to sign up to use the system.

ACTION: Members to email Shola Olowosale if they are interested in signing up to the Eclipse Live system.

Minute No SLB-2020-01.010: Item 10 – Community Respiratory Pathways

- 10.1 Sarah Pezzaioli and Natasha Carthy attended the meeting to talk about the community respiratory pathways. The Respiratory Service was now a nurse-led service with four elements: COPD (Chronic Obstructive Pulmonary Disease) service, oxygen assessment, pulmonary rehab, and COPD self-management workshops. The team were not yet commissioned to look after any other respiratory conditions other than COPD. There were five nurses in the service (4.2 WTE) to cover five localities. Referrals to any of the services could be made via RAS or via email to the team directly. A template was also available for referrals and this has been asked to be uploaded to EMIS.
- 10.2 The COPD service offered clinics and domiciliary care. There will be weekly clinics in each locality for COPD patients with oxygen assessments every other week. The team will be providing patient discharge

support, education, medication optimisation, and exacerbation management, with an overall aim to help patients self-manage their conditions better. Sarah confirmed that the waiting times for the COPD service was about 2-3 weeks and the oxygen service about 6-12 weeks for an assessment. It was advised that in the future the team were hoping to have a Respiratory Consultant available for MDT (multi-disciplinary team) meetings to manage complex patients, but there were no prescribers in the team at the moment which would be addressed. At the moment the nurses would be asking GPs to make any medication changes, but hoped to manage this in the future.

- 10.3 It was explained that any patient who needed oxygen could be referred but the oxygen service was not an emergency service. Patients would need to have a reason for chronic hypoxia, and if there was no known reason this would need to be investigated first. Sarah asked that if anyone in practices prescribed oxygen it would be helpful for the team to be advised about it to monitor concordance. It was confirmed that the team would only need to know about oxygen for palliative patients if prescribed for an extended period. Dr Beanland asked about the emergency service for winter pressures and how long this was available for. Sarah advised that this was for emergency exacerbation and there was an allocated duty nurse on call Monday-Friday 9am-5pm. The funding for this was only until April 2020 and the team couldn't always guarantee a same day visit.
- 10.4 The pulmonary rehab service was a six week programme where patients are invited to attend a two hour session for education and exercise once a week, and a one hour session for exercise once a week. It was advised that there were two specialist physios this service, but that the waiting list was quite long at the moment due to capacity issues. The educational sessions were working well with outcomes showing improvements.
- 10.5 There was a pilot currently running for COPD self-management workshops, these were group sessions with up to 8 patients. The workshops are delivered in a motivational interviewing manner and the whole team had now been trained on this. Patients attend two workshops, with the first being 3 hours long looking at goal setting. There would then be phone calls every week for four weeks and then a second workshop. The pilot was currently located in Shrewsbury but may be rolled out to other areas if it works well. So far everyone who had attended had achieved their goals and the feedback had been very good.
- 10.6 Dr Beanland asked about heart failure as this was an area that wasn't commissioned. Patients developing heart failure would benefit from rehab to learn breathing techniques. Dr Povey advised that there was some work in progress at the CCG looking into a heart failure service.

ACTION: Tom Brettell to investigate Heart Failure work ongoing at CCG to provide update.

- 10.7 A discussion took place about sleep studies being decommissioned as some patients have had sleep studies but no reports sent back to practices. Some practices had been told that they would have to refer patients for another sleep study out of county. Sarah Pezzaioli confirmed that there were around 92 patients who have had sleep studies that were waiting for them to be reviewed, and SaTH had now accepted this work. Sarah advised that Members could email her if they had any queries about the sleep studies.

Minute No SLB-2020-01.011: Item 11 – Commissioning Update

- 11.1 The Commissioning update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No SLB-2020-01.012: Item 12 – Date of Next Meeting

- 12.1 The next formal meeting will take place on: **Thursday 5 March 2020** at the **Mayfair Community Centre, Church Stretton** at **3.30pm**.
- 12.2 Dates of future meetings:
- | | |
|----------------------------|---|
| Thursday 5 March 2020 | Mayfair Community Centre, Church Stretton |
| Wednesday 6 May 2020 | Bridgnorth Medical Practice |
| Thursday 2 July 2020 | Mayfair Community Centre, Church Stretton |
| Wednesday 2 September 2020 | Bridgnorth Medical Practice |
| Thursday 5 November 2020 | Mayfair Community Centre, Church Stretton |
| Wednesday 6 January 2021 | Bridgnorth Medical Practice |
| Thursday 4 February 2021 | Mayfair Community Centre, Church Stretton |
| Wednesday 3 March 2021 | Bridgnorth Medical Practice |

Signed:
Dr Matthew Bird, Locality Chair

Date: